

Biúró an Ombudsman um
Sheirbhísí Airgeadais



Financial Services
Ombudsman

Complaints Findings relating to Insurance Sector

July to November 2008

Joe Meade

Financial Services Ombudsman

25 November 2008

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Complaints upheld

€325,000 specified illness cover directed to be paid and application of Insurance Company's 'loss of independence' test criticised

The Complainant's specified illness policy provided life cover of €325,000, and independent (as distinct from accelerated) specified illness cover of €325,000. The complainant who had been seriously injured in a horrific accident, in which his two friends died, complained that the insurers would not pay him the lump sum benefit he felt he was due.

The insurers took the view that the Complainant did not qualify for benefit under the heading of '*Loss of Independence*'. The Company indicated that whilst the Complainant's injuries limited his physical capacity and his intellectual ability had been reduced as a result of the accident, nevertheless in its opinion, the Complainant did not satisfy the test in the policy document for loss of independence, either on the physical front, or on the basis of intellectual impairment.

The evidence considered by the Ombudsman showed that following the accident the Complainant had suffered a post-traumatic amnesic state for a period of 6 days. His first recollection was from a time almost a week after the accident, and his behaviour in hospital was erratic, showing concern for matters relating to his business, but being unable to retain any detail in relation to the chronology of his day, i.e. who had visited him etc. The Complainant's injuries had left him unable to bend, preventing him from sitting or standing in one position for any length of time, making it immensely difficult for him to move from a standing position to a lying down position and he complained of suffering pain to his groin when moving from a sitting position to standing. The Complainant had reduced mobility and pain in his left arm, causing pain when lifting. He had paraesthesia in the fingertips of his left hand, though it was noted that he was right hand dominant. He had episodic sternal pain and stiffness in his big toe (which had been broken) which appeared to affect his ability to balance. The evidence also recorded that the Complainant suffered frequent nightmares and panic attacks; he continued to suffer severe affects of post-traumatic stress disorder while psychological therapy had been discontinued as it had proved emotionally difficult for him.

In coming to his Finding the Ombudsman considered the following matters

- *The test set out in the policy document for loss of independence, was firstly considered on a physical basis. The test specified that for a policyholder to satisfy the test, he/she was required to be permanently unable to carry out three of the six activities listed. The Ombudsman indicated a concern that such a test might well prove to be unfair as the tasks listed, e.g. 'walk 100 metres', offered no indication of an acceptable timeframe, it failed to indicate whether the walking surface should be flat and even, similar to interior flooring, and indeed it did not specify whether the use of a crutch or walking aid was acceptable for the purpose of 'passing' such a test. In the particular*

circumstances of the case, however, the Ombudsman did not consider it necessary to make any finding specifically in relation to this physical test.

- *The Ombudsman found that the Company's own assessor had reported that the Complainant 'failed' in the test of being able to 'put on or take off all necessary items of clothing' albeit that he could dress himself in a basic sense and could 'get by' in doing without socks and wearing slip-on shoes. The assessor had also reported to the Company that in her opinion the Complainant 'failed' in the test of being able to 'wash yourself all over', owing to his inability to bend and reach below thigh level; various washing aids had been recommended to assist the Complainant in that regard, together with regular visits to a podiatrist, as the Complainant could not reach his toes. The Ombudsman did not accept the Company's opinion in those circumstances that the Complainant was 'able' to complete these two tasks.*
- *In addition, the Ombudsman found that it was unreasonable of the Company to form the opinion that the Complainant could 'climb stairs' when the medical report to hand recorded that the Complainant had difficulty with negotiating even the single step to enable him to use his own shower (preferring instead to use the opportunity, when driven to the gym, to use the floor level showering facilities). The evidence recorded that the Complainant had taken to regularly sleeping downstairs, rather than negotiating the stairs in his home; he had reported having fallen on occasion when trying to do so. Indeed the Complainant's assessor had remarked that the Complainant's descent of the stairs in his own home was 'unsafe'. The Ombudsman found in those circumstances that the Complainant met the criteria in the policy document for "loss of independence" on a physical basis, insofar as he was unable to carry out three of the six tests listed.*
- *In relation to the test for intellectual impairment, the definition in the policy document was again considered, and in addition, consideration was given to the explanation offered by the policy document 'In Simpler Terms' (noting that the policy had been awarded the 'crystal mark' for honesty and clarity, by the Plain English Society). The policy explanation, in simpler terms, referred to the need for 'continued supervision and help of another person' and advised that with regard to the standard tests for measuring elements of brain function (such as awareness of time and place, language, behavioural changes, personality changes, concentration and short and long term memory loss) if a policyholder failed such tests then he/she would be likely to have difficulty with everyday activities such as handling basic household finances, taking prescribed medication and being able to answer the 'phone and take a message. The Ombudsman noted that these were precisely the problems which the Complainant faced on a daily basis, owing to the significance of his cognitive deficits as*

diagnosed. His mother and sister were providing ongoing and continued support to him in relation to his financial affairs, his mother needed to arrange his medication in a weekly medication box and whilst the Complainant was capable of answering the 'phone and taking a message, his short term memory loss was such that he was unlikely to later remember that he had done so.

The Ombudsman also reviewed and was highly critical of the Company's Final Response Letter to the Complainant rejecting his complaint. It stated that in order to meet the definition of loss of independence on the ground of intellectual impairment, the Company would expect an inability on the part of the Complainant to use a computer, to use a mobile phone and to arrange social meetings. In circumstances where no such inabilities were referred to in the policy document itself the Ombudsman held that it was highly inappropriate of the Company to introduce this additional test in the course of assessing the Complainant's claim. Furthermore the Ombudsman stated that such minor tasks were capable of completion by any average pre-teenage child, and could not in any way be indicative of a capacity for independent living.

The Ombudsman therefore decided that the Company ought to have admitted the Complainant's claim on the basis of loss of independence, both on the physical and also on the intellectual impairment front. Accordingly the Company was directed to admit the Complainant's claim for specified illness benefit of €325,000.

€250,000 investment in a geared property fund was unsuitable and was to be refunded

The Complainant was annoyed because she maintained she was never advised in the course of her discussions with the representative of an investment intermediary Company that an insurance firm's UK Geared Property Fund recommended to her was 'high risk' and her investment of €250,000 had significantly fallen in value by over €100,000 in a year.

The Complainant stated that

- *In December 2006, she was a recently retired teacher, and she sought advice from the Company on investment options for a lump-sum of €85,000. On the basis of the Company's advice, she invested her lump-sum in a With-Profits Fund, which offered a guarantee on the 10th anniversary of the investment and she had no complaint about that investment.*
- *However in the course of her discussions she told the Company's representative that she had been approved for a loan of €250,000 to be mortgaged on her family home, as she had been thinking of purchasing an apartment in Paris. She was unsure of this strategy however as she felt that the returns might not justify the cost of the borrowing involved. On the basis of the Company's advice thereafter, the Complainant invested the €250,000 borrowed monies- €85,000*

initially and €165,000 a week later- in December 2006, in a Geared Property Fund.

- *By August 2007, following discussions with an accountant friend she understood that investment of borrowed monies in a Unit Linked Fund presented a serious risk as the returns after annual charges and exit taxes were unlikely to exceed the cost of borrowing, and therefore on balance, such an investment was more likely to result in a loss, than a profit. It was only then she understood that investment in a Geared Property Fund was very high risk, but this was not explained to her at the time the recommendation was made by the Company.*
- *She sought to have the original amount of the investment returned to her and to be recouped interest on her borrowings since December 2006.*

On the other hand the Company stated that

- *In December 2006 it carried out a financial review of the Complainant's affairs to enable it to advise her. The Complainant's decision to borrow the sum of €250,000 was made, before she ever sought investment advice, and the Company had no part in the arrangements for the borrowing.*
- *The Complainant had prior experience of investment in property, as she already owned a property in the South of France, and her arrangements for the borrowing indicated to the Company that:*
 - *The Complainant was willing to borrow to invest and was willing to invest in property.*
 - *The Complainant was willing to appreciate the risks associated with investment in property using borrowed funds and was willing to invest for the long-term.*
- *Diversification into a mix of retail, office and industrial properties would represent a better proposition than investment in a single residential property in a single location in France. It advised the Complainant that the Geared version of the U.K. Property Fund was about to close and an explanation was given as to the difference between Geared and Un-g geared Funds. The risk factors associated with gearing and how an investment of €250,000 would give exposure to €500,000 of an investment, albeit with increased risks was explained. It also pointed out that borrowing within the Fund was non-recourse and that her exposure would therefore be limited to the amount invested.*
- *It believed that both the Complainant's investments were fundamentally sound. These were taken out for the medium to long-term and the question of whether the advice given was good or bad, would only be answered with the fullness of time.*

In investigating the case the Ombudsman noted that while the financial review carried out by the Company in December 2006 identified the Complainant's risk tolerance as 'medium', it was therefore unclear how the Company formed the opinion that the Geared Property Fund was an attractive proposition to her, as an investment because

- *The published Investment Fund Fact Sheet (showing performance figures to 30 June 2006), made it clear that whilst the Property Fund carried a risk profile of 'medium', the Geared U.K. Property Fund nevertheless carried a risk profile of 'medium to high', as the gearing element, i.e. the exposure to double the growth potential of the sum invested, meant that, conversely, the risk involved would be higher.*
- *The financial review certainly showed that the Complainant was comfortable financially, in the sense that there was very little in the way of a mortgage remaining on her family home, which had a substantial value, and she had a comfortable income from her pension and supplementary 'grind' work. It was nevertheless strange, in the Ombudsman's opinion, that the Company formed the opinion that an individual reliant for the most part on pension income, was a suitable candidate for the investment of a substantial sum of borrowed money, in a product which carried a risk profile which was higher than the risk tolerance recorded for her.*

The Ombudsman considered in detail the terms of the suitability statement for the Complainant's investment, which had been included in the Company's papers (and which he noted was not signed by the Complainant). The copy of the document furnished to his office by the Complainant was dated by the Company's representative as January 2007, a month after the initial investment instalment of €85,000 and 3 weeks after the second investment of €165,000. The suitability statement recorded that the Geared Property Fund was suitable for the following reasons:-

- *'You can afford to invest for a 5 year period. You wish to invest in an asset class with potential for strong capital appreciation that lacks the volatility associated with equity markets. The U.K. Geared Property Fund has a gearing ratio of 1:1 which allows you to increase your exposure and potential return.*
- *You are prepared to take on board the risks associated with investment in property. The cost of borrowing within the Fund is reasonable, i.e. Euribor plus 1% and the lending within the Fund is on a non-recourse basis.'*

The Ombudsman was somewhat at a loss to appreciate why these features of the Bond made it suitable to the Complainant's circumstances because

- *The Complainant's 'capacity' to raise borrowings on an interest only basis, mortgaged on her family home, did not equate with such a step necessarily representing prudent action, nor did this capacity in itself, make the product suitable to her situation. The advice that this particular asset class 'lacks the volatility' associated with equity markets was, in his opinion, nothing short of disingenuous; the 'gearing' of the investment was such that property market*

movements were magnified, and consequently, the effects of market movements on the investment were more volatile, both on the positive and indeed also on the negative fronts.

- *The suitability statement advised that the cost of the borrowing was reasonable, but the Company's file gave no indication of any computation carried out in the course of the Company's advice, to establish the level of growth which would be required by the investment, to enable the Complainant's investment to show any profit after (i) the payment of interest charges on the borrowings and (ii) payment of the 1.5% annual fund management charge, in addition to the exit taxes.*

Furthermore the Ombudsman was also surprised and concerned that although the Complainant met with the Company's representative in early December 2006, when the *'Agreed Financial Priorities for Immediate Action'* were recorded in the financial review as *'Rabo deposit – wants to invest for real growth over the long-term to age 65'*, nevertheless no action was then taken to proceed with the Complainant's investment in the recommended With Profits Policy, as a priority. Instead, the €85,000 then available to the Complainant was invested 9 days later in the Geared Property Fund. Approximately 2 weeks later when the Complainant's borrowings became available, an additional sum of €165,000 was invested in a similar fashion, and it was not until mid January 2007 that the Complainant's initial financial priority was put into effect, with the investment of €85,000 long-term in the With Profits Policy. This may be explained by the Company's comment in its December 2007 response letter to the Complainant, that *'the geared version of this Fund was about to close'*.

As regards the Company's suggestion that the question of whether the advice given was good or bad would only be answered in the fullness of time, the Ombudsman did not accept this. An investment product maturing at a loss does not of itself indicate that advice given to proceed with an investment in that product was bad advice. Such a product might well indeed have been ideally suited to the investor's circumstances and requirements, but might have failed to perform as anticipated. Conversely, simply because in the fullness of time a product shows significant growth, does not in itself indicate that the product was suitable to the investor if, e.g. the risk level involved was unsuitable, or if indeed the investment timeframe was not suited to that investor's circumstances. What are appropriate at the point of sale are really what matters and not a pious hope for possible success in the future.

Having considered the evidence before him, the Ombudsman was of the opinion that the investment product recommended by the Company i.e. the Geared Property Fund Investment, was simply not suitable to the Complainant's circumstances. She was retired from work, supplementing her pension income with income from lodgers and by carrying out some *'grinds'* work, but she did not have large amounts of money available to put at high risk. The Ombudsman also stated that there is a world of difference between a person making their own bad investment decisions, and a person being advised to invest in an investment by a Financial Service Provider which is not suitable and which carries substantial risks. He also held that there is a different risk level between investing in a single property and investing in a Geared Property Fund.

Accordingly he directed the Company to reimburse the Complainant the sum of €250,000 which she invested in December 2006. He also held that the interest charged to the Complainant on her borrowings since December 2006 was really a matter for herself as she was willing to and did drawdown those funds.

Though the finding of the Ombudsman was appealed to the High Court by the Company the Ombudsman was informed later that the appeal was being withdrawn by the Company.

Fall of €13,500 in €100,000 investment after only one year merits an award of €3,000

A couple complained that their retirement lump-sum investment of €100,000 in an Insurance Bond in February 2007 had fallen in value by €13,500 after just one year. They had a long standing and fruitful relationship with the Company. They complained that when seeking investment advice from the Company in 2007, they had made clear their requirements of (i) security (ii) a return to supplement their pension payments and (iii) an ability to withdraw funds without penalty, if they needed access to their money before the recommended investment term had elapsed. The Complainants said that they proceeded to make the investment as they were told by the Company that the product was secure, offering a return better than a deposit account.

The Company advised that the investors had undertaken a focused Financial Review in February 2007 and had confirmed that they understood that the investment was for the longer term and would be subject to investment risk and would fluctuate in value. The Company said that the Complainants were willing to invest in equities as well as other asset classes, in order to achieve the required growth in their investment.

The Ombudsman following his detailed consideration to the documentary evidence available arising from the parties' discussions in February 2007, including the Financial Review was critical of the Company's sales process, in a number of respects. He found that the '*focused Financial Review*' referred to show no evidence of any particular focus on issues such as the level of acceptable investment risk, or preferred investment term. He noted that the company's own understanding of the precise risk tolerance of the Complainants was confused and had led to incorrect information issuing initially to the Complainants, after they had complained to the Company. He also expressed significant dissatisfaction with the Company's practice of providing essential information as regards the features/elements attaching to various different risk categories, by way of pages on the screen of a lap-top or a desk-top computer, in paragraphs printed in a size which made it more difficult, in his opinion, for a potential investor to absorb the information in question.

The Ombudsman was also severely critical of the terminology used by the Company to classify risk, categories which included '100% Growth' and '100% Active Growth', which the Ombudsman found carried connotations only of the positive, without any real sense of an alert to the risk involved that negative growth could result in significant loss in value. The Ombudsman also found that the *Reasons Why Document*, was inadequate in respect of its contents and he indicated that these

aspects of the Company's sales process and sales documentation which he had highlighted in his report, required the Company's urgent attention.

However on the particular facts before him, and in particular on the Complainants' own evidence, the Ombudsman found that in February 2007 the Complainants had understood that the suggested investment could rise or fall in value, but that they had taken the view that, on balance, on a historical basis, the investment was 'safe' and had elected to accept the risk involved, with a view to the potential reward. The Ombudsman noted, in addition, that after the investment had been made, the documentation issued by the Company to the Complainants had reminded them that the investment was designed for the longer term and that the capital and the return were not guaranteed.

The Ombudsman found in those circumstances that the Complainants were not entitled to the full €13,500 loss when they cashed in the investment after a period of one year only. Nevertheless, in circumstances where the Company's documentation had been confusing and lacking in clarity, he directed the Company to make a compensatory payment of €3,000 to the Complainants which they were pleased with.

The Ombudsman also drew the Financial Regulator's attention to his concerns about the sales documentation and risk categorisation as it may also apply to other investors.

Reduction from 50% to 20% in no claims bonus for minor car damage was too harsh and Ombudsman directs it to be reduced to 5% and only for one year

This complaint, from a lady in her mid 70s, stemmed from the loss of her no claims bonus as a result of a third party claim against her motor insurance policy following a road traffic accident. The Complainant acknowledged that she bumped into the back of the third party's car but denied that she had caused any damage, contending that the damage claimed must have pre-dated the accident as evidenced by her own undamaged vehicle. The repair cost for the other car was €850. As a result the Complainant's No Claims discount was reduced from 50% to 20%.

On examination of the submissions made, the Ombudsman was satisfied that the Company had acted in accordance with the subrogation clause contained in the policy document, which permitted the Company to take over and defend or settle any claim made against the Complainant's policy, and further permitted the Company the discretion to decide how any claim was to be settled. The papers showed that the claim had been assessed promptly and that the third party vehicle had been inspected by the Company's suitably qualified motor engineer who determined that there was damage consistent with the incident in question.

However the Complainant maintained that an inspection of her car would have supported her case that she was not responsible for the damage. The Company indicated that it would not normally be necessary to do this unless she herself had submitted a claim for damage, which in this case she had not done. Furthermore the Company said it had no evidence that the Complainant had made a request for her vehicle to be inspected but she strongly maintained otherwise.

In the circumstances of the case, the Ombudsman found that the damage was quite slight and the sum for repairs not significant. He also took account of the Complainant's age, her genuine belief that no damage was caused and he was satisfied that she had contacted the Company to inspect her car. He felt that the loss of 30% on the No Claims Discount was rather harsh to say the least and accordingly he reduced the loss to 5%, to be applied for one year only.

Allegation of €35,000 Investment Bond fraud against a foreign broker merits an award of €25,000 by an Irish insurance company

In 2001 the Complainant, while living abroad, invested €35,000 with an Irish based Insurance Company through a Broker (the Broker did not fall within the Ombudsman's jurisdiction as he was based in South Africa). The Complainant stated that the Broker had *fraudulently* encashed the policy in 2003. The Complainant argued that the Company was some way to blame for the loss of his monies. The Company denied any responsibility for the loss. It was alleged that the Broker submitted a fraudulent instruction to the Company requesting liquidation of the funds to a bank account, which he had opened in the name of the Complainant, by using an altered passport and copies of utility documents. The Broker was said to have then proceeded to control the dispersion of the funds, mostly to his own bank account, but also to two other parties, to whom it was said, it appeared to have owed monies.

The Complainant questioned the ease with which the Broker managed to submit invalid and improperly certified '*signature bearing*' passport documentation, the lack of verification or confirmation correspondence to them as clients at the time of the *fraudulent* encashment and the apparent disregard for the safe keeping of the, *fraudulent*, documents. The Complainant's argument was that these alleged irregularities indicated that whatever procedures the Company had in place at the time, had failed him. The Complainant stated that as a result of the Company's failures, he was robbed of his investment without his knowledge.

Having examined all the evidence the Ombudsman pointed out that the general position where an investor devolves the handling of affairs to an independent advisor is that the advisor would deal directly with the Company and instruct it regarding the investment (this would include the receipt of all correspondence connected with the investment from the Company and transferring of same to the investor). A Company and its agents would adhere within reason to the instructions of that Independent Advisor. The Complainant here appointed, in writing, the Broker to handle his investment and deal with correspondence relating to same on his behalf. A certain amount of trust was placed in the broker by all the parties concerned. The Ombudsman found that a number of parties had dealings with the investment in question but from what was alleged there was only one main wrongdoer i.e. the Broker. While checks and balances may frustrate a fraudster in his/her activities, there are circumstances where prevention of such activities may prove near impossible and unfortunately, this appeared to be one such case.

When the Ombudsman contacted the Company regarding the safeguards it had in place against fraud the Company specifically stated it was not at fault. However

having regard to the particular circumstances of the case, the Company offered to make an *ex gratia* award of €25,000 in full and final settlement of the dispute. The Ombudsman felt that the Company's offer was fair and reasonable and €25,000 was paid to the Complainant.

PRSA charging structure and complaint handling by the Company was highly unsatisfactory- €14,000 award and refund of premiums

The Complainant effected in May 2006 a PRSA commencing on 1 July 2006. The monthly premiums were initially €1,000, later increased to €1,500 while a single premium of €13,950 was also paid into the account in July 2006. The Complainant received a Statement of Account as at 30 June 2007 from the Company specifying a total of €31,000 paid into the account, but with an account value of only €17,500. The Complainant was very unhappy with the performance and the charging structure of the PRSA which he alleged was changed by the field sales agent from what was originally agreed. The PRSA was made 'paid-up' in September 2007 as the Complainant stopped paying premiums.

The Complainant complained to the Ombudsman in January 2008. He was very unhappy with how the Company was dealing with his concerns from July 2007 after he asked the Company for the option to have the charges changed back to what was agreed or to have the premiums transferred to another provider. When informed by the Company that the Revenue Commissioners would only sanction a transfer of the current value of the PRSA on the grounds that the 'cooling off' period had expired, the Complainant maintained that he never had been offered a 'cooling off' period.

The Company on the other hand submitted that it found nothing untoward in the sales or advice process. Regarding commission paid, the Company maintained that its commission rates were market standard. The Company also submitted that it approached the Revenue Commissioners to allow the Company to refund in full all contributions made, but that this was declined. It stated that its offer in November 2007 to the Complainant to reverse the commission on the single premium was not acceptable to the Complainant.

The Company files submitted and reviewed by the Ombudsman however indicated that the Compliance Department had acknowledged in correspondence to both the Revenue Commissioners and the Complainant that the charges were not explained to the Complainant. The Ombudsman therefore stated that he found it difficult to reconcile the Company's submission, that nothing untoward was found in the sales process, with the earlier position taken by its Compliance Department that the charges were not explained to the Complainant.

With regard to the manner in which the complaint was handled by the Company, the Ombudsman found that the level of service provided to the Complainant was unacceptable. He also found that the Company had not provided a satisfactory explanation to either the Complainant or his office as to why the charging structure of the PRSA was changed from that which was discussed at the sales meeting in May 2006.

It was also evident to the Ombudsman that the Complainant had spent a considerable amount of time corresponding with the Company since his initial complaint arose in July 2007 and he noted that he was anxious to set up a new pension arrangement as he had a further €10,000 to invest in same.

Taking account of all the circumstances the Ombudsman directed in July 2008 that the following amounts be paid to the Complainant:-

€7,500 for poor service in dealing with the Complainant both at the point of sale and at later stages while €6,556 of commission earned was to be refunded also.

A refund of premiums which had been paid but the Company had to take account of the fact that the Revenue Commissioners had certain restrictions regarding full refunds.

Interest was to be paid at the rate of 4% from September 2007 when the monthly premiums stopped.

The Financial Regulator's Consumer Protection Code which came into force on 1 July 2007 details how complaints should be properly addressed by companies. As the Company's actions, in dealing with the complaint after it was made July 2007, was not of the highest standard the Ombudsman decided to refer this matter to the Financial Regulator as there may be other instances with this Company where similar situations could have arisen.

Sale of €20,000 assurance policy did not meet sale guidelines- €5,000 award

The Complainant proposed for life cover (€20,000) on his wife in 2004. The Complainant's wife sadly died in March 2007. The claim for death benefit under the policy was declined by the Company and the policy was voided for non-disclosure of a medical condition. The Company had offered to return the €400 paid in premiums.

The Complainant was sold the policy by a Company representative who called to the Complainant's home in April 2004. His son and a neighbour were in the house at that time and also met the representative. The Complainant's wife was upstairs in the bedroom reading and did not meet the Company representative until she was called downstairs by her husband to sign the proposal form. It was argued that perhaps given their maturity (early sixties) the policyholders trusted that the information the Company representative sought from them was all the information that was required. They were said to have answered the questions asked and signed the form where they were told to sign. There was no dispute that the Complainant's wife had a significant health history.

The Ombudsman noted that the Complainant and his wife signed the application form which included a declaration to the effect that they had read and understood the 'Important Notes' and that to the best of their knowledge and belief, all the statements made in the proposal were true and that they did not withhold any material information. The declination of this claim rested on the fact that the

Complainant's wife's **full** medical history had **not** been revealed under medical questions set out on the application form. The consequence of a non-disclosure on the application was clearly set out in the declaration signed by the policyholders i.e.: rejection of a claim.

However the Ombudsman noted that if the Company's representative had done all that was required of him i.e. made sure that the person to be insured (the Complainant's wife) was asked the questions set out on the proposal form, the situation may have been different. The Company admitted that the sale did not appear to have been completed in accordance with the guidelines laid down for its representatives.

Because of the non disclosure, the Ombudsman could not uphold the claim for benefit under the policy but having regard to how the policy was sold he directed the Company to pay an award of €5,000 instead of returning the €400 premiums paid.

This case again highlights the importance of everybody reading over a document before signing same but above all for sales personnel to be clear and precise on all matters. It is the responsibility of the person/s seeking insurance to read the information on the application to ensure it is correct before signing. If an insured person/s fails to disclose circumstances which would have influenced the decision of the insurance company in fixing a premium or in determining whether or not to accept the risk, the insurance company has an arguable case to decline liability under the policy.

Permanent Health Insurance benefit confusion resolved and €91,000 arrears paid

The Complainant submitted a claim to a Company under a Group Permanent Health Insurance Scheme which was paid from 1998 until September 2002. The Complainant disputed the Company's decision to cease benefits and numerous letters of correspondence arose between both parties. He complained to the Ombudsman in July 2007 about the matter.

The Complainant confirmed that after the cessation of benefits in September 2002, he was obliged to work part-time. The Company requested financial evidence of the Complainant's income earned since he started part-time working, but the Complainant was unable to meet these requests, as the income earned by him was submitted to the Revenue Commissioners as part of his wife's tax returns. The Company agreed to use 50% of the declared income earned for the part-time job in order to calculate the benefits payable.

The Company offered in December 2007, when the Ombudsman was dealing with the complaint, to reinstate the Complainant's proportionate benefit and backdate it to September 2002. The Complainant was dissatisfied with the Company's offer, was disappointed with the delays in receiving benefits, felt that he was being mistreated by the Company and wanted interest to be paid on the arrears.

The Ombudsman noted that there was some confusion on the Complainant's part regarding the overall proportionate benefit payable. However having examined the

detailed breakdown of the Company's settlement offer the Ombudsman was satisfied that the Complainant's claim was correctly assessed in accordance with the policy terms and that the offer was fair and reasonable.

The Ombudsman did have some concerns regarding the length of time taken by the Company to assess the claim and the resultant inconvenience caused to the Complainant. He awarded a once-off payment of €500 to the Complainant in view of this.

Following the Ombudsman's finding the Company in July 2008 paid the arrears of €91,000 and confirmed that benefits would be paid on a monthly basis going forward. The Ombudsman also pointed out to the Complainant that it was at the Company's discretion to review this claim in the future by way of medical assessment in accordance with the policy conditions.

Personal Accident Benefit definition was not clear - 50% benefit to be paid as a result

The issue which arose in this complaint was the whether the Company was entitled to decline the Complainant's claim for Personal Accident Benefit, on the grounds that the circumstances which resulted in the Complainant's injury did not meet the criteria of accident under the policy. The Complainant submitted that, while lifting a box of tiles he felt a sharp pain in his back and numbness in his leg, resulting in an acute disc bulge with bilateral sciatica and limitation of movement in his spine.

On the other hand, the Company argued that it did not accept that the injury was as a result of an accident and that an injury resulting from the lifting and carrying of the box of tiles was the consequence of a deliberate action and was not the result of an accident. Whilst accepting that the injury was the unforeseeable result of a deliberate act, the Company stated that it did not accept that that the deliberate act of lifting and carrying tiles constituted an accident.

The policy in question provided that entitlement to 'Personal Accident Benefit' arises due to 'an accident' and the 'bodily injury' occurred 'through accidental means'. In this regard, the Ombudsman took account of the policy wording and the level of guidance it provided in the event of a claim being submitted under the 'Personal Accident' section. The Ombudsman also examined the definitions provided in the policy. From the evidence submitted, there was no definition of 'accident' or 'accidental means' contained in the policy documentation.

The Ombudsman held that the inclusion of such a definition would have provided more clarity as to the level of cover under the policy and avoided confusion when the claim was submitted. Taking into account the overall circumstances of this dispute, the Ombudsman directed the Company to pay the Complainant 50% of the benefit that would have been paid had the claim been admitted.

Travel Insurance

(a) Definition of 'relative'/'step-parent'; Ombudsman directs 75% refund of €1,100 claim

The Complainant planned a holiday for August 2007 and purchased a travel insurance policy for same in April 2007. Her stepfather became ill in July 2007 and sadly passed away shortly afterwards. The Complainant cancelled her holiday as a result and submitted a claim to the insurance company amounting to €1,100. The Company rejected the claim, stating that while the policy did provide cover for the death or illness of a 'relative', a step-parent was not included under the definition of 'relative'.

The Ombudsman noted the close relationship between the Complainant and her step-father as her step-father had been married to her mother for 35 years. He also considered the meaning of 'relative' as defined in the policy. Of particular note was the policy's reference to 'parent' without specifically mentioning 'step-parent'. The Ombudsman considered the normal, everyday meaning of step-parent, as well as dictionary definitions of same, and whether 'parent' could be taken to include 'step-parent'.

Taking into account the overall circumstances of the case and the possible confusion that could arise from the policy definition of 'relative', the Ombudsman directed the Company to pay 75% of the claim submitted.

(b) Cancellation of holiday due to pre-existing illness merits 50% award of Stg£1,500

The complainant had purchased in September 2006 a holiday for August 2007 and had also taken out holiday insurance. The issue for determination in this dispute was whether the Company was entitled to decline the Complainant's claim for the cancellation of her holiday - Stg£3,000 - on the grounds that the primary cause of the Complainant's father's death, heart disease, was a pre-existing condition suffered prior to the policy issue date, the Complainant having failed to disclose the pre-existing medical condition to its Medical Pre-Screening Company.

According to the Complainant, no post mortem was carried out at her mother's request, the on-call GP noting the cause of death on the death certificate as cardiac arrest. It was stated that, whilst the hospital specialist and the GP who initially referred her father to the hospital both confirmed to her that her father's death was directly related to the brain tumour, and that the most probable cause of death would have been a blood clot on his lungs based on swelling of her father's legs days before his passing, this could not be proven as no post mortem was carried out

The Company on the other hand submitted that it was a policy condition that in order for cover to be accepted in relation to pre-existing medical condition, an insured must at inception of the applicable policy, must contact its medical pre-screening company and disclose any pre-existing medical condition and/or material facts relevant to the insured or a relative. According to the Company, it based its decision on the medical evidence as submitted and the information provided stated that the Complainant's father's primary cause of death was due heart disease, with a secondary cause of death as a brain tumour. It submitted that the primary cause of the Complainant's father's death was a pre-existing condition suffered prior to the policy issue date.

In the context of this complaint, the section of the Complainant's policy entitled 'Pre-Existing Medical Conditions' specified that if an insured person was aware that a relative had received any form of medical advice, treatment or medication for any heart or circulatory related condition then the insured person must contact the Medical Pre-Screening company in order to arrange cover for that condition. It also stated that failure to advise the Medical Pre-Screening company of a pre-existing medical condition would result in claims not being paid.

The medical evidence indicated that the Complainant's father, who had heart disease since 2005, did have a pre-existing medical condition which the Complainant failed to advise to the Company's Medical Pre-Screening company. The effect of the Complainant's failure to disclose her father's pre-existing medical condition was that this material fact would entitle the Company to decline a claim under the policy. However the evidence submitted to the Ombudsman - from the Complainant's father's GP and the treating hospital - indicated that the medical condition which caused the Complainant to cancel her holiday in July 2007, and which subsequently gave rise to the claim for the cancellation of the holiday, was mainly her father's brain tumour, the symptoms of which only commenced in June 2007.

While accepting that the Company had justifiable grounds for refusing the claim on the grounds of non disclosure nevertheless the Ombudsman taking into account all the circumstances of the case and bearing in mind what was fair and reasonable, found that the Complainant was entitled to 50% of the benefit payable under the policy in respect of the cancellation of the holiday.

Complaints not upheld

Provider was entitled to alter inpatient only medical insurance cover

The Complainant had an Inpatient only medical insurance policy with a Health Insurance Company. The Complainant acquired the stand alone policy so as to ensure that she would have adequate maternity cover. The policy provided unlimited coverage for routine maternity and unlimited coverage for complications of childbirth.

At renewal the Company introduced limits on maternity benefits. The Company further provided maternity cover only as an optional extra which had to be taken out together with outpatient cover. The Complainant argued that the Company had breached the implied condition of utmost good faith in altering the terms of cover at renewal. Further the Complainant argued that twelve months notice of these changes should have been provided so as to enable policyholders to maintain continuity of cover for such benefits should they decide to move to an alternative insurance provider.

The Ombudsman found that the renewal of an annual non-life insurance policy constitutes a new contract for both parties involved. Insurance Companies are entitled to assess the risk involved and alter the terms of the contract upon renewal.

It was further noted that the policy document itself included a clear condition allowing the Company to reassess and change cover terms at renewal. In regard to the notice period the Ombudsman found that the Company in this instant case had complied with the requirements of the Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007 in relation to the applicable time periods. Further the Company had in this instant case allowed the Complainant an additional sixty day period to review the details of the renewal terms. Accordingly the Complaint was not upheld.

Medical Expenses Insurance complaint not upheld due to Pre-Existing Condition Waiting Period

The Complainant purchased a health insurance policy in January 2004. He was 52 at the time of purchasing same. The Complainant's policy contains a 'pre-existing condition waiting period'. This means that a set amount of time has to pass before the Company pays for claims relating to conditions that existed before taking out the insurance. The length of the 'pre-existing waiting condition period' depends on the age of the policyholder at the time of purchasing the insurance.

In February 2007 the Complainant claimed under the policy for expenses relating to arthritis. The Company declined the claim, stating that the Complainant had suffered from arthritis before purchasing the policy. The Company stated that the 'pre-existing condition waiting period' had to elapse before cover could be granted for treatment relating to arthritis. The Complainant disputed the Company's decision.

The Ombudsman referred to the 'pre-existing waiting period' in the policy documentation. He noted that the Complainant was 52 at the time of buying the cover and therefore a 5 year 'pre-existing condition waiting period' applied to the Complainant's policy. The Ombudsman examined the medical evidence submitted and concluded that the Complainant had suffered from arthritis since 2002. This was a relevant factor and the Ombudsman decided that the Complainant's arthritis was a 'pre-existing condition' and the waiting period would apply to claims for arthritis. The Ombudsman found that as the policy was taken out in January 2004, the waiting period would expire in January 2009.

While the Ombudsman was very mindful of the medical expense incurred by the Complainant, he found that the Company was correct in declining the claim on the stated grounds.

Daughter led the Company to believe that she was making €90,000 investment solely on her own behalf and not on behalf of her 92 year old mother

In March 2007, following discussions with the Company's advisor, a teacher in her mid 40s placed €60,000 in an insurance investment fund and also commenced a fortnightly contribution from her salary. She had had a long standing satisfactory investment relationship with the advisor. The money had been in a low interest earning deposit account and she wanted a higher return. Two months later she placed another €30,000 in the investment. However early in 2008 she notified the Company

that she had never been told that her capital would be at risk, and she was shocked that the investment had fallen significantly in value. The Complainant maintained that the Company had been advised in 2007, that the money being invested was her 92 year old elderly mother's - she was her only child- and that any investment risking that money would be unsuitable. She also maintained that she had been given to believe that the return would be subject to market conditions, but that the capital lump-sum itself would be safe. The Complainant said that she had never been told about any cooling-off period and she advised that the money was now required for her mother's care. She sought to have her losses made good by the Company.

The Company however maintained that the manner, in which the investment policy would operate, had been clearly explained to the Complainant in 2007 and that, in fact, the advisor's handwritten notes bore this out. The Company stated that the chosen investment term of 17 years had been selected to coincide with the commencement in university of the younger two of the Complainant's children, though the money could be accessed at any time, without penalty. The Company also vehemently refuted the Complainant's suggestion that she had said that it was her elderly mother's money. The Company indicated that had any such suggestion been made in 2007, the Company would have met with the Complainant's mother herself, in order to discuss her requirements in relation to an investment.

The Ombudsman found that in March 2007, whatever the original source of the funds, the Complainant was essentially treating those funds as her own, and had proceeded on her own behalf to make the investment decision. The suggestion that the money belonged to the Complainant's elderly mother was simply not borne out by the evidence. All the documentation completed identified the Complainant as the client and the two lump-sums invested had been drawn respectively from the Complainant's own bank account and her joint account with her husband. He was satisfied on the evidence before him that the Complainant led the Company to believe that she was making the investment solely on her own behalf.

The Ombudsman also found that it was clear from the evidence that after both investments in March and May 2007 respectively, the Complainant had been issued with correspondence offering her a 30 day cooling-off period during which she could cancel the investment.

The Ombudsman noted that the Financial Health Check carried out in March 2007 recorded that whilst the Complainant advised of a 'low' risk tolerance in relation to pension, her risk tolerance for savings was, by way of comparison, 'moderate'. The investment strategy chosen by the Complainant, according to the Financial Health Check, was 'medium risk' for 100% of the investment monies. The Ombudsman also noted that the Complainant stated that she believed at all times that her capital would not be at risk and that it was only 'benefits' which would fluctuate in value, i.e. the return, as distinct from the capital lump-sum. She admitted nevertheless that *'historically, these funds had never dropped, had always performed well and had positive projected returns'*. It seemed therefore to the Ombudsman that the Complainant's belief that the Fund was 'safe', may have stemmed from the historical performance figures, notwithstanding the explanation in the product brochure that the selection of a 'median' investment strategy *'provides the potential for better returns and involves a medium level of risk'*, as opposed to the selection of a conservative

strategy (offering low risk) or an adventurous strategy (involving the ‘highest level of risk). The Ombudsman found, on the basis of the information in the documentation provided to the Complainant that she ought reasonably to have understood that the Plan she had selected would not operate, as she was now suggesting, just like a bank account, except that her return might be higher. In essence the policy she had chosen exposed the money invested to a medium level of risk, in accordance with the ‘Median’ investment strategy she had selected.

The Ombudsman did not uphold the complaint but indicated that if the Complainant’s financial circumstances had changed since 2007, and she now required access to the funds invested, it was a matter for her alone to decide whether to encash the policy sooner than had originally been intended, and crystallize her losses. Otherwise she should consider whether to remain invested for the longer term in the hope of recovering those losses.

SSIA roll over complaint not upheld

The complainant commenced an equity-based Special Savings Incentive Policy with an Insurance Company, from April 2002. He complained in 2008 that he had always believed that the Policy would end after a five year period, in April 2007, when the Government contributions would cease. At the end of the SSIA period in April 2007, however, the Complainant’s Policy was rolled over by the Company and his monthly contributions continued. The Policy then subsequently fell in value and the Complainant argued that the Company should pay him the differential in value, for the loss he had sustained after April 2007.

The Company pointed out that the Complainant had selected an open-ended investment Policy in April 2002, with a recommended investment term of 5-7 years. The product brochure had carried an investment warning that the capital was at risk and that the value of the Policy could fall as well as rise. The Company pointed out that when the Revenue Declaration had been sent to the Complainant for signature in January 2007, he had been reminded in writing that the Policy would continue, unless he contacted the Company to arrange otherwise.

The Ombudsman found that in addition to the warnings given to the Complainant in 2002 that the Policy was designed for a period of 5-7 years, the Company had also in January 2007, written to the Complainant to advise that notwithstanding the end of the SSIA timeframe, the Policy would continue, with ongoing monthly contributions, unless the Complainant advised the Company otherwise in writing.

Having considered the evidence, the Ombudsman found that the Complainant ought reasonably to have been aware of the position with regard to the Policy and the complaint against the Company was not upheld.

Investment loss not upheld as proper notification to transfer funds was not given

The Complainant sought compensation for €8,000 losses incurred as a result of the Company's alleged failure to transfer investment funds amounting to €131,000 at a specific time. The Company stated it did not receive a precise instruction to transfer the funds. This complaint essentially was whether a particular email constituted an instruction to act and transfer funds.

The Complainant stated that in April 2007 he discussed with the Company the possible movement of three investment funds. Later he met with a Company representative in September 2007 and he accepted a recommendation for two funds. The Complainant stated that the representative asked him to email an instruction and that he did this the following day. At a later date in October 2007 when the Complainant discovered that the transfer had not taken place he noted his funds had dropped significantly in value. The Complainant stated that he immediately sent an email to the representative in question requesting that the transfer be made at the rates pertaining in September 2007. The Complainant stated that he had given both a verbal and an emailed instruction, as requested by the representative.

The Company stated that the wording of the Complainant's email of September 2007 did not constitute a specific instruction to transfer funds. The Company stated that the email was a request for a valuation, that the Complainant would consider his position and decide on a course of action after he received the valuations requested. The Company stated that its standard terms and conditions, which issue with each new investment, precluded emailed instructions and that the Complainant had experience in the transfer of funds and the requirement for a signed document as conclusive proof of an individual's intentions.

The email under scrutiny asked for an evaluation for two funds which the Complainant wanted to move to two different funds. In it the Complainant stated he understood that there were '*no new entry charges but that tax on profits (if any) will apply*', he asked '*for the valuations when available and documentation when completed*' and finished by stating '*I will consider my situation when this is complete.*'

The Ombudsman noted that the Complainant had made withdrawals of funds on two previous occasions in recent years, on these occasions he had given a written signed instruction to transfer funds and the Company had requested and received from the Complainant the appropriate signed form before effecting the withdrawals. The Ombudsman noted that the policy provisions required notification in writing of any withdrawal by the policyholder and/or completion of '*the relevant form*'.

The Ombudsman on reading the email concluded it was not a valid instruction to transfer funds particularly as it stated '*I will consider my situation when this is complete*'. He found that it was reasonable of the Company to interpret this email as a request for valuations upon receipt of which the Complainant would consider his position in relation to his desire to transfer funds.

Charges applied to investment bond were correct

The Complainant invested €220,000 in an investment bond with Insurance Company in 2000. She decided to cash in her investment in 2008 and received approximately €243,000. The Complainant stated that the return on the investment was below her expectations, particularly in the context of the charges applied by the Company during the term of the investment. The Complainant also referred to the policy documentation and promotional literature issued by the Company, stating that it was misleading as to the possible return on investment.

In reaching a finding on the case, the Ombudsman examined the documentation issued by the Company and considered whether it was clear regarding the investment being made and the level of risk attached. Particular attention was paid to the policy documentation referring to investment performance, the nature of investment being made and when bonuses may / may not be paid. The Ombudsman also considered the extent to which charges were explained in the documentation and whether said charges were clearly detailed.

The Ombudsman found that the policy documentation was clear and explained the risk involved. He also found that the charges applied by the Company were clearly explained, were properly applied and he did not uphold the complaint.

Encashment value of policy had to be based on the value when written notification to cancel was received and not on a previous value given over the phone

The policy giving rise to this complaint was a Mortgage Protection Policy and the Complainant's view that she was entitled to rely on a policy valuation provided over the telephone. While the term of the mortgage loan was 15 years the Mortgage Protection Policy was a Whole of Life Policy which had the potential to continue after the end of the mortgage loan term.

In February 2008 the Complainant contacted the Company by telephone regarding the Policy. The Complainant was advised that as the Policy was a Whole of Life Plan it would continue until a written cancellation request was received. The Policy Conditions stated that a written request was needed to encash the policy.

During the telephone call the Complainant was quoted a current policy value of €20,160. This value was based on the latest price available for the fund on that day. The written request to encash the policy was not received until March 2008; the Complainant then received a value based on the unit price available on that date. Regrettably the Unit Price had fallen since February 2008 and consequently the value of the policy on encashment amounted to €19,900. The Company had explained that the fall in the Unit Price was solely due to a fall in the equity markets in the intervening period.

The Ombudsman found that the encashment value sought by the Complainant was not possible, as an encashment value based on a unit price prevailing before the receipt of the written encashment request and confirmation of the release of the Bank's assignment would also have to be in accordance with the policy provisions. To do other wise, the Company would not be administering the Policy uniformly as between all policyholders. The Ombudsman held that the encashment request

received by the Company was given effect to in accordance with the policy conditions.

Other cars insurance cover did not extend to cover commercial vehicles

The Complainant effected a motor insurance policy with the Company in November 2005. In February 2007 the Complainant was involved in a Road Traffic Accident involving a third party. She was driving an Isuzu Trooper at the time of the accident, which was insured in her father's name under a commercial policy with a third party insurance company. The accident was reported to the Company, but following investigation the Company declined to provide indemnity under the Complainant's policy on the grounds that the "*Driving of Other Cars*" extension of the Complainant's policy does not extend to cover commercial vehicles.

The Complainant however, was adamant that she was covered under her motor insurance policy. She believed that there was an onus on the Company to make the Insured fully aware of the extent and scope of the cover being provided, but it failed to do so in this case, and should therefore be obliged to provide indemnity. She also regarded a section of her insurance certificate to be misleading. She felt that it showed that she was insured to drive her own vehicle registration number, as well as any motor car being driven by the Insured provided such vehicle did not belong to him/her and was not hired to him/her under a hire purchase agreement. She submitted that as the Isuzu Trooper was not owned by her or hired to her under a hire purchase agreement, she verily believed that she was covered under her policy to drive it.

The Ombudsman found that the Company did adequately inform the Complainant of the extent and scope of the cover being provided by means of policy documentation and that it would have been prudent for the Complainant to contact the Company directly, had she concerns regarding the extent of cover under her policy. He also found that the terms of the policy document, insurance certificate and proposal form must all be considered in this case, and not merely the insurance certificate. The completed proposal form clearly indicated that third party cover would be operative in respect of any private motor car only being driven by the Complainant, provided that such vehicle did not belong to him/her and was not hired to him/her under a hire purchase agreement. The policy document also clearly highlighted that the "driving of other cars" provision extended to private motor vehicles only. It was noted that the Isuzu Trooper in question was insured as a commercial vehicle with the third party insurance company.

The Ombudsman stated that the fact remained that the vehicle that the Complainant was driving on the date of the accident, which had no rear seats, rear passenger doors or rear windows could not be categorised as a private motor car. He found therefore that the Company had correctly declined indemnity in accordance with the policy terms in this case.

Travel insurance

(a) Loss of money and valuables while mugged on holidays

The Complainant bought a multi trip insurance policy. While travelling in South America in September 2005 the Complainant was mugged. A number of items including €1,000 cash were stolen from the Complainant's person. The goods in question were stated to be all of high value.

The Complainant submitted a claim in amount of €4,000 to the Company in November 2005. The Company requested proof of ownership. The Company stressed that such proof could include, the receipt, the warranty or the instruction documentation associated with an item, chargers or accessories for electric and electronic goods, the box or certificate associated with jewellery, bank statements showing the purchase or withdrawal of foreign currencies, or photographs showing the claimant wearing the stolen items.

The Complainant confirmed that she had exchanged the Euro for foreign currency at her local bank branch in Ireland but did not submit proof of this. The Complainant confirmed with the Company in March 2008 for the first time that she could not for various reasons submit any proof of ownership to the Company in relation to any of the goods stolen.

In this instant case the Ombudsman considered the amount of the claim, the lack of proof of purchase for any item claimed, as well as the clear and unambiguous wording of the policy document in relation to the proof of purchase requirement. Further to this consideration had to be taken of the lengthy delay on the Complainant's part in corresponding with the Company. The Complaint was not upheld.

(b) Lost baggage complaint and a delayed baggage situation arose

A claim by the Complainant under her travel insurance policy for 'lost baggage' was assessed by the Company as a claim for 'delayed baggage', but subject to a maximum payment of €130.

The Complainant's luggage had been misplaced when the Complainant inadvertently took another person's suitcase upon alighting from the air coach at Dublin airport. She travelled to South Africa with the wrong suitcase, while her own suitcase in turn was taken to Canada. The Complainant was not reunited with her own suitcase until she returned to Ireland some three weeks later.

The Ombudsman noted that the policy offered indemnity to the insured in the event of lost or damaged personal baggage. In the case of lost baggage, the policy made a distinction between the temporary loss of baggage and the permanent loss of baggage. Baggage which was lost for more than 12 hours was considered delayed (subject to a maximum payment of €130) unless it was never recovered, in which case it was considered 'permanently lost', and assessed as such with a maximum payment of €2,750.

Although the Complainant's luggage was not returned to her until she came back from her trip, thereby being significantly delayed, the facts were that she was aware

of its location during her holiday and the luggage did not prove to be permanently misplaced or lost. In these circumstances the Ombudsman found that the Company had acted reasonably in assessing the Complainant's claim under 'delayed baggage', subject to a maximum payment of €130.