



Financial Services  
Ombudsman

## **Twenty Significant Complaints Decisions**

### **Update on ISTC complaints**

*January to June 2008*

**Joe Meade**

*Financial Services Ombudsman*

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### (a) Complaints upheld

#### ***Insurance agent drove a customer to an ATM cash point to secure sale of policy-action condemned by Ombudsman, €1,520 premiums returned as well as €1,500 compensation***

A sister complained on behalf of her sixty year old farmer brother, who lives alone. She stated that as his reading and writing ability was not great he preferred her to deal with how he was treated by two insurance sales people as it was causing him a great deal of distress. In essence the complaint was about feeling annoyed after the purchase of two health illness protection policies from two representatives of an Insurance Company who called to him at his home in October 2007. The complaint was that he was given false information, purchased the policies and paid for them on the spot, because he was forcibly led to believe that if he did not do so, his existing medical insurance cover with a third party health insurer would be insufficient for his needs. When it was realised a short time later that he was misled he applied to the Company to cancel the policies and received a full refund of the premium amounts paid-€1,520. After the Ombudsman commenced to investigate the matter a more specific complaint was subsequently made that one of the Company's representatives had driven him over twelve miles to the nearest ATM cash point in order to procure the necessary cash to pay the balance; this was done under duress while the other representative stayed behind in the house until his return.

The Company advised the Ombudsman that it was limited in its investigation of the Complainant's grievances as he was unwilling to meet with any representative of the Company, and accordingly it was unable to conclude that its representatives had misled the Complainant. The Company had nevertheless cancelled the policy in accordance with the Complainant's request and issued him with a full refund. The Company also stated that its representatives had understood that the Complainant was happy to be driven to the local ATM but that nevertheless, such a type of situation was not good practice and it was the Company's policy to discourage such actions on the part of its representatives. The Company indicated that it was not satisfied that the agents were operating within the Company's rules, and that a formal warning would be issued to them. In recognition of this fact, the Company offered an *ex gratia* payment of €1,000 to the Complainant.

Whilst acknowledging that the Complainant had received a full refund of the premiums paid, nevertheless the Ombudsman expressed serious concern that in circumstances where it appeared that one of the Company's representatives was undergoing in-field training and supervision, the more experienced agent considered it appropriate to leave his co-agent in the Complainant's home while he drove the Complainant to a cash point over a dozen miles away, in order to procure more cash. The Ombudsman found that such action was entirely inappropriate, irrespective of whether the Complainant's consent was given at the time. The Ombudsman also stated that "*discouragement*" of such

an action on the part of an agent, by the Company, was not sufficient as such action must in no uncertain terms be unreservedly prohibited.

The Ombudsman found that the agents of the Company acted in a highly improper manner, the policy was inappropriate to the needs of the Complainant anyway and in all circumstances the complainant could not comprehend what he was purchasing. Whilst noting that the Complainant was not out-of-pocket, given the refund of premiums already received, he directed the Company to pay an award of €1,500 to the Complainant also for the distress caused. The Ombudsman has brought this disgraceful sales practice to the attention of the Financial Regulator also.

***Naive bank official facilitated an 'interfering neighbour' to improperly deal with elderly peoples' account- €1,200 awarded***

An elderly couple, a brother and sister, had a joint deposit account with a balance of approximately €106,000 at a Bank branch in a provincial town. The monies in the account came from renting out land to a neighbour. The brother was 78 years of age and had become deaf while his sister was 85 and in hospital.

A strange tale unfolded when a complaint was made to the Ombudsman by the brother, after his sister died. He alleged that when the sister was gravely ill in hospital, a third party (a friend and neighbour of the couple) approached the Bank branch and suggested that the Complainant's name be removed from the joint account so that the account would solely be in the sister's name as that is what the sister allegedly wanted. The neighbour - who allegedly had tried to rent the land - had approached an official of the Bank who helpfully explained how this could be accomplished and then furnished the third party with documents which each of the account holders were to sign. The Complainant said that while visiting his sister in hospital, both of them signed the documents under duress which were authorisations to turn the account into the sole account of the sister and that a draft for €55,000 was to be issued in favour of the Complainant at the same time.

In response to the Ombudsman's investigation the Bank stated that the transaction was entirely legitimate and had been carried out in the proper way with valid signatures. The Bank stated that it had at all times acted in good faith and had no reason to think that the Complainant's signature was obtained under duress. The Ombudsman, however, took the view that, having regard to the age and infirmities of the account holders, the Bank was under a particular duty of care to them and ought to have contacted the account holders themselves, rather than acting on the instructions of an interfering third party. The Ombudsman accepted that the Bank official involved in this transaction had acted in good faith but had been naive to the point of negligence. Furthermore the Bank had in effect discussed its customers' business with an interfering third party; had explained the steps to be taken to change the account and had facilitated the said change. The Ombudsman found the

actions of the Bank official to be highly irregular and unsatisfactory. The official apparently knew all three individuals.

The Ombudsman decided that the most appropriate remedy to do justice in the case would be to regard the change in the account as being invalid because of duress and he so found. He directed the Bank to reinstate the joint account and to lodge the Bank draft (which had not been cashed) for €55,000 to the said account, the entire proceeds of which the Complainant was now entitled to by right of survivorship. In addition, the Ombudsman awarded €1,200 to the Complainant in compensation for the Bank's negligence and failure of duty and requested that a letter of apology should also be sent.

***Husband who met with the Bank and signed what purported to be his wife's signature costs bank €52,000***

A husband and wife who had recently sold property invested €100,000 in a Property Fund which then fell sharply in value. At the time of the complaint being made the investment was worth only €68,000. The Complainants alleged that the Bank was negligent in selling them this particular investment which was not the type of investment which they had wanted. The Complainants were 69 and 70 years of age respectively.

The Ombudsman's investigation showed that the Bank had set out a range of possible investments for the Complainants to consider. The Complainants chose the disputed investment. The Ombudsman was satisfied that the investment was correctly described as "*medium risk*". The Complainant stated that he had not wanted this type of investment and instead he had wanted only a short term investment. The Ombudsman however was satisfied from the evidence that the husband had not made any such thing clear to the Bank which had provided a brochure, prospectus and Terms of Business to the Complainants. The Ombudsman noted that it was clearly pointed out that the value of the investment could fluctuate and that an investor might not get back the full amount invested. The husband had conducted the business and the Ombudsman was satisfied that of his own volition the husband had knowingly decided to invest on behalf of his wife and himself in something which did not have capital security. The Ombudsman found no failure of duty of care by the Bank in respect of the suitability of this investment for the husband.

The Ombudsman however discovered that the position in regard to the wife was quite different. This was because the evidence disclosed that only the husband met with the Bank and that the husband had signed the documents on behalf of his wife who was not present. An internal note of the meeting made by a Bank official stated that the husband "*signed the application on behalf of both parties*". The Bank was asked to account for this and stated in reply that the person who wrote it had left the Bank. The Ombudsman found this to be unsatisfactory. He would have expected that the Bank would possess clear records establishing conclusively that the second named Complainant had signed the application form for her 50% interest in this investment and that she had made an informed decision in regard to the investment. No such records

were forthcoming from the Bank. The Ombudsman stated that it was not sufficient to state that the official concerned had left the Bank as it should be in a position to produce meticulous, clear records demonstrating unequivocally that the wife had signed the forms in the presence of a Bank official and had been made aware of the features of the investment.

In conclusion the Ombudsman was satisfied that the husband knew the true nature of the investment. He also found as a fact on the balance of probability that the husband knew that the investment was not capital guaranteed and that its value could fluctuate. The Ombudsman found that the Bank was not guilty of any wrongdoing or breach of duty insofar as the husband was concerned.

The Ombudsman did consider that a breach of duty had been established in relation to the wife's application for the investment. The Bank had failed to follow satisfactory procedures to ensure that the wife signed the application form in question and had made the investment on a fully informed basis and this aspect of the complaint the Ombudsman found to be justified.

By way of remedy the Ombudsman decided that half the sum invested was to be regarded as belonging to the wife. He therefore directed that €50,000 must be returned to her and since this money could have earned about 4% interest in the twelve months since the investment was made, he directed the Bank to pay to the wife the sum of €52,000 in return for 50% of the investment in the Bank's Fund made by the Complainants.

***€50,000 award following delayed review of Unit Linked Whole of Life Policy-systemic problem in 1,800 other cases also identified by Ombudsman***

The dispute in this case related to a Company's administration of a unit linked whole of life policy, which had been taken out in 1988, in particular the Company's actions relative to the policy review where serious delays had arisen. The policyholders, in their late 60s, were medical professionals paying premiums in excess of €780 a month since 1999 for substantial life cover. In order to maintain their existing level of cover the Company informed them in September 2006 that the premiums were to increase to €2,000 a month in 2007. They were understandably upset and sought a return of over €60,000 of premiums already paid since 1999. The Company acknowledged that there had been errors in its administration of the policy but would not return the premiums.

The evidence reviewed by the Ombudsman indicated that the Company:

- carried out the first scheduled review in 1999, one year after its due date in 1998
- did not apply the default option, to automatically increase the premiums, when the complainant did not contact the Company regarding the options put forward by the Company in 1999.

- neglected to carry out the second scheduled policy review five years later in 2004, and
- quoted an incorrect fund value following a request for same by the complainants in 2007.

It was the Company's argument that despite its errors the Complainants remained on full cover and had a valid claim been made on the policy, full benefits would have been paid. The Ombudsman then considered the following further submissions made by the Company to him after he raised certain matters

- External legal advice as to the validity of the contract and the Company's obligation to pay the protection benefits in the event of a claim.
- Evidence showing that the protection benefits were reinsured with an external provider and that the Company continued to pay the reinsurance premiums for the highest level of protection benefits even after the failure to implement the reviews.
- The Company agreed that the policyholders had experienced inconvenience as a result of poor administration and considered €15,000 as appropriate compensation.
- The Company considered that the policyholders were not disadvantaged by its failure to carry out the reviews as the Complainants were held on higher level of benefits despite paying premiums which were inadequate for that level of cover.

The Ombudsman noted that the effect of the errors was cumulative and great inconvenience and frustration had undoubtedly been caused to the policyholders. He considered that it was disingenuous for the Company to expect the Complainants to merely accept that the full level of benefits would have been paid. Having met with the Company and having reviewed all of the Company's submissions (legal opinion etc) the Ombudsman accepted however that the evidence supported the Company's argument that it would have paid out full benefits had a claim arisen.

While the strict legal position may well have been that a return of premiums paid since 1999 would not be the most appropriate remedy for such poor administration, the Ombudsman stated that great inconvenience had been caused, the people had not been given an opportunity to consider alternative options even in 2004 and indeed any trust that the Complainants had in the Company's handling of their policy was lost because of the errors. Therefore, he considered that a substantial compensatory award was called for in this case. In coming to this conclusion, he had particular regard to the high level of cover that the Complainants sought to insure and the substantial premium that they were paying the Company to provide the cover and to properly manage their policy. He also held that the Complainants' current ages of 65 and 69 years meant that finding alternative cover at the current level and at

premiums of €780 a month would be difficult if not impossible to obtain. Accordingly the Ombudsman directed the Company to pay the Complainants €50,000 instead of the €15,000 it had offered.

The Company at the Ombudsman's request reviewed its records and discovered that it had failed to carry out a contractual review prior to the 10<sup>th</sup> anniversary of approximately 1,800 other Whole of Life policies. The Company indicated that it was remedying the matter and that it had informed the Financial Regulator. A copy of the Ombudsman's decision was forwarded by him to the Financial Regulator for any action it considered needed to be taken on this identified serious issue.

***Bank's threatening letter debacle costs it €4,000***

A customer who held a mortgage with a Bank was told that his mortgage repayments would now have to be made by a different method. The Complainant was advised that all direct debits, standing orders and other payments would be automatically changed and that the Complainant was not required to take any action at all.

However, it turned out that the Bank made a number of errors as a result of which the Complainant's mortgage fell into arrears. Although this arrears situation was entirely the fault of the Bank, the Complainant began receiving letters from the Bank demanding immediate payment of arrears of €6,000. The Complainant paid the arrears by cheque but two months later the same thing happened again, generating more letters. The Complainant then had had enough, changed his mortgage to another bank and subsequently brought a complaint to the Ombudsman against the first Bank.

The Ombudsman found that the Bank was entirely responsible for the debacle and noted that the Complainant had not lost any money and that his credit rating had not been adversely affected. Nevertheless, he found that the Complainant had been put through a great deal of stress and annoyance. In particular in deciding on a remedy, the Ombudsman took account of the fact that the Bank had written to the Complainant stating "*the conduct of your account is totally unacceptable*" when the fault turned out to be entirely that of the Bank. In view of this and in view of the fact that the matter remained uncorrected for five months, the Ombudsman awarded €4,000 in compensation for the Bank's failure and for the distress which occurred.

***Bogus non resident account allegedly held by a member of the Gardaí - €2,000 compensation follows as bank at fault***

A man received a letter from the Revenue Commissioners asking him to account for a bogus non-resident account held in his name at a branch of a Building Society in the West of Ireland, the Revenue having been notified by the Building Society in accordance with law. This man had never had such an account and he brought a complaint to the Ombudsman seeking compensation for upset, distress and trauma as a result of the Revenue enquiries which he

alleged had been facilitated by the Building Society in opening the account in his name.

The Ombudsman was satisfied from his investigations that this was not what had happened. It was clear that the person opening the account had the same name as the Complainant and had used an address in London with which the Complainant had absolutely no connection whatsoever. The Building Society had made an error and supplied incorrect details to the Revenue. The Building Society, while admitting to, and regretting the error, said it was no big deal and the matter had been easily cleared up.

The Ombudsman, however, found that the Complainant should never have found himself in this position and that he was fully justified in feeling wronged (all the more so because he was a member of An Garda Síochána where allegations of tax evasion would be particularly distressing). The Ombudsman awarded €2,000 in compensation.

***Accountant's unnecessary delay in submitting financial accounts to Insurance Company resulted in the Claimant's Income Protection claim not being assessed.***

In 2004 the Complainant received payment under a Serious Illness claim. The Complainant also had Income Protection cover at this time, but did not make a claim under same until 2005. On receipt of the claim the Company gave deadlines as to the receipt of information relative to the claim. Following the late receipt of information in 2007 the Company declined to assess the claim.

From the Ombudsman's investigating officer's initial examination of the evidence it was found to be clear that the Company gave the Complainant ample time to submit information relative to his claim, but unfortunately the Complainant failed to comply with the Company's requirements within the appointed time frame. The policy specifically stated that the refusal or failure to comply with requirements, to the satisfaction of the company, and within such period of time as the company deemed reasonable, would result in the non payment of benefits in respect of the life insured. The initial Finding was that the Company acted within its contractual rights when declining the claim. However, because of the particular circumstances of the case, an award of €2,500 was made.

The Complainant indicated that he was unhappy with the Finding and requested to meet 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 documentary evidence, be it in the form of replies to questionnaires or an examination of file. However, there are occasions at final review stage where the Ombudsman, may decide to meet with the parties to either elaborate on certain conditions or where he feels that the person may not be capable of putting their genuine thoughts into writing. Having preliminarily reviewed the matter, he felt that this was an occasion where he would meet the Complainant.

At the meeting the Complainant explained that the real reasons for delay in submitting the claim and the late submission of his financial accounts to the Company were:

- lack of energy (due to his illness) to pursue the matter at the relevant time
- his Accountant delayed in preparing the information for the Company.

The Ombudsman noted that his investigating officer was not made aware of these mitigating circumstances prior to the initial Finding having been issued. The Ombudsman did accept that the Complainant had problems with his Accountant in having his financial accounts submitted to the Company even though the accounts had been completed when the Company asked for them; this he felt was a matter that he should have addressed with his Accountant as the Company could not be held responsible for same. While the Ombudsman found that the Company could not be expected to keep a claim file open indefinitely and that there were policy requirements regarding the provision of information, it was his opinion that a person with a serious illness may not have the energy to pursue matters to the fullest within time frames that normally apply particularly where his accountant was a major problem.

Accordingly he directed the Company to re-open the claim and assess the Complainant's claim for Disability Benefit in accordance with the terms and conditions of the policy. As well the award of €2,500 originally given under the initial Finding was to stand on the following terms; the Complainant was to receive the greater of (i.e. not both) the benefit payable under the policy (subject to him medically and financially qualifying for same) and, the €2,500 award. In other words the least the Complainant should receive was €2,500.

***Loan protection insurance not extended to consolidated loan-bank directed to write off €17,000 of a €23,000 loan***

The Executors of the estate of a man who, shortly before he died, obtained a top-up Bank loan for €6,000 which brought his indebtedness to the Bank to €23,000 brought a complaint to the Ombudsman. The earlier indebtedness of €17,000 had been covered by loan protection insurance. However, the new consolidated loan was regarded as an entirely new loan and was not covered by the loan protection insurance which he had enjoyed on the earlier loan. The man died shortly afterwards. His Executors complained to the Ombudsman that because of the consolidation of the loans the new debt of €23,000 was not covered by any loan protection, whereas the earlier loan balance of €17,000 had been covered.

The Bank pointed out in response to the Ombudsman's enquiries that the deceased borrower had stated clearly that he did not want insurance. The Ombudsman found that although the Bank had acted within its rights in consolidating the loan into a new loan of €23,000 without loan protection being in place, it did have an obligation to its customer to point out forcibly that whereas the original loan was covered, the consolidated loan was not (even for the original amount).

The Ombudsman's decided that on balance the Bank had failed in its obligation to the deceased customer in allowing him to add the €6,000 extra loan into a consolidated loan for €23,000 with the consequence that the loan protection of the original €17,000 was forfeited. The Ombudsman felt this was grossly unfair and he directed the Bank to write off €17,000 of the consolidated loan, thus reducing the debt owing to the Bank from the estate to €6,000.

***€7,500 awarded for partly 'unsuitable' investment advice***

A man who had received compensation for a work accident and was on an invalidity pension contacted a Bank in 2001 and enquired about investments for the capital sum he had obtained - €127,000. He had wished to invest in a five year term deposit account but claimed that a member of the Bank staff told him that he would be better advised to invest in a Bond. He accordingly invested in the bond in the hope of a better return but withdrew €52,000 after ten days prior to the issue of the bond. The return on the bond failed to materialise and at the end of the five year period of the Bond the Complainant was advised that he would receive back only the original €75,000 he had invested five years earlier.

The Bank justified the advice on the basis that its customer would have been taken through the Terms & Conditions of the Bond and a copy of the brochure would have been given to the Complainant. The Bank also pointed out that there was a cooling-off period of two weeks during which the Complainant could have changed his mind. On considering these points the Ombudsman took the view that one would have had to have a considerable amount of financial literacy to follow the Terms & Conditions contained in it. The Ombudsman thought that just as a letter had been sent out giving clear and concise calculations for ordinary term accounts, a letter should have been sent to the Complainant in this case and it was not.

The Ombudsman came to the conclusion that it would have been better had the Complainant placed his money in a five year term deposit account. However, he was by no means forced to do so and the Ombudsman felt that the responsibility for the lost opportunity to him should be divided between himself and the Bank with the Bank being responsible for 35% of the loss and the Complainant for 65%. Accordingly, the Ombudsman directed that the Bank should pay the sum of €7,500 to the Complainant for the partly unsuitable advice which had led to the investment he made.

***Switch of Medical Plans recommended by the Health Insurer resulted in no cover for cardiac treatment expenses; restoration to original Medical Plan, without a two year waiting period, directed by Ombudsman and €5,000 compensation***

In November 2005, the Complainant received a mail-shot from his medical insurer, advising that the Company believed that a change from his current Medical Plan to an alternative Medical Plan, would offer the Complainant and

his family health care cover which would be more relevant to their current needs. The mail-shot listed benefits which included a much reduced excess for day-to-day medical expenses, improved maternity benefits, improved cover for dental treatments etc., and advised that in the event of a change to this Plan, the policyholder would no longer have cover in the Blackrock Clinic or Mater Private Hospital. A brochure was enclosed providing full details. The Complainant considered the terms of the mail-shot and on the following renewal date, he proceeded to change to the Medical Plan which had been recommended by the Company.

Almost two years later in July 2007, the Complainant was admitted to Blackrock Clinic for cardiac treatment, but the Company subsequently declined his claim for cardiac treatment expenses, because his Medical Plan did not cover Blackrock Clinic. The Complainant was naturally highly annoyed and he took the view that because of his age profile and that of his wife (49 & 48 respectively in 2005) and because their only child had then been 12 years old, the Plan recommended by the Company in 2005 had not in fact been suitable for them. He felt it was rather a Plan which might be more suitable for a family with a lower age profile. He was also very annoyed that when he sought to change back to his original Medical Plan, he was advised by the Company that he would be subject to an “*up-grade clause*” which would rule out any cover for cardiac treatments at Blackrock Clinic or Mater Private Hospital for a period of two years, even though at the time of the change of Plan in 2005, he had not been warned by the Company that the change recommended, was in fact a down-grade of cover. The Complainant sought the reinstatement of the original Medical Plan with retrospective effect, with no penalty or waiting period, together with payment by the Company of his medical expenses which amounted to some €25,000.

The Company advised that whilst it had offered information on the new Medical Plan available, it had not actively advised the Complainant to change his cover, and the information furnished had clearly set out the differences in the cover provided by the Plans. The Company maintained that it was always a matter for the Complainant himself to make the decision, on the basis of the information provided. In those circumstances, the Company considered that it would not be appropriate to reinstate the Complainant’s original Medical Plan with retrospective effect.

On the basis of the evidence furnished by the parties, the initial finding by the Ombudsman’s Investigating Officer was that although the decision by the Complainant was ultimately one for himself alone, nevertheless, the Company ought not to have directed the particular mail-shot letter to the Complainant in August 2005, as the change of Plan (which the Company advised the Complainant would provide more relevant medical cover to him and to his family) was not in fact a suitable change given the age profile of the family in question. In addition, the Company had not alerted the Complainant to the implications of the change as regards the applicable waiting period, if the Complainant wanted subsequently to revert to the original Medical Plan. The Investigating Officer awarded the Complainant a sum of €5,000 towards his medical expenses and directed the Company to restore the Complainant and

his family to the original Medical Plan with effect from 1 November 2007, without the application of any waiting period.

Both the Complainant and the Company were unhappy with this finding and both made further submissions on the matter to the Ombudsman. Having considered these submissions, in his Final Decision the Ombudsman stated that:

- He agreed with the finding that the Complainant must take responsibility for his own decision to embark upon the change in Medical Plan which the Company had offered to him, and he ought to have fully acquainted himself with the relevant information before he proceeded to make the change.
- The Company ought to have been aware that the type of mail-shot directed to the Complainant could easily persuade a policyholder to proceed with the switch of Plan recommended, on the basis of the Company's "*belief*" that it would provide more relevant health care; policyholders were likely to trust the Company's belief implicitly, given its high reputation for good service delivery.
- The Plan which was most relevant to the Complainant and his family was a Plan which was suitable to the entire family circumstances.
- The mail-shot should have been more explicit in its advice, in respect of the implications of a change of Plan, with regard to the requirement for a waiting period, if the policyholder subsequently wished to change back; he accepted nevertheless that the Company had acted in good faith.

The Ombudsman directed the Company to pay €5,000 to the Complainant but the Complainant be also allowed switch back to his original Medical Plan from November 2007, without the application of a waiting period. He also directed that the Company, for the future, as soon as was administratively possible, should clearly warn a policyholder in writing of the consequences, in circumstances where a change of Plan would give rise to a waiting period condition, if the policyholder subsequently wished to change back.

***Lack of clarity as to what was covered under an insurance travel policy-€600 awarded and a review of former claims follows***

A claim for the theft of a personal laptop computer was repudiated by an insurance Company. The Company argued that the laptop was not covered, as the circumstances leading to the claim i.e. theft of the laptop, would fall under the policy exclusion i.e. "*[the Company] will not pay for loss or damage to computer equipment*". However the Ombudsman noted that the policy clearly stated that cover was provided if Personal Property was lost, damaged or stolen. On a strict interpretation of the policy computer equipment was excluded for cover in all eventualities i.e. loss, damage or theft. However, as the Ombudsman considered that there was lack of clarity in the policy

document as to what were personal property and this lack of clarity could reasonably cause confusion an award of €600 was accordingly made by him.

The Ombudsman had concerns that there may have been other claimants over the years that were affected by this lack of clarity in the policy document. In this regard he noted that a previous complaint under this policy against this Company in May 2005 resulted in a finding for another claimant also. In the interim period the Company did not appear to have considered altering the wording of the policy to take account of the identified lack of clarity. The Ombudsman then inquired whether other claimants over recent years were adversely affected with their claims under the particular section of the policy and (if there were any claimants identified), what action the Company were proposing to take with regard to those claimants. The Company advised that it had provisionally identified approximately 800 property claims that had been rejected over the past 3 years. The Company also advised that it was getting the files back from storage and that it intended to reconsider and review them individually. Following this review 4 other claimants were recouped their loss. The Ombudsman commends the Company's action.

The Ombudsman referred the matter to the Financial Regulator for any action it considered needed to be taken.

***Award of €15,000 made as Broker did not draw to the Complainant's attention the possibility of increasing her disability cover***

A complaint about the payment of disability benefit under the Complainant's Personal Pension Plan was received. The Complainant was unhappy that the level of disability benefit had not increased since the plan commencement (the Complainant having chosen not to index the cover). She stated that it was the responsibility of the Broker, when reviewing and increasing the pension contributions annually, to have also increased the disability benefit also- the Ombudsman specifically noted that the Complainant had instructed the Broker to have aspects of her pension plan changed, including premium increases, lump sum injections into the plan and fund switches. The Broker argued that no instruction either written or verbal was ever received from the Complainant to have her disability benefit increased.

The Ombudsman noted that when the agency for the personal pension plans was transferred from her corporate pension's adviser to the Broker in April 2003, the Broker issued the Complainant with Terms of Business, which set out the general terms under which the firm would provide insurance and investment business services, and the respective duties and responsibilities of both the firm and the policyholders. On the basis of the evidence submitted the Complainant did not specifically ask for a review of the disability policy on a periodic basis by the Broker. Whilst the Disability Benefit policy did provide for increases in the level of disability benefit, on the basis of the evidence submitted to the office, the Complainant did not at any time elect to increase the amount of the PHI cover under the plan.

Noting the Broker's Terms of Business for the review of policies stated - "*With your agreement, we may review the policies you take out on a periodic basis to ensure you are kept informed as to their benefit and to check whether they are still suitable for your needs*"- the Ombudsman felt that it could be argued that it was unclear whether it was the Complainant or the Broker who should instigate a review of the Complainant's policies. He considered that the Broker's documentation should have been clearer as to the Complainant's responsibilities with regard to ensuring that the benefits were adequate to her needs. While it was ultimately the Complainant's responsibility to ensure that the benefits under the disability plan were adequate to her needs, the Ombudsman was also of the view however that the Broker had some responsibility in this regard. Indeed it would have been prudent for him to have at least raised with the Complainant the issue of a review of her policies particularly as the pension plan element was reviewed regularly. Also other aspects of her policy were reviewed annually.

Taking all of the circumstances of the dispute into consideration, the Ombudsman held that a once-off award of €15,000 was called for by the Broker in this instance solely because he did not draw to the Complainant's attention the possibility of increasing her disability cover. As this was not done the Ombudsman also stated that he could not know whether the disability cover would have been increased by the complainant and the award reflected this.

#### ***Lost property title deeds merits €3,500 compensation***

Customers of a Bank gave a legal charge to the Bank over property which they owned in the U.K. Three years later they asked that the Deeds be forwarded to their solicitor on an accountable receipt in order to facilitate sale of the property. The Deeds could not be found. It seems that the Bank's solicitors in the U.K. lost the Deeds and the proposed sale of the property had to be cancelled. The customers in Ireland had to bear the cost of re-constituting the Deeds.

The Ombudsman decided that although the Irish Bank had not lost the Deeds, the Bank was vicariously liable to these customers for the loss of the Deeds and its consequences. The Ombudsman awarded €3,500 in compensation (this sum to include the cost incurred by the Complainants in having the Title to the property re-constituted).

#### ***€8,000 awarded against credit union over loan insurance for a disabled person***

A lady who had a loan of €25,000 from a Credit Union had become disabled as a result of an accident and she was then unable to keep up repayments on the loan. The Credit Union did not inform her that her loan was covered by permanent disability insurance. Two years elapsed during which extra interest accrued on the loan. Finally the Complainant herself raised a query on her own behalf with the Credit Union and the Credit Union confirmed that the loan did indeed enjoy insurance cover. The Credit Union then lodged a claim

on her behalf. The insurance company allowed 70% of the claim but repudiated 30%, leaving a balance of approximately €8,000. The Credit Union then lodged an appeal against the partial repudiation. This appeal was rejected. The Credit Union did not furnish the Ombudsman with any explanation of this refusal despite being asked to do so and the Ombudsman could not be satisfied that the application for the insurance and the subsequent appeal had been done properly.

The Ombudsman found that the Credit Union had failed in its duty of care to this member in respect of loan insurance and in the circumstances directed that the Credit Union make a payment of €8,000 by way of credit to the account of the said member.

***Incomplete address on motor insurance company records had serious consequences for a teenager after an accident***

The Complainant incepted and paid for comprehensive motor insurance in April 2007 costing €2,000 for a smallish type car. She was aged seventeen and later included her brother on her insurance for one day in May 2007 by phone contact at an extra cost of €177-apparently they were going to a music festival and he was the designated '*none alcohol*' driver. The Company stated it issued a letter to the Complainant confirming these details and requesting payment for cover for the Complainant's brother. The Company stated that no payment was received. After attempts to contact the Complainant the Company issued a letter by recorded post to the Complainant in July 2007 requesting payment for the additional driver within 10 days to avoid cancellation of the motor policy with effect from 00.01 hours on 21 July 2007. The Company stated that within the said 10 day period it made numerous attempts to contact the Complainant by phone without success. However on 19 July 2007 the Company stated it made contact with the Complainant and advised her of the outstanding balance and the cancellation date of 21 July 2007 but the Complainant stated that from this conversation she believed she had ten days to pay the outstanding amount.

When the Complainant contacted the Company on 23 July 2007 to report an accident that had happened the previous day she was informed that "*her insurance was cancelled on 21 July 2007*". The Complainant stated she had no notification of the insurance being cancelled. She stated the Company stated it sent her a registered letter. The Complainant stated that no registered letter was received by her and that the Post office confirmed (on the phone) that '*no registered letters has been sent to the address*'. The Company stated there was no evidence that this letter was returned undelivered to the Company. The Company also stated that as no payment was received it cancelled the Complainant's policy with effect 21 July 2007. A letter confirming the cancellation and the refund due was issued to the Complainant on 25 July 2007. The Company believed it followed all procedures before proceeding with cancellation of the Complainant's policy.

The Ombudsman noted a significant error by the Company in relation to the Complainant's insurance policy as the address used to communicate with the

Complainant was seriously inadequate and incomplete and may have contributed to the Complainant not receiving notification of cancellation of her motor policy. The address used by the Company carried no town name just a street name and county. The Ombudsman considered that this may have contributed to letters not being received. However he got confirmation from the complainant's father that she had received her insurance policy and disc before the accident. The Ombudsman considered that the incorrect address details could mean that some letters were delivered while others may not. He also noted that the complainant was making no claim for damage to her own small car but an estimate for €4,200 was submitted as the cost of the damage to the other SUV vehicle.

Due to the address mix up, the precise recall as to what was said on the phone by both parties and taking account of the person's young age and sincerity the Ombudsman on balance directed the Company to pay the Complainant what it considered to be an appropriate amount for the damage caused to the other vehicle as well €400 for bad customer service. He made the €400 award as he was not satisfied that the complainant had received the other notifications even though she had received the insurance disc and policy in May and had incurred distress and expense since the accident happened. He also asked that the company file regarding the Complainant carry an explanation regarding the circumstances of the cancellation in order to ensure the Complainant has no adverse repercussions when she is seeking motor insurance in the future and the company readily agreed to this. The Ombudsman also suggested to the Company that its internal auditing department review their procedures to ensure that its database had complete and correct addresses for their policy holders.

In coming to his decision the Ombudsman accepted that the Company acted in good faith in cancelling the policy in accordance with its terms and conditions especially when the amount was not paid after two months.

### **(b) Complaints not upheld**

#### ***Take reasonable care while on holidays-stolen property claim***

A middle aged man travelled to Asia on a two week holiday. Before his departure he decided to purchase a single trip travel insurance policy to cover the duration of his trip in the event of any unforeseen eventualities. Approximately a week into his trip the Complainant had a suitcase stolen from his hotel room. A substantial claim for €3,700 was subsequently submitted to the Insurance Company for the theft of the suitcase and its contents. The case had contained valuable items such as the Complainant's passport, airline ticket and €1,600 cash.

The Insurance Company after assessing the claim repudiated it on two grounds after reviewing a police report, embassy report and CCTV evidence. Firstly the claim was declined due to the fact that the suitcase was stolen by a local woman who was known to the Complainant. Secondly it transpired that prior to the theft the Complainant and this woman were in his hotel room, both had

left some time later but afterwards she returned on her own and gained lawful access to the room. She was later seen leaving the room with his luggage before he returned. The Company stated that this was an apparent lack of care taken by the Complainant for the security of his belongings. Furthermore, the cash was not covered as under the Company terms and conditions there was a requirement that it be held in a *'safety deposit box/safe or on your person'*. The Ombudsman after assessing all the submitted documents could not find in favour of the Complainant. While the Ombudsman was in no doubt that a genuine theft had taken place, he was in agreement with the Insurance Company that the Complainant had failed to exercise due care for the safekeeping of his personal items. Allowing individuals access to your personal belongings especially on holidays carries the risk of some unforeseen event taking place which unfortunately resulted in a theft in this instance.

The Ombudsman publishes this matter solely to put the public on notice of the responsibility to safeguard their belongings at all times. An insured person carries responsibility for safeguarding his/her luggage and valuables and must remain vigilant especially when travelling abroad. An insurance claim is not the answer for such negligence.

### ***Cancelled cheque***

A customer of a Bank issued a cheque for €4,100 and then tried to have the cheque stopped. The cheque was paid however. The customer claimed that the Bank was negligent in allowing the cheque to be cashed despite his order to stop it. He claimed that a Bank official had said *"that cheque is now cancelled"*. The Ombudsman's investigations revealed that the Complainant had telephoned the Bank at 11:23 a.m. on 7 March and requested that a stop be placed on the cheque which he had issued on 6 March. He said he was given an assurance that this would be no problem and he attended at his branch the following day and filled out the necessary form for stopping a cheque. The Ombudsman's investigations also revealed that the cheque had been issued on 6 March and was cashed at 10:29 a.m. on 7 March at the Complainant's branch, so that when the Complainant telephoned a stop order at 11:23 a.m. on 7 March, it was already too late.

Even if a Bank official had in fact said *"that cheque is now cancelled"*, such a statement had clearly been made in good faith and had been predicated on the possibility of the funds being retrievable had the said cheque been lodged to an account at the same branch. The Ombudsman found that the onus was entirely on the Complainant to give the stop order before the cheque was cashed and he had not done this. Attending at the branch subsequently and filling out a "stop notification form" could not alter this. The Ombudsman found that there had been no failure or negligence on the part of the Bank and the complaint was not upheld.

### ***Motor Insurance dispute concerning notification of policy cancellation***

The dispute arose over the alleged failure of the Company to notify the Complainant that his policy had been cancelled. The Complainant was

involved in an accident while he was driving his private motor vehicle. The following day his father reported the accident to the Company only to be told that his insurance policy had been cancelled some four weeks previously, and that the Complainant no longer had cover in place. The Complainant insisted that he had not received any pending cancellation notice nor was he put on notice of the cancellation after it had been carried out. The Company on the other-hand was quite adamant that the Complainant had been advised through different mediums that his policy was cancelled. The Company stated that one of the forms of communication was through a recorded letter advising him that his policy would be cancelled 10 days from the date of said letter.

Having reviewed all the relevant submissions by both parties to this dispute the Ombudsman was satisfied that the Company had in fact informed the Complainant of the cancellation of his motor policy. He found that the Complainant had twice contacted the Company's offices after the date of cancellation and that he was advised on both occasions of the current status of his policy.

However, the Ombudsman noted that the Company had issued the Complainant's final 10 day cancellation letter by regular post and not through recorded post thereby breaching its own policy terms and conditions. He communicated with the Company about this lapse and felt it appropriate to bring this aspect to the attention of the Financial Regulator.

***Death certificate determined that personal accident travel insurance was not payable***

The insured English female died whilst on holiday in Greece in 2006. The Complainant's solicitors made a 'personal accident' claim under the insured's travel policy. The Company declined the Complainant's claim for accidental death, as it stated the deceased's death was as a result of a heart attack. The Complainant's solicitors argued that the death certificate stated deceased's death was "unascertained". The Complainant's solicitors asked that the Company reconsider its declinature of the claim as they could not see how the Company could "*have determined that the death was as a result of a heart attack when there was clearly medical evidence to the contrary*".

In coming to his Decision the Ombudsman noted that

- The information recorded in Greece included, *inter-alia*, the Death Certificate, postmortem information, the incident report and contemporaneous information from those who observed the Insured being taken from the sea.
- Information supplied in relation to the insured's death stated "*she was dragged from water – tried to resuscitate for 40 minutes... postmortem found the insured had heart attack*". The post mortem was carried out on the deceased in Greece.
- The Greek Death Certificate stated "*according to the certificate established by the Forensic MD, the death was caused by a recent*

*infarct of the myocardium*". Additionally, the appendix to the Death Certificate stated the "*the insured deceased having succumbed to a recent infarct of the myocardium*"

- The UK Coroners Court in December 2006 stated the injury or disease causing death was "Unascertained", and the conclusion reached by the Coroner as to the death was "Open". The UK Coroner's Court in a letter of February 2007 also stated "... *(the) unfortunate death was recorded in Greece, therefore no Death Certificate will be issued in England*"
- Though the Complainants solicitors had argued that the death certificate stated the deceased's death was unascertained in fact it was the Coroner's Court that stated the deceased's death was unascertained but no English death certificate issued.

As the death certificate issued in Greece was clear in its pronouncement that the insured died from a heart attack and having considered all the other evidence submitted the Ombudsman could not uphold the complaint despite having the utmost sympathy for the next of kin.

### ***Insurance Company not responsible for failure of car engine***

A car owner claimed comprehensively on his motor policy, when he skidded and damaged his vehicle. He was originally very happy with the repairs undertaken at the repair shop which the insurer directed him to, but some weeks after the repaired vehicle was returned to him, the vehicle simply lost power whilst he was driving and came to a halt. Though the insurer offered to discharge 50% of the cost of the new engine required, the Complainant was unhappy, as he was firmly of the opinion that the original repairs had caused the ultimate engine failure, and he believed that the insurer was responsible because it was the Company which had directed him to the particular repair shop in question. Although the Company had paid the Complainant 50% of the cost involved, a subsequent engineer's report ruled out the possibility that the fault had been connected to the original repairs. The Company nevertheless advised the car owner that the payment already made could be considered as a goodwill gesture.

The Ombudsman's Investigating Officer noted that the repair shop was not a financial service provider and that, consequently, the office had no jurisdiction to investigate any complaint which the car owner had against the repair shop. It was also found that the repair shop was not an agent of the Insurance Company; it was simply a repair works which the Company approved for the purpose of carrying out work to the vehicles of its insured customers. In addition, if the Complainant was correct in his opinion that the ultimate engine failure had been caused by the repair works, then this would be a matter between the Complainant and the garage, as the insurer would have no part to play in relation to any alleged negligence on the part of the garage in carrying out those repairs. The Investigating Officer found that the Company had acted reasonably in all of the circumstances and the complaint was not upheld.

The Complainant was not happy with this finding and after receiving his appeal the Ombudsman sought further information including a copy of any agreement between the Company and the repair shop. Having considered that documentation, the Ombudsman found that the repair shop had been accepted by the Company onto its panel of recommended repairers, having agreed to certain minimal standards of service levels for the Company's policyholders. The Ombudsman did not accept however that the repair shop was an agent for the insurer as its principal, and he did not uphold the Complainant's grievance in that regard.

### **(c) ISTC Bonds sales**

At the launch of his 2007 Annual Report in April 2008, the Ombudsman indicated that complaints had been received regarding the Creative Step-Up and Income Bonds that were marketed during 2007 on behalf of International Securities Trading Corporation plc. (ISTC) a financial institution established in June 2005 but not regulated by the Financial Regulator. The bonds were unit-linked lump sum investments which were to mature either at the end of a five or seven year terms. They were subordinated loan notes and no encashment was allowed before the fifth or seventh year redemption dates.

In November 2007 ISTC went into Examinership and following completion of this process in February/March 2008, the value of all the bonds sold was nil. Significant and substantial monetary losses naturally arose for all investors and it was not surprising that the Ombudsman received complaints where the investors had not got satisfaction when they initially sought recompense from the providers who sold them the bonds. The complaints received indicate that the bonds were mainly sold in May/June 2007 and the minimum investment was €75,000 or €50,000.

The Ombudsman at the April 2008 launch had also expressed a general worry that some of the bonds were sold with an insurance company *wrap around*; his main concern was whether or not the *wrap around* product was clearly understood by its sellers, promoters and purchasers as being an ISTC product in reality, and not an insurance bond. Future products of this nature he believes merit careful consideration by the industry as to their overall suitability but especially their common understanding by ordinary people.

The situation regarding the number of complaints received by the Ombudsman by 31 May 2008 regarding the sales of this product is outlined on page 22. By then 25 complaints where €5.2 m was invested had been received comprising 2 people over 80 including one person aged 94, 6 people were over 70, another 10 were in the 60-70 age category while another 4 were in the 50-60 age category. 1 complainant was under 50 years of age while 2 credit unions also lodged complaints.

*Complaints received to 31 May 2008*

<b>Provider</b>	<b>Investor's Age</b>	<b>Amount invested</b>	<b>Status of complaint</b>
<i>Credit Institutions</i>	70 - 80	€103,216	Settled
	70 - 80	€75,000	Settled
	Under 70	€400,000	Settled
	Under 70	€250,000	Settled
	Under 70	€120,000	Under Investigation
	Under 70	€100,000	Settled
	Under 70	€99,393	Settled
	Under 70	€75,000	Under Investigation
	Under 70	€50,000	Settled
	Under 70	€50,000	Settled
	<i>Insurance Company</i>	Credit Union	€200,000
		<b>€1,522,609</b>	
<i>Stockbrokers</i>	81 - 95	€125,000	Settled
	70 - 80	€50,000	Under Investigation
	70 - 80	€50,000	Under Investigation
	Under 70	€76,000	Settled
		<b>€301,000</b>	
<i>Intermediaries/brokers</i>	81 - 95	€350,000	Under Investigation
	70 - 80	€100,000	Under Investigation
	70 - 80	€50,000	Under Investigation
	Under 70	€1,000,000	Under Investigation
	Under 70	€400,000	Under Investigation
	Under 70	€200,000	Under Investigation
	Under 70	€175,000	Under Investigation
	Under 70	€50,000	Under Investigation
	Under 70	€50,000	Under Investigation
	Credit Union	€1,000,000	Under Investigation
	<b>€3,375,000</b>		
<b>Total Invested-25 cases</b>		<b>€5,198,609</b>	
<b>Total Settled - 10 cases</b>		<b>€1,453,609</b>	

As complaints were mainly received after February 2008, 14 of them are naturally at various stages of the Ombudsman's resolution processes. In line with his normal procedures, when a complaint is received it is registered and sent to the financial institution concerned which is given 25 days to resolve the matter, otherwise the complaint becomes subject of investigation and decision by the Ombudsman. He also noted that while the minimum investment was supposed to be €75,000 for one of the bonds, lesser amounts were accepted for investment in some instances.

The Ombudsman is pleased to note that in 10 instances so far where €1.5m was invested he did not have to carry out any investigation as the matter was resolved to the Complainants' satisfaction after being initially referred by the Ombudsman to the providers as part of his mediation process. He is not aware of the settlement terms reached. He is naturally pleased when these 10 complaints have been resolved and indeed he understands that other investors have had their cases resolved without having to have recourse to the Ombudsman. He compliments these institutions for their appropriate remedies.

However noting the age profile of some of the complainants the Ombudsman is seriously concerned as to why this product was sold to them at all as he has serious reservations as to whether it could ever be an appropriate investment product for people of advanced years.

Some of the financial service providers who sold the bonds indicated to the Ombudsman that neither ISTC nor the Insurance Company fully apprised them of the risks involved; indeed they also stated they had they been informed that the product was one where capital was guaranteed. However the Ombudsman had to decide whether the providers who sold the bonds exercised a proper duty of care in ensuring that no misleading information was given at the point of sale. The allegations made against the insurance company and ISTC by the providers who sold the bonds are not matters for him to decide on.

The overall sale of these bonds is also the subject of review by the Financial Regulator and the Ombudsman is liaising with it.

*Joe Meade*

*Financial Services Ombudsman*

*3 July 2008*