



Financial Services
Ombudsman

Significant Complaints Decisions

July to December 2007

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Case 1 - A Bank Manager allowing his personal affairs to be mixed with the business affairs of a customer gave rise to a conflict of interest - €10,000 compensation

The dangers of a Bank Manager allowing his personal affairs to be mixed with the business affairs of a customer so as to give rise to a possible conflict of interest were apparent in a case where a company was allowed to run up a large overdraft by a Bank Manager who was, at the time, having extensive renovations carried out on his family home by the said company. In the end the company could not manage its indebtedness; became insolvent and was wound up. The company brought a case to the Ombudsman to the effect that the Manager ought not to have allowed the build up of debt and felt it was treated in a vindictive manner by the Manager. It appears problems over payment for the building work arose.

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

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

Case 2 - Mis-selling of Insurance Investment Fund- €10,000 awarded as management misled sales team and Financial Regulator asked to investigate Company

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

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

The Complainants on noting the performance of the *Unit Linked Fund* switched their investments in April 2006 to a Cash Fund but stated that they shortly afterwards decided they could not trust the Company or the PFA. Accordingly they surrendered

the Policy at a loss of approximately €10,000 by August 2006. The PFA no longer works with the Company.

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

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

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

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

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

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

As the sales practices of the company raised concerns the Ombudsman referred the matter to the Financial Regulator as other cases like this may have arisen particularly as the PFA stated that other sales persons were misled by management. There could also be an issue of *churning* here as it was doubtful if it was in the policyholders’ advantage to surrender mid-term and invest in another Fund. He had already referred to the Regulator another case of an inappropriate sale by the same company- see July 2007 case studies- regarding the sale to an unemployed single mother.

Case 3- Credit Card Fraud and ‘on the town’ event merits compensation of €2,500

A night out, or perhaps more precisely, a morning out *“on the town”* in Brussels, had unfortunate consequences for a Credit Card holder. It appears he visited various night spots. At one place, officially described by the Credit Card Company as a *“drinking place/alcoholic beverages merchant”*, it appears from his Credit Card account that the Complainant made four purchases totalling €7,750. One item was for €250 and was

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

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

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

Case 4 -Property Investment advice is still a problem - €55,000 awarded in two more cases

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

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

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

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

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

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

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

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

Case 5 - Injured carpenter gets €10,000 award as bank did not keep recording of 'cold call' insurance policy sale; title of policy was also misleading

A dispute involving a misunderstanding arising from the selling of an insurance policy over the phone by a bank was submitted to the Ombudsman. The Complainant was a self-employed carpenter who suffered a serious injury at work in which he broke both his arms. He had purchased the policy some three weeks earlier. When he made a claim under the policy, his claim was rejected. It turned out that the policy he had entered into was for "*personal accident insurance*" but this policy provided cover only for "*permanent disability or death*". The Complainant was under the clear impression that the type of cover he had been sold provided cover for the type of accident he had had, but it did not.

It turned out during the Ombudsman's enquiries that the policy had been sold as a result of a 'phone call from the bank to him as a credit card customer of the bank. It was unsolicited; a "*cold call*". The Ombudsman looked for a copy of the recorded conversation, or at least a transcript of it. The bank said that these were not available.

The Ombudsman also noted that the detailed Policy Conditions did not issue until ten months after the accident occurred and this was not satisfactory.

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

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

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

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

Case 6 - Insurance Policy review led to a proposed 300% increase in premiums

In September 1991 the Complainant took out Life Cover/Critical Illness protection with the Company and alleged that he was advised that for a monthly premium of IR£50 (€63) throughout his life he would receive the sum assured of IR£150,000 (€190,460) in the event of his death or critical illness. The Complainant stated that he believed from the outset that the policy was designed to provide cover of a specific value for the entire of his life, giving certainty in the amount and circumstances of

cover. The Company informed him in December 2005 that it had conducted a review of his policy and presented him with two options as follows:

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

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

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

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

The Company did not exercise its right to cancel the policy but instead offered to maintain the Benefits by a 300% premium increase or maintain the existing premium but thereby significantly reduce the Benefits by 60%. The Ombudsman considered that the policy was poorly worded and unfairly weighted in favour of the Company. In saying this he was particularly minded of the onerous nature of the policy condition and the fact that there is no policy review clause under this plan. Having said that he could not make a determination on the wording of the policy as the policy was sold more than six years before a complaint was made to him and so any such determination would be *ultra vires* the Ombudsman's statutory powers. The Ombudsman did, however, bring this aspect of the complaint to the attention of the Financial Regulator as other consumers may be similarly affected and other companies may have similar policies.

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

Case 7 - Mortgage Protection Policy - €25,000 awarded in dispute over direct debit non payment of premium

The Complainants - parents of the deceased assured - sought payment of a mortgage protection sum assured of €100,000 following the death of the Life Assured. The Company refused payment, pointing to the Policy having lapsed due to non-payment of the monthly premium. The premium was payable on the 10th of each month by direct debit. The application for the premium due on 10th February 2006 was returned by the Bank “refer to debtor”. The Company applied a second time later in the month, but advised the Life Assured that it was again returned by the Bank “refer to debtor”. The Company wrote another letter to the Life Assured pointing out that the premium was still unpaid and advising that “*we will continue to provide life cover under this policy for 30 days after the due date*”. The Company finally sent a letter advising the Assured that the policy had lapsed in March 2006. The Assured died tragically 3 days after the policy lapsed and - as a weekend intervened - more than likely had not received the Company letter regarding the lapsing of the policy.

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

In considering this case the Ombudsman noted during his investigation that

- The Company has a rational system for dealing with unpaid direct debit applications i.e. it made a second application. The Company had previously issued four unpaid premiums reminder notices and the Assured did not communicate with the Company regarding same.
- A direct debit presented by the Company on the 10th December 2005 was unpaid. This direct debit request was again presented for payment on 30th December 2005 and was paid successfully. With regard to the February 2006 premium a request was made on 10th February 2006 but not paid. This was again presented for payment by the Company on 20th February 2006 and it was unsuccessful. It was argued by the Complainants that had the Company presented on the same date in February 2006 as it did in December 2005 i.e. at end of month, then there would have been sufficient monies in the account.
- The Complainants stated that that the deceased would have had no prior knowledge as to when the Company would seek to present the direct debit if the initial application was not successful. It was also confusing from a customer’s point of view that though the policy stated that if a direct debit was unpaid no further direct debits would be presented until the requirements to recommence debiting had been fulfilled; clearly this was not the practice adopted by the Company in that it did further present for payment. It was also stated that what the deceased could not have known

was what day that a request would be made for a second time, that this was not made clear to him in any letter, nor indeed, the policy terms and conditions or otherwise. It was argued that the deceased had only past direct debit presentations for payment by the Company to guide him.

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

In his decision the Ombudsman stated that

- The Company issued unpaid premiums reminder notices in February 2005 and the policyholder did not communicate with the Company regarding same. The onus is on the Policyholder to pay premium when due. If a policyholder has elected to pay premiums by direct debit then he has a responsibility to see that his bank account is in funds on the day the premiums are due.
- He recognised that the Company did give a second chance; by making a second application for payment a Policyholder cannot place responsibility on a Company to make repeated applications in the hope that funds will become available. However he considered that the Company in this case could have made its position much clearer in its communications regarding its presentations for payment. The Company could have at the very least notified the policyholder (in its letter outlining its second unsuccessful request for payment) that no further requests would be made to his bank. The Company has accepted this recommendation.
- Regarding the intermediary's presentation for payment on a third occasion for house insurance he noted that the Company forwarded its unpaid notices and lapse of cover notice to this intermediary. The Company's argument that the companies making up the Group were separate legal entities and operate independently of each other was correct legally but, he considered that the varying procedures within the group regarding direct debits, could not, but confuse a consumer as to any leeway being given.

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

Case 8 - Travel Insurance – cancellation costs of €4,000 repaid

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

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

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

Case 9 - Credit Card sent to wrong address results in €4,500 compensation for fraudulent transactions

The constant vigilance needed by both banks and customers against the possibility of fraud were illustrated in a case about a mistake in relation to an address. When the bank sent out the Complainant’s new Credit Card and PIN it was sent to an old address and it was taken by a fraudster and used fraudulently. By the time the customer realised what had happened he had lost €12,000. The Complainant claimed that the bank was responsible because he had notified the bank of his change of address in relation to his current account and he assumed that the bank would apply the change to his Credit Card account also, but it did not.

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

Case 10 - Misleading Investment Advice by Bank- €17,000 in compensation

A customer who approached his bank for investment advice invested €100,000 in a Bond as a result. Four years later the Bond was worth €74,000. He complained to the

Ombudsman that he had been misled. He said he had wanted a low risk investment only.

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

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

Case 11- €8,000 award made as the Insurance Company did not seek the opinion of Specialist Consultant as required under a Total Permanent Disablement policy.

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

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

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

After investigation a finding issued by the Ombudsman's investigating officer did not uphold the complaint of mis-selling; it did find that the Company had not sought the opinion of a Specialist Consultant as required under the policy, and that as a result it was not possible to adjudicate on whether the Complainant satisfied the policy

definition of Total Permanent Disablement. The Finding stated that, whilst the medical evidence was inconclusive as to whether the policy definition was satisfied for a certain period of time, it was clear from the medical evidence that the Complainant had been seriously ill for this period. Accordingly taking all the circumstances of the case into account, a once-off payment of €8,000 should be made to the Complainant in recognition of her serious illness.

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

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

Case 12 - Incorrect information supplied to holder of Approved Retirement Funds - €28,000 of management charges refunded

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

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

The Ombudsman noted that the Company's decision about when it will apply a Market Value Adjustment (MVA) and how large it will be, together with its decisions about bonuses, are usually matters that are entirely for the Company itself to determine and the policy document submitted in this case covered the situation where these determinations are made by the Company. On the question of management charges, the Company argued that a fund management charge of between 1.25% and

1.75% was standard and well-known within the industry. Expenses are indeed incurred in the administration and management of funds and while there was a policy provision specifically referring to investment management fees, it was a policy requirement that these fees had to be specifically mentioned on the policy schedule, which was not the position here. The Ombudsman also noted that the true position in this case was that the charges were not explicit charges but were reflected in the declared bonus rates. He was satisfied that the Company was correct in that such charges are well-known within the industry and that one could not expect that such a policy would be immune from such charges without the policy expressly stating so. The Complainant's policies did not specifically say that there would be no charges applicable.

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

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

Case 13- Income Protection Policy and what constitutes farmers income – 'look back' carried out at Ombudsman's request

In 2004 the Insurance Company agreed to pay Income Protection benefit in respect of the Complainant's disability. The benefit payable under the terms of the policy was up to 67% of the Complainant's earnings in the twelve months prior to his disability, minus earnings after disability. The Company's position was that if the Complainant did not suffer financial hardship, it offered to make payments "*On Account*" while waiting for the Complainant to supply her income details that would enable the Company to calculate her exact benefit amount. The Company specifically reserved the right to "claw back" any overpayments.

On receipt of income details, the Company noted that the Complainant's income reduction post-disability was less than was estimated. As a result the Company calculated that an overpayment was made and sought the return of same from the Complainant. The Complainant alleged mis-sale of the policy, in particular that the policy did not make it clear how income was to be calculated.

The dispute here concerned what accounting figure represented the Complainant's income for the purpose of calculating income protection benefit. The Complainant's occupation was farming and therefore self employed. The Complainant argued that the profit/loss (described as '*actual profit*'), from her audited accounts, rather than taxable income (described as '*profit after income averaging*') should be the basis of

the calculation of her income. The Company were given the opportunity by the Ombudsman to consider this method of calculation. The Company accepted that it was appropriate to use the 'actual profit' formula. The result was that the amount said to be overpaid by the Company was substantially reduced.

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

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

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

Case 14- Insurer forwarded an incomplete company file to Ombudsman and a recommended compensation award was doubled to €500

The Complainants each had a Capital Options policy with an Insurance Company since July 1998. The Company argued that it issued a cheque for Stg£500 to each of the Complainants in February 2002. These cheques represented the Complainants' entitlements for loss of membership rights at demutualisation. The Company stated that it forwarded the cheques to the Complainants' individual addresses and insisted that both cheques were cashed, in March 2002 and May 2002 at the same bank. However, the Complainants contended that they never received these cheques and never received copies of these cheques despite their many requests. The Complainants argued that they had to make numerous telephone calls to the Company, wrote numerous letters and emails and still failed to obtain copies of these cheques from the Company.

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

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

In his final decision the Ombudsman

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

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

Case 15 - Confusion as to bank transactions by an elderly customer

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

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

The Ombudsman found this to be a relatively difficult case to resolve; there was a shortage of compelling evidence either way and it was clear that both the Complainant and the Bank genuinely were satisfied that their version of events was correct. He noted that there was no CCTV in operation at the branch at the time. The Ombudsman decided, on the balance of probabilities, that the Complainant had not made the withdrawal in question and that when the Complainant signed the slip he

believed it was a lodgement slip for €1,115, and not a withdrawal slip for this amount. While he noted and accepted that the daily cash balanced for the day nevertheless the Ombudsman felt that the bank may have made a mistake and accordingly should refund the sum in question, €1,115, to the customer.

Case 16 - Dormant Bank Account of €25,000 is ownerless

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

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

In response to the Ombudsman’s enquiries, the respondent bank set forth in some detail the steps taken by it in the last three or four years to ascertain the ownership and origin of these funds. In its efforts to establish title to these funds the bank contacted both solicitor firms, conducted a thorough review of its own internal records and went to the trouble of interviewing a retired employee who had handled the account of AB. The Ombudsman was satisfied that the respondent bank had amply demonstrated that it had taken all reasonable steps to determine the ownership of these funds. Messrs. AB made no claim as to ownership of the funds and the respondent bank wrote to Messrs. XY stating that “*in the absence of evidence from you that your firm is beneficially entitled to the funds, we cannot take the matter further*”.

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

Case 17 - Forged or stolen cheques lodged to a bank account- complaint not upheld

A customer had four cheques totalling in value €5,460 lodged to her account by other sources. She then withdrew €5,000 on the strength of this lodgement. Some days later the cheques were returned to her bank unpaid. It turned out they were stolen and/or forged cheques and the bank charged the amounts to her account. The

Complainant claimed that the bank should be held liable for the amount because it was at fault in allowing her to withdraw €5,000 against the cheques and that the bank should not be allowed to retain the money and debit her account with the costs of the transactions.

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

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

Case 18 - Disposal of shares by stockbroker - conflict of interest complaint not upheld

A Complainant who had a portfolio of investments with a stockbroker complained that the stockbroker had disposed of shares in a particular company from the Complainant's discretionary portfolio one week before takeover took place in which the stockbroker was acting for the takeover team. The Complainant would have done much better in respect of these shares if they had not been sold and his complaint in effect was that his shares were sold in circumstances where a takeover followed shortly thereafter and another division of the stockbroker had been advising the takeover team.

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

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

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

Case 19 - Motor Insurance Policy- Complainant failed to keep his vehicle in a road worthy condition.

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

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

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

Case 20 - Death Benefit Claim of €800,000 not upheld for non disclosure of prior medical condition

The background to this case was that the Insurance Company repudiated a death benefit claim. The deceased was the managing director of a product provider company for financial advisors and was a shareholder in the business. The deceased was insured under a Group Life Assurance Scheme set up for the staff of the business. The Complainant was the deceased's company i.e. the policyholder. The Company's declination of the death benefit claim (for €800,000 plus) rested on the argument that the deceased's medical condition had not been revealed to the Insurance Company and that the requirements of the '*Statement of Attendance*' (i.e. *actively in work and not absent for more than 10 days in past 3 months*) as set out on the application form were not conclusively proven.

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

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

- The normal practice in the industry for Group Life Schemes is that the Insurer will offer a non medical / non declaration limit to facilitate their securing large business and to keep the costs at a minimum.
- It was argued that no underwriting was required for any benefit below the stated limits. The Complainant pointed to the information on the Company's web site in this regard.

- It was argued that this case qualified under the Company's conditions for a non selection limit as all employees were inclusive for a uniform level of benefit and all were capable of completing an 'actively at work' declaration.
- The Complainant argued that insurers are aware that that they get both good and bad risks, but on balance will write a profitable book of business and that the Company accepted the risk and issued a cover letter to the insured.
- The declaration of attendance had been completed in good faith by the proposers and that when the cover was proposed for, the Insurance Company were aware of the nature of his illness as it was common knowledge in the industry.

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

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

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

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

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

- The Complainant's argument was that the Group Policy differed from an individual policy and excluded a requirement of full disclosure. The doctrine relative to disclosure in insurance contracts was dealt with in the case of *Argo*

Road and Land Vehicles Ltd v ICI [1986] IR 403. In that case Henchy J. in the course of his judgement at page 408 stated as follows:

Generally speaking contracts of insurance are contracts uberrimae fidei, which means that utmost good faith, must be shown by the person seeking the insurance. Not alone must that person answer to the best of his knowledge any question put to him in a proposal form, but, even when there is no proposal form, he is bound to divulge all matters within his knowledge which a reasonable and prudent insurer would consider material in deciding whether to underwrite the risk or to underwrite it on special terms. This is the general rule. Like most general legal rules, however, it is subject to exceptions. For instance, the contract itself may expressly or by necessary implication exclude the requirement of full disclosure. It is for the parties to make their own bargain – subject to any relevant statutory requirements – and if the insurer shows himself to be prepared to underwrite the risk without requiring full disclosure, he cannot later avoid the contract and repudiate liability on the ground of non-disclosure.

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

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

- This was accepted as an accurate statement of the principle of limitation of the obligation for disclosure arising from the particular form of questions, in *Hilda Kelleher v Irish Life Assurance Co. Ltd (SC) 8 February 1993, (unreported)*. In the *Kelleher* case the court held that the insurance company had significantly limited the disclosure required from the proposers and the non-disclosure by them did not entitle the company to repudiate liability.
- The declaration on the proposal form in the *Kelleher* case was:

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

whereas in the case before the Ombudsman the declaration stated:

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

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

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

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

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

Joe Meade
Financial Services Ombudsman
10 January 2008