

COMPLAINTS DECISIONS in the April to September 2005 period

(a) Credit Institutions***Elderly Couple's Unsuitable High Risk Investment - €56,000 compensation***

The Complainants in the case, an elderly couple, invested €127,000. When the investment matured four years later, they received a cheque for €34,000. That was all that was left of their original investment. They complained to the Ombudsman that the Financial Service Provider had failed to discharge its duty of care to the Complainants by recommending an investment which was completely unsuitable to their circumstances.

The couple were approaching 70 years of age and the husband was suffering from a severe disability. In these circumstances, the Ombudsman felt that a high-risk investment was unsuitable and should not have been recommended by the Provider. The Ombudsman considered that there was a failure on the part of the Provider to explain properly to these consumers what the extent of the risk was.

In arriving at a measure of compensation, the Ombudsman took into account that when the Complainants made the investment they must be taken to have accepted a degree of risk to their capital sum. Nevertheless, the Ombudsman felt that the Provider should carry the larger part of the loss in the light of his finding that, having regard to the age, disabilities and circumstances of the Complainants, the Financial Service Provider had largely failed in its duty of care to these consumers who had sought its advice. The Ombudsman considered compensation of €56,000 to be appropriate.

Fall in investment value of an 80 year old person's joint investment-not upheld

A customer who invested €120,000 in an Investment Bond found after 2 years that the value of the investment had fallen by 26% and she complained to the Ombudsman that the Bank was negligent in selling investment policies which were not appropriate to her circumstances and the Bank should be made responsible for the loss which occurred.

The chief customer in this case was a lady in her 80s. However, the account was jointly held with her son, who was closely involved in the discussions and the decision-making process concerning the investments, and he had had previous experience in investing in medium-high risk investments at the same Bank.

Following investigation, the Ombudsman observed that although the investment had been made in a medium-high risk Bond, he found that the information that the investment could go down as well as up was clear from the information brochure which the Complainants had seen and read and the Complainants had been fully advised as to the nature of these investments in discussions with the Advisor.

On the basis of the evidence he had seen, the Ombudsman did not consider that the Bank was in any way negligent in selling this investment product to these customers. The evidence

showed that the customers themselves had elected to take up this particular investment from a number which had been offered to them. The Ombudsman came to the conclusion that the investment policy sold was not inappropriate to the Complainants' circumstances and that the Complainants had been fully aware that there was a considerable element of risk in the product and he found no negligence or failure of duty on the part of the Bank. The complaint was not upheld.

Inappropriate Investment Advice - €20,000 compensation

This case concerned a six figure sum invested with a Bank. The Complainants alleged that their investment was placed in an inappropriate investment policy, contrary to their instructions, and that a substantial loss resulted. The Bank denied the allegation and said that all elements attaching to the investment were fully explained to the Complainants before they opted to proceed with the investment. The Bank claimed that the Complainants were given a copy of the relevant brochure and were taken through the details of the investment. In addition, there was a 15 day cooling-off period during which they could have rescinded the investment.

Having investigated the complaint fully and all the documents involved, including the financial circumstances of the Complainants (which the Bank should have clearly established), the Ombudsman was not entirely satisfied that the advice given to the Complainants in this case was correct and appropriate. A very, very high proportion of the Complainants' available total capital was placed at risk and a large sum of money (€30,000) was lost as a result. In the circumstances the Ombudsman awarded €20,000 in compensation.

Fee of €25,000 on transfer from fixed to variable rate of interest- not upheld

This was a dispute arising from a commercial loan of €270,000 at a fixed rate of interest. Some five years later the Complainants wished to change the loan to a variable rate and the Bank advised that if this was done, a funding fee would be payable – a fee of €25,000 was the stated fee. The Complainants objected that this was unfair and unreasonable and contrary to the terms of the agreement.

The Ombudsman, on investigating, found that the loan was to be for a term of 15 years and it was clear from the terms of the agreement that if anytime during the fixed rate period the borrower was to seek to change the agreement to a variable rate, then a funding fee would be payable. The Complainants must be taken to have agreed to this. The Bank calculated the funding fee on the amount being paid off at that stage.

The Ombudsman found that the Bank, when it enters into a fixed interest contract, will have entered into a matching contract with a third party to supply the funds, and if the customer to whom the Bank has lent the money terminates the loan early, the Bank is still left with its obligations under the contract with the third party. The object of the funding fee is to leave the Bank in the same position it would have been in if the customer had continued with the original contract. Once the customers decided to seek to change the terms of the contract, the Bank still had its third party obligations to meet. In these circumstances the charging of the funding fee by the Bank was in line with the loan contract which had been agreed by the customers and the Bank was within its rights under the agreement to charge this. The complaint was not upheld.

Endowment Mortgage shortfall – not upheld

A complaint relating to an endowment mortgage was considered by the Ombudsman. The basis of the complaint was that the customers were advised that the 15 year mortgage would be repaid after a period of 13 years & 7 months. On that basis, the Complainants selected the endowment mortgage. After a period of 14 years, the Complainants received a notification that the proceeds of their policy would not be sufficient to discharge the mortgage debt. The complaint was that the Financial Service Provider, having sold the endowment policy to the Complainants, failed subsequently to assess the performance of the policy or at any time, to report on the policy's performance to the Complainants so that it was not until 14 years of their 15 year mortgage term had elapsed that the anticipated insufficiency of the proceeds was drawn to the Complainants' attention.

However, having investigated the case, the Ombudsman was satisfied that the Complainants had indeed been updated on several occasions over the course of the 15 year mortgage term and the correspondence which had been sent to them explained the manner in which the endowment worked and why the Fund value fluctuated up and down.

The Ombudsman noted that the performance of the Fund had been reviewed on a regular basis and he considered that the Complainants' allegation that they did not know of the potential shortfall of the Fund was not justified. The complaint was not upheld.

Direct debits and technical problems in bank - €750 awarded

This case arose involving a Credit Card customer whose direct debit payments had been processed incorrectly by the Bank due to technical difficulties. It was alleged that the Bank wrongfully debited the sum of €1,500 from the Complainant's current account held at another bank, and while the Respondent Bank had undertaken to make the correction within 24 hours, it had not done so, resulting in embarrassment, inconvenience and expense to the Complainant.

Having concluded his investigation, the Ombudsman was satisfied that the Bank had wrongfully debited the sum of €1,500 from the Complainant's current account, and when the mistake was pointed out to it, had undertaken to correct the mistake within 24 hours, but had failed to do so.

The Ombudsman found that the Complainant's account had indeed been wrongly debited through technical difficulties and when these technical difficulties recurred, the Bank had not provided any explanation to this customer. The Ombudsman found that as a consequence of these debits, the Complainant was caused considerable inconvenience and some expense. The Ombudsman awarded €750 in compensation for the wrongful actions of the Bank.

ATM card withdrawals – not upheld

A case involving monies wrongfully taken from a customer's account using her ATM Card was investigated by the Ombudsman. The Complainant went on holidays abroad and left the Card in safekeeping with her sister. The Card was subsequently stolen and when the Complainant returned, she reported the theft of the Card to the Bank. The Complainant said at this stage that

she was not unduly concerned as she was the only person who knew the PIN Number and therefore believed that no withdrawals could be made. However, when she checked her account, she found that all the money in it had been withdrawn (a sum of €2,300) in unauthorised withdrawals. The customer sought the return of the money because the monies had been withdrawn from her account without her knowledge and consent.

On investigating, the Ombudsman found that the withdrawals had been made over five successive days, withdrawing the maximum amounts on each occasion. On reviewing the audit trail, it was clear to the Ombudsman that whoever had accessed the Card had used the correct PIN each time with the correct Card. There was no evidence of malfunction at the ATM and no evidence either of some foreign electronic device having been used.

The Courts have ruled that when an ATM Card is inserted and the correct PIN is used, provided there is money in the account and the withdrawal sought is within the amount of money to be withdrawn for the day, then the Bank involved is contractually bound to pay out the money. After a full enquiry, the Ombudsman could discover no failure on the part of the Bank or of the machinery or of the systems, and the complaint was not upheld.

(b) Insurance complaints

Life Assurance – Customer care issue –partly upheld and €1,000 awarded.

The Complainant insisted that he was entitled to the Policy Fund Value plus the Sum Assured following the death of his wife (the Life Assured) as this was the deceased's alleged understanding of the position. A partial surrender was taken a short time before the Life Assured's death without affecting the life cover. Subsequent to the Partial Surrender the Life Assured submitted a request for a further surrender up to the maximum allowed and later had face to face talks with a company representative regarding same.

The evidence showed that the company representative appeared to believe that the second proposed surrender together with keeping the Sum Assured intact was possible. However, it was later established that the second proposed surrender was not possible and this information was communicated to the Life Assured. In the circumstances it could not be said that there was an agreement on the matter.

On the death of the Life Assured the Company offered the Sum Assured as its total liability under the Policy. It was found that while there was some confusion caused by the Company, the contractual position regarding surrender was that surrender may affect the level of benefits provided for under the policy. The Life Assured's wish to take a second surrender to the maximum amount with the same level of cover as before was not possible. A full encashment would have had the effect of terminating the policy. On the Life Assured's death her estate was accordingly only entitled to the death benefit under the policy.

However on a customer care issue the Company acknowledged they may have caused distress to the family at the time of a bereavement and offered a small sum on an *ex gratia* basis. In considering what was fair and reasonable in the circumstances of the case and having regard in particular to the likely distress caused by the Company the Ombudsman recommended that the Company uplift its *ex gratia* offer.. The company agreed to the increased figure of €1,000.

Travel Insurance – Claim for cost of replacement passport repudiated by Company – €50 awarded

While on holidays the Complainant lost her handbag containing cash and passport. Her subsequent claim for Personal Money was settled by the Company subject to the maximum under the terms of the contract. The claim for a new handbag was declined by the Company under the personal Baggage section of the Policy, as the total cost was less than the excess of €40 and a sum of €20 in respect of postage was also declined as consequential losses are not covered under the Policy. The Company also refused the claim for a replacement passport on the grounds that the Policy only covers an insured person for certain expenses incurred **abroad** in obtaining a replacement passport.

Regarding the repudiated claim for a replacement passport, the Complainant submitted that her interpretation of the relevant section of the policy was that the passport should be covered. On the other hand, the Company stated that cover is provided for certain reasonable expenses incurred **abroad** in obtaining a replacement passport, and from the information provided by the Complainant, it was clear that she did not incur any such costs abroad.

As no costs were incurred aboard, cover was therefore not ordinarily applicable in this instance. That said the definition of “Money”, in the Policy contained a joint definition of “Money and Travel Documents” which included, *inter alia*, passports. Applying the test of reasonableness, it was the Ombudsman’s view that the Complainant was entitled to some benefit of the doubt regarding the lack of clarity in the Policy definition of “Money”. As a result the Ombudsman found that the Complainant was entitled to a payment of €50.

Income Protection Policy – Policy voided for non-disclosure- not upheld but contributions refunded

The background to this dispute was that the Complainant submitted a claim in respect of income protection benefit. The cause of the disability was described as severe back pain. The Company repudiated the claim on the ground of non-disclosure of information in the period prior to cover commencing.

The application form had been completed in early 2004. The Complainant was accepted for cover in mid March 2004. Premium collection did not commence until end of March 2004. The Complainant had a road traffic accident in mid February 2004. At this time the Complainant underwent X-rays and MRI scans on his back. It was also recommended at this time that further tests be carried out. The Complainant remained absent from work from date of the accident up to the date of the acceptance by Company. The Complainant had been absent from work after the date of acceptance but did return to work in May 2004. The Complainant later ceased work due to back pain.

The Complainant had declared when filling out the application form that he understood that Company must be notified of any changes in health and / or circumstances prior to the assumption of risk. The Complainant also declared that he understood that failure to disclose a material fact, (being a fact which may influence the assessment and acceptance of the proposal by the Company) may constitute grounds for rejection of a claim and render the contract void.

The Complainant declared that he understood that cover under the Scheme would not commence until the application had been accepted by the Company.

It was the Company's case that had it been notified of the change in circumstances i.e. road traffic accident, X-rays, MRI scans and further recommended medical investigation it would have deferred acceptance pending the outcome of the medical investigations. It was the Company's case also that when the diagnosis was confirmed, the likely decision would have been to decline.

Having examined all the documentation submitted and considered both parties arguments the Ombudsman's finding was that a contract of insurance is voidable if a party fails in preliminary negotiations to disclose a fact material to the risk. A material fact is any fact that will influence the judgement of a prudent underwriter in assessment of the risk. The duty to disclose all material facts ultimately falls on the proposer. It is important to note the duty to disclose all material facts extends right up to the date the Company accepts the proposal and goes on risk (*Canning v. Farquhar* (1886) 16 QBD 727). The declaration on the proposal form specifically made this clear i.e.: *It is understood that [Company] must be notified of any changes in health and / or circumstances prior to the assumption of risk.*

The Ombudsman also found that the Company was entitled to be informed about the circumstances of the Complainant's road traffic accident, the undergoing of X-rays on his back of a MRI scan and the proposed tests in order to assess the risk accordingly. (*The Complainant's road traffic accident, the undergoing of x-rays and the proposals were prior to commencement of cover*).

The Ombudsman concluded that the Company had acted within its rights in repudiating the claim and voiding the insurance cover but as the Complainant's insurance cover was void the Company should refund all contributions paid by the Complainant.

Life Assurance – Mortgage Protection Policy – Complaint partly upheld.

The Complainant's case was that as her mortgage loan was repaid premiums taken by direct debit from her bank account in respect of the Mortgage Protection Policy after payment of loan should be refunded. The Company's case was that the Policy remained in force and it was liable to pay the Sum Assured in the event of the death of the Life Assured.

It was pointed out to the Complainant that although a Mortgage Protection Policy is usually arranged to pay the outstanding amount under a Mortgage it is in fact a Term Assurance with a Decreasing Sum Assured. It stands independent of the Mortgage and the Sum Assured is payable whether or not there is an outstanding Mortgage at time of claim. Some Borrowers do in fact continue this relatively cheap form of Life Assurance even when the Mortgage is repaid. If premiums continue to be paid the Company is liable for a claim and therefore entitled to the premium.

The Ombudsman was satisfied that the Complainant was sufficiently aware that the policy was still in force *i.e.* from annual statements sent by the Company and the fact that direct debits continued to be taken from her account. The Company offered *as gesture of good will* to refund a portion of the premiums.

Having regard to the overall circumstances of the dispute, the Ombudsman could not uphold the Complainant's claim to a full refund of premiums. However, having regard to the lack of specific requirements in the policy documentation how to effect a cancellation, an uplift of the Company's *good will* gesture was recommended by the Ombudsman and accepted.

The Ombudsman also communicated with the Financial Regulator so that steps are taken industry wide to inform consumers when a mortgage is being redeemed as to the protection policy position.

Travel Insurance - definition of "close relative" - not upheld.

The background to this travel insurance claim was that in early 2004 the Complainant went on a five weeks holiday abroad, but returned home after four days due to the death of his aunt. The subsequent claim for curtailment was declined by the Company on the grounds that an "aunt" did not come within the Policy definition of "close relative". The Complainant maintained that the use of the word "relative" in the documentation was very confusing and that the policy conditions were unclear.

On examination of the policy document the Ombudsman found that while the Policy did provide curtailment cover in the event of the death of a close relative, the specified definition of "close relative" did not include an "aunt". The Ombudsman found that the policy wording was clear on this point.

"Close Relative: *Spouse or Partner, mother, mother-in-law, father, father-in-law, stepmother, stepfather, daughter, daughter-in-law, son, son-in-law, (including legally adopted daughter or son), stepchild, sister, sister-in-law, brother, brother-in-law, grandparents, grandchildren, or fiancé (e) of an insured person".*

While the Ombudsman sympathised most sincerely with the circumstances which required the Complainant to curtail his holiday the Company was contractually within its rights to decline the claim for curtailment and the complaint was not upheld.

Motor Insurance Policy - Pre-Theft Value – up-lift of value to €3,000

The background to this dispute was that the Complainant was dissatisfied with the market value (€2,000) offered by the Company following the theft of her car. The car was found to have been previously damaged in an accident. The car had been classified as being Beyond Economic Repair (BER) after the accident.

The Complainant felt that the pre-theft value of the car should have been in accordance with other cars of a similar specification as advertised in various car sale manuals. The Company felt that its offer was fair. The Company's offer was based on an engineer's report and took into account such factors as the mileage, the age and the condition of the car.

In the Policy document the Company stated that it would not pay for '*Loss or damage exceeding the current market value of the car or the amount specified in the policy schedule, whichever is the less*'.

In order to obtain independent valuations, five main dealers were contacted by the Ombudsman's staff. The dealers acknowledged the fact that as the car had previously been classified as BER this would have had a serious impact on the value of the car. However each stated that it really depended on the quality of the individual vehicle. From the valuations supplied by the dealers and review of various car guides it appeared to the Ombudsman that the car could fetch a substantial amount over the €2,000 offered.

Having regard to what was fair and reasonable in the circumstances of the case and taking into consideration the research carried out, the Ombudsman recommend that the Company increase its pre-accident value from €2,000 to €3,000. The company accepted and paid this amount.

Loan Protection Plan –trouble in settling case- €200 and apology

The Complainant pointed to a very poor level of service in pursuit of his disability benefit claim. The Complainant acknowledged that all benefit for which he qualified had been paid. However he felt an apology and some recompense for the unnecessary trouble he was put to in pursuing his claim was needed.

Having investigated the complaint the Ombudsman expressed to the Company his concerns about the quality of the service provided in this instance and suggested that the matter be reviewed. The Company subsequently indicated to the Ombudsman that it was willing to make an *ex gratia* payment of €200 and apologised for the customer service issues raised. The Ombudsman considered that this was a reasonable resolution of the matter.

Medical Expenses Insurance Policy – Repudiation of Claim on Grounds of Pre-existing Condition – Complaint not upheld

The Complainant took out a policy for medical expenses with the Company in 2001, under which her daughter received cover. The Complainant stated her daughter had an ear problem since birth but both the Complainant and her daughter only considered it to be a problem from 2002 onwards. She underwent ear surgery in 2004 and the Complainant claimed for medical expenses from the Company which repudiated the claim on the grounds that the condition for which she was treated pre-existed the inception of the policy.

The Complainant maintained that the condition which needed surgery arose in 2003, by which point they had been members of the Company for over two years and therefore their claim should not be precluded by the policy terms the Company relied on. The Company maintained that as the Complainant's daughter had the ear problem since birth, the condition was present prior to her application for membership. Accordingly the cost of the surgery was not recoverable under the policy which provided *inter alia* that

No benefits are payable for medical conditions the date of onset of which is determined on the basis of medical advice to have been prior to the date the member was included on the contract, unless the member has been insured continuously for a minimum period of time. The minimum period is as follows:

<i>MEMBER'S AGE WHEN HE/SHE IS INCLUDED:</i>	<i>MINIMUM PERIOD</i>
<i>Under 55</i>	<i>5 years</i>

While the Company accepted that the Complainant did not seek treatment for her daughter in respect of her ears until September 2003, the condition was, nevertheless, present prior to her application for membership and therefore the Company could not provide any benefit in this case.

Having considered this complaint in detail the Ombudsman noted that the Complainant's daughter's condition has been present since birth, a fact which the Complainant accepted. The Ombudsman also noted that the Complainant's daughter had been insured for only over 2 years. The condition, therefore, pre-existed the inception of the policy while no benefits were payable for such a condition under the terms of the policy until the member has been insured for a continuous period of 5 years. On the facts presented the complaint was not upheld by the Ombudsman.

This decision highlights the importance of all material facts being disclosed when applying for medical or any form of insurance so as to avoid unnecessary disappointment later.