

Biúró an Ombudsman um
Sheirbhísí Airgeadais



Financial Services
Ombudsman

Sample of Complaints Findings

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INDEX

Page

- €345,000 to be returned to two elderly investors 3
- €300,000 six year bond should not have been sold to 85 year old couple 4
- €90,000 for not clearly explaining the downsides of a geared property fund 6
- Conflict of interest not disclosed merits €53,000 award 8
- €7,500 award to widower told in error on four occasions of €130,000 death benefit 9
- €116,000 refund to elderly investors for ten year bond sale 10
- Alleged €1m inappropriate investments by elderly person not upheld 11
- High Risk Property Fund Investment of €75,000 was unsuitable - €60,000 award 13
- Unsolicited approach to old age pensioner for €35,000 investment - €6,500 award 14
- €3,000 insurance fund increase for reviews not carried out - possible 96,000 cases 15
- Benefit of €25,000 paid to blind person as Company's actions were unfair 16
- €25,000 to be paid as cause of death insurance benefit condition was inequitable 18
- Cardiac Surgery costs of €15,000 repaid and pre-existing medical condition 19
- Benefit of doubt in complaint regarding €18,000 disability payment 20
- Credit card fraud of €540 in Thailand 21
- Only €2,000 of foreign ATM withdrawals of €4,000 were fraudulent 22
- 50% of health claim of €11,400 paid as pre existing condition not fully proven 23
- €30,000 stolen property from guesthouse and non disclosure of prior claims 24
- Burned out stolen car complaint of €3,500 and son stealing it not disclosed 26
- Fall of €10,500 in €40,000 investment merits €6,660 award 26
- €100,000 Investment Bond complaint not upheld 28
- Bank account of deceased could not be released to a brother 28
- Six month notice period for cashing in investment policy cost investor €5,000 29
- Concerns about motor insurance policies cancelled over the phone - €800 award 29
- Accountancy firm's role in 'execution only' €500,000 investment was confusing 31
- €200 awarded for delay in paying travel insurance claim 32
- Hair transplant eyebrow treatment health insurance claim not upheld 33

€345,000 to be returned to two elderly investors

A couple in their 70s had their life savings on deposit but were approached by their Bank in late 2005 and advised that they would get a much better return if they took the money off deposit and invested in a Managed Fund instead. After a short discussion they agreed to do this and in early 2006 they invested €345,000 in these Funds. In July 2008, the Complainants were again contacted by the Bank and advised to switch the investment into cash as the Fund was losing heavily in value. The Complainants were very concerned about this and met with the manager of the local branch. They stated that it was only at this meeting that the investment was explained to them in detail and it was the first time that they fully understood how the investment functioned. It was only at this stage that the Complainants claimed they were informed that 70% of the investment, €245, 000, was based on the performance of the stock market. The Complainants claimed that they had never been told this before and that they would not have entered into an investment that was based on the stock market performance. By then in 2008 the €345,000 investments were worth only €265,000, invested funds of €240,000 (then valued €170,000) could not be withdrawn for at least six months and an early encashment penalty of €9,000 would also arise. The money had been mainly invested in an Irish Property Fund for a period of 5 years and 9 months. They complained to the Ombudsman that the investment was unsuitable for them.

The Ombudsman had to consider whether the recommended investments were appropriate or not. He noted that the investors were in their 70s; the husband was retired and had no pension; he suffered from heart disease (from which condition all five of his brothers had died) and was a diabetic. This personal and individual history had been pointed out to the Bank's representatives according to the Complainants, and though the Bank denied it was aware of the specifics of the Complainant's illness it accepted that its sales representative had been given basic information about the health issues.

Having regard to these circumstances and to the fact that the introduction to these products was at the instigation and initiative of the Bank and that the sales pitch and financial review had been carried out at the home of the Complainants, the Ombudsman found that the Bank had not exercised appropriate care and caution in dealing with the Complainants, given their age, investment inexperience, previous investment profile and the health of the husband. It was clear to the Ombudsman that the Complainants had misunderstood the issue of risk and the nature of the investment. He also found that the Bank, in recommending and rushing through these investments with an unacceptable degree of haste, had failed in its duty of care to these customers.

The Ombudsman directed that the full amount of money paid for the investments, €345,000, should be paid back to the Complainants in return for the surrender of the investments to the Bank.

€300,000 six year bond should not have been sold to 84/5 year old couple

A widow complained that she and her late husband had been mis-sold a Capital Protected Bond by a financial provider in December 2006. The Complainant and her late husband were 84 and 85 years of age respectively at the time, and were living with their son and his wife. A considerable sum of money was invested, some €300,000, which the Complainant indicated was from the proceeds of the sale of their house. The investment in the Bond had a term of six years and the Complainant and her husband could not access the funds invested before the age of 90/91 without incurring large penalties though they would get an annual income.

Sadly the Complainant's husband passed away within 18 months of making the investment. As the Bond contained a provision that any death claim would be paid out only on the death of the surviving investor, sole ownership of the Bond transferred to the Complainant as surviving investor. On making the complaint in September 2008, the Complainant, now aged 87, had taken up full time residence in a private nursing home. Though the Bond had a capital protection value of €283,000 at January 2013 nevertheless if the Bond was cashed in August 2008 the surrender value was €248,000 with an early cashing in penalty of €10,000. This value was falling each day however.

In defending the investment advice the provider submitted considerable documentation to establish that the Complainant and her husband fully understood their investment in the Bond, including reference to a €100,000 deposit account which should cover their emergency needs as well as a monthly pension of €2,000. Also another open ended unprotected capital investment bond of €265,000, cashable without penalty and with an annual income, had been taken out with the same provider in 2004/5 - there was no complaint about that bond. The Ombudsman noted that while their son was present at the meetings in 2004/5 the provider stated that the couple declined its request to have the son present at the December 2006 meeting. However, what concerned the Ombudsman was not the Complainant's and her husband's understanding of the type of investment involved, although that was significant, but rather the **suitability** of this investment for them at the time of investment meetings in 2006, i.e. had the Provider adequately considered and discussed with the Complainant and her husband the suitability of the product, taking into account their life expectancy, circumstances and particular financial needs.

The Provider submitted a copy of the Personal Finance Review carried out with the Complainant and her husband in December 2006, purporting to contain details of their existing financial arrangements, agreed investment action to be taken, and a summary explaining the recommendations made. The stated purpose of this review was "*to review your current financial arrangements and to analyse your other financial needs*". Upon examination the Ombudsman was struck by how little information was contained within this Personal Finance Review document. There was no mention of the customers' age profile, other than to state that both were "*retired*". There was no analysis of the customers' attitude to risk or the need to provide for future health care needs such as nursing home care. While the Provider maintained that the financial adviser had been "*very careful*" to ensure that the Complainant and her husband were adequately provided for in this regard, the possible financial provision for nursing home care received no mention whatever in the Personal Financial Review report.

The Ombudsman accepted that the Complainant and her late husband were provided with detailed information on the working of the Bond, the risks involved, and the long term nature of the investment. While he also accepted that they signed the application

form, however, in all good conscience he could not accept that the investment was suitable in their circumstances. Furthermore, the evidence did not support the Provider's contention that adequate consideration and discussion had taken place with regard to the age of the Complainant and her husband, the very real possibility that they would not see out the term of the investment, or the overriding requirement that they make adequate financial provision for potential long term health care costs. In short, he was of the view that recommending an investment product with a term of six years as well as hefty penalties for early encashment to an elderly couple of 85 and 84 years was a dereliction in the Provider's duty of care. In effect, this Bond should not have been sold to the Complainant and her husband.

Accordingly, he directed that the financial provider should buy back the Bond for the original investment amount of €300,000 and pay such value to the Complainant less any income received from the Bond to date. He also considered that an additional sum of €5,000 should be paid to the Complainant as compensation for the mis-sale.

€90,000 for not clearly explaining the downsides of a geared property fund

A husband and wife who invested €150,000 in a Unit Linked Fund found that after three years their investment was worth less than €40,000. The Fund was a UK Property Fund.

The Complainants alleged that the investment was inherently unsuitable for their needs in that they had specified a low-medium risk. The Ombudsman found that the investment was not in itself unsuitable. However, the reason for the disastrous fall in the value of the investment was that the money was invested in a Geared Property Fund where the property which had been purchased by the Fund had been funded using 75% of Bank borrowings and only 25% of investors' equity. The effect of this "gearing" was that if the value of the property increased, it would be advantageous to the investor. However, if the value of the property was to fall this would have a disproportionate and disastrous effect on the value of the investor funds. This is what happened. The Complainants alleged that they had had no idea what gearing meant in this context and that the Bank should have informed them of "gearing". The Bank stated in its defence that these customers had been properly informed at two meetings

which had taken place between officials of the Bank and the customers. The Complainants denied this.

There being a total conflict on the written evidence as to what was said at the meetings in question, the Ombudsman decided that an Oral Hearing was required in order to resolve the conflict of fact which had arisen. At the Oral Hearing, both parties were represented by counsel and evidence on oath was given by all the parties present at the meetings and they were cross-examined on their evidence.

Having reviewed the Oral Hearing evidence and taken all the written submissions into account, the Ombudsman concluded that the crucial question in the case was whether the Bank had wrongfully failed to disclose risks associated with the geared nature of the Fund to the Complainants at the moment of sale. After considering all the evidence, especially the evidence given at the Oral Hearing, the Ombudsman said that *“it was perfectly obvious that whereas recourse borrowing had been explained in some detail, the implication of ‘gearing’ to this investment was not explained at all”*. Gearing in this context means that with a decline in the value of the property, the value of the investment will fall further and faster than the market value of the property itself. If there had been no gearing then the fall in the value of the investment would be the same as the fall in the value of the property itself. However, he found that this complicated method of financing this particular investment had not been explained to the Complainants and he was satisfied from the oral evidence that if it had been pointed out in such stark detail, which it should have been, then the Complainants would not have invested in this product at all.

However, in apportioning blame, the Ombudsman also referred to the brochure which had said *“gearing by its nature may increase the potential returns from an investment such as this but it also increases the risk associated with the investment and in a worst case scenario, investors could lose all of their investment”*. The Ombudsman felt that the Complainants (who had had the general summary of the brochure) had not read into the brochure in detail and beyond the general summary and if they had, prudent investors would have come across this passage and it may have affected their decision.

Nevertheless, the Ombudsman was satisfied that the greater onus is on a bank when advising clients and bank advisors need to be clear and straightforward in explaining every nuance of an investment policy to people who are going to invest their money. Accordingly, the Ombudsman found, on the balance of probabilities, that had there been an explicit verbal discussion of the downside risks associated with gearing, the Complainants would not have proceeded with their investment in this Fund. However, the Complainants, for the reasons stated above, had to carry some of the blame for the loss that had been incurred because they did not read the brochure in great detail, this being a contributory factor in mitigating the loss. The Ombudsman assessed this at 40%

The Ombudsman therefore directed that the couple should surrender the Bond to the Bank after €90,000 in compensation for the breach of duty which occurred was paid.

Conflict of interest not disclosed merits €53,000 award

A couple had €100,000 to invest and sought investment advice from a broker. It recommended investing in a property scheme of apartments in the United Kingdom. The Complainants alleged that they were advised that they would not actually have to buy the property but that it would be sold on or “*flipped over*” within 12-18 months. The Complainants indicated that they wanted to have their own solicitor but the Broker said that they would have to use a particular firm of solicitors in the UK. They went ahead. They invested €53,000. The Complainants signed what was called a “*Pre-Contract*” and they alleged they were told it was not a binding contract although it turned out to be so.

A year later they learned that the sale of the apartments had fallen through and they lost €53,000. The Complainants then learned that the Broker had got a commission from the developer of 50% of the deposit which they had paid.

As a result of the Ombudsman’s investigation he was satisfied that the Broker had a clear conflict of interest which he had not disclosed to the Complainants in that he was promoting the development himself and had an interest in doing so. The conflict of interest should have been disclosed to the Complainants and it was not.

Furthermore, the Complainants should not have been discouraged from having their own solicitor. The Ombudsman found that the Broker had misrepresented the nature of the documents which the Complainants had signed and he directed that the broker should pay €53,000 to the Complainants. He also reported the case to the Financial Regulator as this was one of a number of complaints of this type that he had received.

€7,500 award to widower told in error on four occasions of €130,000 death benefit payout

Two years after a married couple commenced a policy of life assurance, sadly, the wife died. The following year, enquiries were made by the husband's sister in relation to benefit payable and the Company reverted indicating that €130,000 was payable to the husband, upon his wife's death. This information was subsequently reiterated by the Company and then confirmed again to the husband in person when he attended at a meeting. Subsequently however, the Company wrote indicating that the deceased had not in fact been insured on the policy, and the husband had been given incorrect information, owing to a training error. The husband was very upset that he had been told by the Company on at least four occasions that benefit of €130,000 was payable to him on his wife's death. On the strength of that information he had taken time off work to attend meetings, in order to re-arrange his financial affairs.

Investigation of the matter by the Ombudsman revealed that at the time when the policy commenced, it was only the husband's life which was covered by the policy, and that the couple had been informed by the Company when the policy was incepted, that the wife's life would not be covered, owing to existing medical issues. Policy documentation had issued to the husband and wife confirming this, and indeed this had also been clear from the annual benefit statements issued by the Company.

The Company noted, with regret, the error made in giving incorrect information to the deceased's husband, following her death, arising it seems from an error on the part of a staff member, who had interpreted joint policy holders to mean joint lives assured. The Company advised that steps had been taken to ensure that no similar error would occur again, including the re-training of a number of staff members.

The Ombudsman noted that for a period of over a month, the deceased's husband, who had a young family to provide for, had been given to believe by the Company that he would be issued with a benefit payment of €130,000, following the loss of his wife. He had taken time off work to re-arrange his financial affairs, and was clearly therefore very distressed when he was subsequently advised that in fact no benefit was payable. The Ombudsman found it assuring that the Company had taken steps to re-train staff where appropriate, in order to avoid a similar situation arising again.

However, the Ombudsman considered that the goodwill gesture of €1,000 which the Company had previously offered to the deceased's husband, in recognition of the distress caused (subsequently increased to €1,500) was totally inadequate and he directed the Company to increase it to €7,500 instead.

€116,000 refund to elderly investors as ten year bond was sold rather than a five year one

In December 2006, an elderly couple invested €560,000 in a 10 year Bond upon the advice of an Intermediary. The Bond was surrendered for €445,000 in September 2008 at a considerable loss owing to an early exit fee and an additional deduction of €116,000 for "*Market Value Adjustment*" (MVA). The Complainants were unhappy with the imposition of the MVA which they considered penal, as they had been unaware of the potential extent of the MVA and had not realised that it could apply at any time during the term of the investment. They indicated that they had believed that penalties for encashment would only apply within the first 5 years of the investment and pointed out that they had never wished to invest in a 10 year policy.

A complaint was made against the Intermediary which had recommended the policy to the Complainants. The Intermediary referred to the Recommendation Document indicating that the Bond should be viewed as a 7-10 year investment. It also relied on the clear explanation in the "*Terms Explained*" which made it clear that the MVA was relevant to the investment if a decision was made to surrender the investment before or after the 10th policy anniversary. The Intermediary pointed out that references to the MVA were highlighted in bold type, to indicate its significance and that it had been made clear to the Complainants that it was not possible to quantify the MVA in

advance. It also stated that the Complainants had signed an explicit statement that they would not encash the Bond while an MVA was in place.

The Ombudsman took the view that the Key Features Document, Reasons Why Letter and the Intermediary's Recommendation Document clearly explained how the MVA would operate. He also noted that the Intermediary's representative had explained the impact of the MVA by means of graphs and examples. He therefore found that the MVA applicable to an investment had been properly explained to the Complainants.

Nevertheless the Ombudsman noted that at the time of the parties' discussions, the Complainants had indicated a clear investment goal to invest for a period of 5 years and the timeframe for their investment was described as "a 5 year view" and also "5-6 year view". The Ombudsman noted that although any early exit fees would not apply after the 5th anniversary of the investment, nevertheless it was clear that the operation of an MVA might well apply at the very least, up to the 10th anniversary of the policy. In light of this, he failed to see how this product was suitable for elderly persons who only wanted a 5-6 year view. In effect a ten year Bond was sold and not a five year one as desired.

Accordingly, although the Ombudsman was satisfied that the MVA was adequately explained, this was not an appropriate product for the Complainants. He directed that the Intermediary reimburse the Complainants the 20% MVA of the fund value which had been deducted upon encashment in September 2008 - €116,000.

Alleged €1m inappropriate investments by elderly person not upheld

An elderly man in his early eighties complained that he had made two very substantial lump sum investments totalling €1m upon the recommendation of an Investment Bank in 2006 and 2007 respectively, but he had only later discovered that these investments did not provide the capital guarantee he had always said he wanted. The Complainant indicated that his wife's health was very poor, he himself was suffering from failing eyesight and therefore he had put his trust in the Company's recommendations. The investments had since fallen considerably in value and he wanted to be reimbursed the €1m.

The bank maintained that the investment options selected by the Complainant had been fully explained and clarified with him in 2006 and 2007 respectively, and that he had fully understood the nature of the investments undertaken. The bank said that the Complainant was a very experienced investor with significant financial acumen, who had a varied investment portfolio of guaranteed and non guaranteed items, but nevertheless because the Complainant was 80 years old in 2006, additional precautions had been taken (as required by its quality procedures) to ensure that the investments being incepted were suitable to the Complainant and that he understood the risk being undertaken. The bank also said that the Complainant had decided against a secure investment as he wanted the flexibility of being able to access his funds, if required and was of sufficient financial net worth, in order for the investment to proceed.

The Ombudsman noted that the two investments, whilst very substantial, nevertheless left the Complainant with very considerable other cash assets available to him. He also accepted that he was an experienced investor and noted that bank had been aware of the Complainant's wife's medical circumstances and, in fact, because of this, the Complainant had transferred by agreement other investments in their joint names, into his sole name in 2006.

The Ombudsman noted the Complainant's failing eyesight, but pointed to the Complainant's own evidence that in 2006 and 2007, he had "*signed everything put in front of him*" not because of any issue with his eyesight, but rather, because he said he had complete trust in the Company. Insofar as the Complainant made the case that he had only ever wanted a "*safe*" investment for his monies, the Ombudsman noted that the Application Form stated on the front page in bold lettering that the investments "**can go down as well as up and are not guaranteed, so you may not get back the full amount you invested**". The Ombudsman also noted the additional steps taken by the bank, because of the Complainant's age, to ensure that he fully understood the nature of the investment being commenced. In that regard, the evidence showed *interalia* that in November 2006 the Complainant had signed his own additional handwritten note confirming his acceptance that his capital was not secure, and that the sum invested could fall as well as rise. A similar handwritten note had been signed

by the Complainant in May 2007 incorporating a statement that *“I am aware that the capital invested €...., is not secure, and can fall as well as rise”*.

The Ombudsman stated that in circumstances where the parties had been in dispute in respect of a number of facts, he had given consideration to whether a sworn oral hearing would be necessary. He had determined however that the documentary evidence and submissions available were in fact sufficient to enable him to reach a decision in relation to the case.

The Ombudsman found that the Complainant could not but have been aware in November 2006 and May 2007, that the capital being invested was in no way guaranteed, and that it could fall in value, as well as rise. The Complainant’s suggestion that he had always wanted a *“safe”* investment was simply not borne out by the evidence. The Ombudsman also considered it highly unlikely that the Complainant had simply signed everything put in front of him and that he had not read any of the documentation he had received in relation to these very substantial investments particularly as he was an experienced investor. The complaint against the bank was not upheld.

High Risk Property Fund Investment of €75,000 was unsuitable - €60,000 compensation

Concerns by a husband and wife who took out three investments through a bank were raised with the Ombudsman. The Complainants invested proceeds from the sale of land, of €86,000 in June 2006, €100,000 in March 2007 and €75,000 in April 2007 respectively in three different property funds as a means of increasing their income when they retired from their other employments some years later. All three investments had substantially decreased in value by September 2008.

The Ombudsman found that the Complainants were appropriately advised in relation to the first two investments and had received the necessary documentation and cooling off periods for these investments.

However the Ombudsman had a serious issue with the third investment in April 2007. He noted that this investment was advised by a different Financial Consultant of the

bank to the two previous investments. This fact find noted the Complainants as not being 'savvy investors' and were 'getting cold feet' about this investment. It also noted that the Complainants were unsure of the terms and conditions of this proposed investment and didn't understand them. The Consultant however advised the Complainants to invest €75,000 in this high risk property fund which they did.

The Ombudsman concluded that the bank should not have recommended such a high risk investment, taking into consideration the Complainants obvious concerns over taking out a third property fund investment. In making his decision the Ombudsman could not find fully in favour of the Complainants as he was mindful of the fact that they had already made their second investment just three weeks previous with the bank. He also took into consideration the fact that the Complainants did receive a suitability letter, had a cooling off period which gave them the opportunity of withdrawing from the investment if they felt it was not reflective of their needs and could not but be aware of some investment risks.

The Ombudsman accordingly directed the bank to buy back this bond at 80% of its value - €60,000.

Unsolicited approach to old age pensioner to change a €35,000 investment - €6,500 award

A 71 year old age pensioner who invested €35,000 in an investment portfolio in June 2006 complained to the Ombudsman in September 2008 that he had been sold a 5 year product which was unsuitable for him, its value was falling by February 2008 and it did not have a fixed rate of return. His money had been originally invested in another investment with a fixed rate of return and he had changed his investment on foot of an unsolicited telephone call from his Bank. He also stated that the Bank was very slow in dealing with his complaint.

The Bank stated in evidence that the official who had conducted the transaction had since left the Bank but that where a new product was being launched it would not have been unusual to bring the advantages of such a product to the attention of existing customers where it might be to their advantage. At the time the investment was sold it offered unlimited growth potential with capital guaranteed. The Bank

asserted that while it understood that the Complainant had been unhappy with the performance of the investment to date the final growth would not be known until the maturity date. There were 3 years of the 5 year investment term to run and there was the possibility that market conditions may improve before the end of the term.

On reviewing the totality of the evidence, the Ombudsman was satisfied that it was the Bank which had made what was a completely unsolicited approach to the customer asking him to call at the branch so that he could be sold a new and different investment. The Ombudsman found that the pensioner should not have been targeted in this way, that the Bank had not given good advice and should not have sold this particular investment to the pensioner, having regard to his age and financial circumstances. The Ombudsman found that the Bank had failed in its duty of care and he directed the Bank to pay a sum of €6,500 in compensation for the negligent advice given.

€3,000 insurance fund increase for reviews not carried out - possible 96,000 other cases

The Complainant purchased a unit-linked, whole of life insurance policy with the Company in 1983. Life cover under the policy was approximately €240,000, with a yearly premium payable of €900. Her policy included a 'policy review' provision which provided for the review of the premium and benefit payable under the policy at stated intervals.

A review was carried out on the 10th anniversary of the policy. The Company advised the Complainant at the time that there was no need for her to change the premium payable in order to maintain benefits under the policy. However, in 2008 the Company wrote to the Complainant advising her that the premium payable was no longer sufficient to maintain the level of cover under the policy. The Company advised the Complainant that she could continue to pay annual premium of €900 for life cover of €85,000 or maintain life cover of €240,000 for an increased annual premium of €4,900. The Complainant was shocked at the requested increase in premium and referred the matter to this Office.

In assessing the complaint the Ombudsman looked at the policy documentation and examined whether the Company had carried out the policy review in line with the policy's terms. The Ombudsman concluded that the Company was entitled to carry out policy reviews and these were clearly provided for under the policy documentation. However, the Ombudsman noted that while the Company carried out a review on the 10th anniversary, it failed to carry out reviews in 1998 and 2003. The Ombudsman found that reviews should have been carried out at these times and by not doing so, the Complainant did not have the opportunity to consider her life cover options at an earlier date than 2008.

The Ombudsman directed the Company to increase the value of the Complainant's fund by €3,000 and to carry out a review based on this increased value.

The Ombudsman had serious concerns that this failure may have occurred in other instances and he informed the Company and the Financial Regulator in March 2009 that he would expect similar policies be reviewed to ensure that this was not the case. Due to a High Court judgment he could not direct the Company to do so and he was accordingly pleased to note the May 2009 Company's response. It indicated that to identify if each policy had all relevant reviews carried out would involve manually checking 96,000 policies which would be an inordinate amount of work. Instead it proposed to carry out a sample review in the region of 160 policies and the results of same would be furnished to the Ombudsman. While the Ombudsman was satisfied with this approach he requested that the random sample be increased to 300 and he awaits its outcome.

Benefit of €25,000 paid to blind person as Company's actions were unfair

A woman in her 50s held a critical illness policy with an Insurance Company and submitted a claim for benefit arising from her loss of sight. The Company declined the claim on the basis that the Complainant did not meet the criteria set out in the policy of "*total, permanent and irreversible loss of all vision in both eyes*". The Complainant had suffered for many years with a rare debilitating disease categorised by the fragmentation of elastic fibres in the skin and the membranes of the eyes. The

particular disease from which the Complainant suffered was not covered by the policy but the Complainant sought to qualify under the heading of “*Blindness*”.

The Ombudsman considered the medical evidence available which confirmed that prior to the inception of the policy the Complainant had suffered from tired eyes and eye strain as a result of which she had been referred to a Consultant Ophthalmic Surgeon. The policy had commenced in 1994 and the medical evidence disclosed a marked deterioration in the Complainant’s vision during the late 1990s ultimately leading to the Complainant’s claim to the Company in September 2006 on the basis that she had then become blind.

The Ombudsman noted that in considering the Complainant’s claim, her Ophthalmic Surgeon had been required to complete an assessment and had been specifically asked whether the Complainant had permanently and irreversibly lost the sight in both eyes and when this had occurred. The Surgeon’s response had been “*yes*” and he had confirmed that visual acuity had dropped to the level outlined by September 2004. He also confirmed that there was no prospect of vision improvement by way of surgery. In those circumstances the Ombudsman took the view that it was inappropriate for the Company to have refused the Complainant’s claim on the basis that she did not meet the criteria set down in the policy.

The Ombudsman noted that it was a full two years after the Complainant’s claim had been refused, that the Complainant’s Consultant Ophthalmologist, upon being pressed, had confirmed that the Complainant had a level of peripheral vision and that, in that sense, her loss of sight was not “*total*”. In circumstances where the policy document contained no reference to the exclusion of claims for benefit, where peripheral vision was noted to exist, the Ombudsman took the view that the opinion of the Surgeon in October 2006 that the Complainant had permanently and irreversibly lost the sight in both eyes, was sufficiently clear in respect of the position and the Company ought to have admitted the Complainant’s claim at that juncture.

The Ombudsman also noted that it was not open to the Company to decline the claim on the basis that the Complainant’s condition pre-existed the inception of the policy as the policy set out the limits of the pre-existing conditions relevant to loss of sight

and the Complainant had not suffered from any of the pre-existing conditions identified in the policy, nor had she become blind within the first two years of cover.

The Ombudsman upheld the Complainant's grievance and directed payment of the lump sum benefit of €25,000 pursuant to the critical illness policy.

€25,000 to be paid as cause of death insurance benefit condition was inequitable

A woman living in rural Ireland complained to the Ombudsman in relation to her 71 year old husband's Accidental Death Benefit Policy. Her husband had suffered a serious fall giving rise to a fracture of the pelvis and, notwithstanding hospitalisation, died within a period of 3 weeks. The Insurance Company had nevertheless refused her claim for benefit, on the basis that the Policy criteria required that for benefit to be payable, the "sole" cause of the policyholder's death must have been bodily injury, as defined. The Company pointed out that the deceased had suffered from Parkinson's disease and Dementia, and the death certificate confirmed the primary cause of death as a heart attack.

The Ombudsman noted the evidence from the deceased's GP that prior to the deceased's fall, he had been in relatively good health, although being frail, but the immobilisation caused by the fracture of the pelvis had resulted in his confinement in a hospital bed. His dementia and confinement in unfamiliar surroundings caused him considerable disorientation and distress resulting in him being unable to eat. This led to a rapid decline in his health three weeks after being hospitalised to treat the broken pelvic bone and he had suffered a heart attack and died.

The Ombudsman considered that the policy wording requiring that the "sole" cause of death be the bodily injury, was unduly narrow and unworkable on a practical level, and indeed was likely to cause unfairness to policyholders. This likelihood of unfairness in his opinion was compounded in this particular case, by the age and frailty of the policyholder. The Ombudsman noted that serious fractures in geriatric patients are accepted by the medical profession as carrying a very substantial risk of increased morbidity and indeed mortality. The Ombudsman opined that the strict application of a criterion for the "sole" cause of death to be the bodily injury alone

would be likely to cause considerable inequity in the particular circumstances of the case.

The Ombudsman accordingly directed the Company to admit the Complainant's claim for €25,000 and he also directed the Company to examine the issue of the very strict policy wording, with a view to amending it in order to reduce the risk of unfairness to policyholders. He also brought this matter to the attention of the Financial Regulator as it may apply to other insurance industry policy providers also.

Cardiac Surgery costs of €15,000 repaid as pre-existing medical condition did not arise

A health insurance Provider had declined the Complainant's claim for medical expenses incurred on three occasions for cardiac surgery in the Blackrock Clinic in early 2008 on the grounds that his symptoms were present prior to his joining the health insurance scheme. The Complainant disputed the Provider's decision on the grounds that he had telephoned the Provider prior to each surgery to confirm that he would be fully covered and proceeded with the surgery on this basis. He further stated that he did not have any symptoms of coronary disease prior to joining the Scheme.

The Ombudsman found that the rules of the Health Insurance Scheme in dispute were clear. The Company would not pay benefits for treatment which a person required during any waiting period that applied under their scheme. Under the terms of the Complainant's scheme, waiting periods applied to all new joiners and, in the Complainant's case, a pre-existing waiting period of 10 years applied. This was clearly explained in the policy booklet and also in the policy brochure. The policy terms and conditions defined a pre-existing condition as

“Any disease, illness or injury which began, or the symptoms of which began, before the person with the disease, illness or injury started his or her current continuous period of membership of the scheme.”

Mindful of the Complainant's allegations regarding advice received from the Provider over the telephone, the Ombudsman examined the Provider's customer log recording the content of telephone calls between the Complainant and a customer representative of the Provider in early 2008. He was satisfied that these records showed that the

Complainant was properly advised by the Provider and that it was explained to the Complainant on two occasions that if the symptoms of the medical condition being treated arose before membership of the Scheme, that condition would not be covered under the policy.

The question which then remained to be decided by the Ombudsman was whether or not the Provider had correctly assessed the Complainant's claims as relating to a medical condition the symptoms of which pre-dated his joining the Health Insurance Scheme in question. It was clear that the Claim Forms submitted and signed by the Complainant's Consultant gave no indication that the symptoms of the condition being treated pre-dated the Complainant's membership of the Scheme, and indeed stated that they did not. The Complainant's GP had confirmed in writing that the information he had provided, and upon which the Provider had based its decision to decline the Complainant's claims, had been in error and without reference to his medical notes. He later confirmed that the Complainant had not attended him with chest problems until a date after joining the Provider's Health Insurance Scheme, and he appended full medical notes dating back to 2004 in support of this. It was also clear that while the hospital records submitted contained a note that the Complainant was receiving a drug to reduce blood cholesterol in December 2005, there was no suggestion that this drug had been administered to the Complainant for the treatment of coronary atherosclerosis, as contended by the Provider.

It was therefore questionable whether, irrespective of the date the symptoms began, the coronary disease with which the Complainant suffered, and for which he required surgical intervention some four months after his date of membership, had begun prior to the date of membership. However having considered all the submissions, the Ombudsman was satisfied on the balance of the evidence before him that the symptoms of the Complainant's condition did not pre-date his membership of the Provider's health insurance scheme. He accordingly directed that the costs of €15,000 be borne by the health insurance provider.

Benefit of doubt in complaint regarding €18,000 disability payment

The Ombudsman examined a case where the Company admitted liability in respect of the Complainant's disability claim with effect from 2005. As part of the regular review of the claim, the Company sought a number of medical reports and following examination of these reports the Company ceased payment of €18,000 in 2008. The Complainant appealed this decision.

In order to be eligible for benefit the Complainant had to demonstrate she was *'totally incapable by reason of illness or injury of following her normal occupation'*. The Complainant argued that she was physically totally incapable of carrying out her job. In particular, the Complainant pointed to the fact that she had a metastatic cancer lesion and stated the psychological aspects of her condition, with their attendant debilitating effects rendered her totally incapable of working.

The Ombudsman noted that her employer's doctor retired her on the grounds of ill health in June 2008. Following the Complainant's appeal, the Company arranged for a number of medical assessments for the Complainant with *inter-alia*, an oncologist, an occupational physician and a psychiatrist. The Complainant submitted a number of her own medical reports supporting her position. The Company on receipt of all these reports did not change their position regarding the declinature of the claim.

The Ombudsman examined all the reports and took note of the comments regarding metastatic disease which stated *"the behaviour of which is unpredictable"* and other medical evidence which stated *"the Complainant is now well established in the "sick role" and she cannot countenance a return to work"*. The Ombudsman took into account the conflicting medical evidence and he considered that the benefit of the doubt should apply in this case. He directed that the claim should be paid subject to an annual review thereafter.

Allegation of €540 Credit Card fraud in Thailand was upheld

A complainant who went on a trip to Thailand found when she came back that three transactions had been deducted from her Card, transactions which she claimed she had not incurred and which she claimed were unauthorised.

In response to the complaint, the Bank carried out a comprehensive investigation into the disputed transactions, during which it looked at previous fraudulent activity in the geographic region in question in order to ascertain whether there were any fraudulent patterns in these transactions. The Bank's investigation concluded that no fraudulent activity was present on the account. This conclusion was arrived at due to the sporadic nature of the transactions over the course of a month and the pattern of the said transactions. The Bank pointed out that the disputed transactions were PIN verified and that the correct combination of Card and PIN were used to carry out the transactions, therefore the Bank was contractually bound to debit the sums from the Complainant's account.

The Ombudsman, having investigated the matter, found that the Bank was absolutely correct to debit the money initially as the transactions were both Card and PIN verified. However, once a report of fraud is made there is an onus on the Bank to investigate this matter. An investigation was duly carried out as a result of which the Bank was satisfied that no fraud had occurred.

However, the Ombudsman, having examined all the evidence and considering all the surrounding circumstances, came to a different conclusion. In his opinion, on the balance of probability, a fraud of some kind did take place. There was no evidence of negligence on the part of the Complainant and therefore the Ombudsman directed the Bank to credit the Complainant's account with the amount debited, €540.

Only €2,000 of foreign ATM withdrawals of €4,000 were fraudulent

A university student who, during his holidays, went on an exchange trip to various European countries complained that he had €4,000 withdrawn from his account through the ATM system without his authorisation. €2,000 of the money had been withdrawn in small amounts in France, Spain, Germany, Poland, Czech Republic, Croatia and Slovenia and a further €2,000 was withdrawn in Italy. He had not been in Italy but the internal complaints procedure revealed that he had been present in the other countries on the dates of the transactions. The Bank stated that its investigation revealed that the transactions in Italy did have a fraudulent pattern to them and

therefore the Bank was satisfied that he had been defrauded in Italy and the €2,000 was refunded to him by the Bank. However, the Bank refused to return any of the money withdrawn in the other countries on the grounds that the pattern of spend normally seen on a counterfeit Card did not occur.

The Ombudsman was satisfied that the Bank had carried out a full investigation and he found that the Bank had not acted unfairly in refusing a refund for the transactions, apart from those that took place in Italy. This was because those transactions were made using the correct combination of the Card and PIN and the circumstances were clearly distinguishable from the transactions which had taken place in Italy. The complaint was not upheld.

50% of health insurance claim of €11,400 paid as pre existing condition not fully proven

The Complainant transferred Health Insurance cover to another Health Insurance Company in March 2003 with a break in cover of 17 weeks. It was explained to the Complainant that due to his cover with his previous insurer lapsing for a period greater than 13 weeks, waiting periods would apply to him on joining. This meant that no benefit would be payable for any treatment he would receive during any applicable waiting period. The Complainant subsequently submitted a claim for €11,400 to the Company in respect of treatment received for Alcohol Dependence Syndrome in June 2008. The treating hospital stated “*Nature of symptoms to be Depression, insomnia, and regular alcohol intake*”, and went on to note “*the primary diagnosis as being Hazardous drinking, Depression/OCD*”.

A pre-existing condition was defined under the policy of insurance as “*Any disease, illness or injury which began or the symptoms of which began before the person with the disease, illness or injury started his or her current continuous period of membership of the scheme.*” Pre-existing conditions are not covered under the policy until such time as the applicable waiting period has passed. The applicable waiting period in this instance case was the first seven years of membership. This meant that the Complainant would not be covered for any pre-existing condition until seven years of membership had passed.

The Company assessed the claim and repudiated same on the basis that the condition suffered by the Complainant was a pre-existing condition since 1999 for which the applicable waiting period had not been served. The Complainant in his submissions to the Ombudsman argued that the condition suffered by him in 2008 i.e. alcohol dependence syndrome was not a pre-existing condition. The Complainant stated that the condition which required treatment in 1999 was Depression / OCD, while the condition suffered in 2008 was alcohol dependence syndrome. The Complainant's treating doctor strongly supported this view.

The Ombudsman during the investigation of the complaint had regard not only to the terms and conditions of the insurance contract but also to what he believed to be fair and reasonable under the circumstances. He formed the opinion based on all the medical evidence submitted that a question did arise as to whether the cause of the Complainant's admission to the treating hospital was due in fact to alcohol dependence syndrome or whether it was due to a pre-existing condition i.e. OCD / Depression. The Ombudsman pointed out that the evidence submitted indicated that the Complainant had not a history of serious alcohol abuse. In the circumstances he requested the Company to pay the Complainant 50% of the benefit payable under the policy for the treatment received.

€30,000 stolen property from guesthouse not upheld for non disclosure of prior claims

The complainant was a guest house owner who had incepted a Guest House Multiperil Policy of Insurance in March 2006. In May 2006 the Complainant reported two stolen property claims under the policy amounting to €30,000. Following investigation of the claims the Company cancelled the Complainant's policy *ab initio* on the grounds that the Complainant had failed to disclose a number of previous property damage claims with previous insurers as required by the Proposal Form. A refund of all premiums paid was then made. The Complainant was unhappy with this decision.

The Complainant argued that the Proposal Form in dispute failed to set out clearly the information which it specifically required, e.g. dates and amounts of previous claims and the insurance company to whom these claims were made. The Complainant also

queried the Company's interpretation of the details provided her in response to a particular question on the form as referring to two claims only, one in 2003 and one in 2004. The Complainant stated that the information she had given specified no particular dates.

Having studied the Proposal Form and the questions contained therein, the Ombudsman noted that the Complainant was asked clearly to provide the details of "*any accident, loss, damage, or liability during the last 5 years, whether insured or not*". It appeared to be the case, and the Complainant did not dispute, that within the previous five year period the Complainant had made four separate claims under previous household insurance policies with two other insurance companies. The Ombudsman did not find, by any interpretation, that the response given by the Complainant to the question, i.e. "*damage to dining room ceiling by burst radiator pipe upstairs; carpet damage by leaking radiator €1100 (2005)*", was a full and accurate disclosure of the details requested.

Furthermore, in response to the question "*Are you **at present** or **have you ever been insured** [Ombudsman's emphasis] in respect of the perils and contingencies to which this Proposal refers? If "Yes", state name of Insurance Company*" the Complainant disclosed the name of only one insurance company with whom she was insured at that time or immediately prior to completing the Proposal Form, but failed to disclose that she had had insurance cover with another insurance company previously and against which policy she had also made a number of claims.

The Ombudsman emphasises again that it is important to remember that an insurance contract is a contract *uberrimae fidei* - a contract of the utmost good faith. This is one of the fundamental principles of insurance. An applicant for insurance is in the best position to know the facts and circumstances relating to his or her application, and he or she has a duty to disclose all such material facts to the insurer. Such facts have to be disclosed fully, accurately and truthfully. If an applicant for insurance is in any doubt as to whether a fact is material, then it should be disclosed to the insurance company.

The Ombudsman found that the Proposal Form drew the Complainant's attention to the serious consequences of failure to disclose all material information, all material information had not been provided and in the circumstances the Provider was entitled to void the Complainant's policy from inception.

Burned out stolen car complaint of €3,500 not upheld as son stealing it not disclosed

The Complainant had his vehicle stolen from outside his daughter's house. The vehicle was subsequently recovered by Gardai but had been burned out. A claim for €3,500 was submitted to his Insurance Company for the loss of the vehicle.

The Insurance Company issued a Motor Theft Report Form to the Complainant. This form was completed and signed by the Complainant before being returned to the Insurance Company. The Insurance Company upon receiving the Motor Theft Report Form carried out extensive investigations and contacted the investigating Gardai. As a result of these investigations it transpired that the Complainant's own son had stolen the vehicle, crashed it and later burnt it out.

After submitting the claim to the Company the Complainant and his son were called to the local Garda station for questioning. During this questioning his son admitted taking the vehicle. The Complainant had withheld this information when completing the Insurance Company's Motor Theft Report Form and continued to withhold the information. The Ombudsman also noted that the Company called the Complainant into its office and conducted a face-to-face interview. During this interview the Complainant admitted that he had known that it was his son who had stolen the vehicle.

The Company repudiated the claim on the grounds of non-disclosure of a material fact and the Ombudsman upheld its decision.

Fall of €10,500 in €40,000 investment merits €6,660 award

A bank customer who had just retired on pension received €50,000 in a tax-free lump sum and a pension of €570 per month. He went to the Bank for investment advice

and was advised to put €40,000 in a particular fund and place €10,000 on deposit. One year later the fund was worth only €30,500. He cashed in his policy and complained to the Ombudsman that he had been badly advised.

The Bank stated that the Complainant was regarded as a “*growth investor*”. In other words, he was a person who, in its eyes, was looking for opportunities for his investments to outperform inflation and that he was therefore prepared to invest in equities, assets and property etc. The Bank also stated that it did expect that these assets would outperform deposits in the medium/long term and that the Complainant understood fully that they were subject to investment risk in that the worth of the investment could fluctuate and might end up worth less than what was put in. The Bank stated that the Complainant admitted that he understood that if the investment did not perform as intended, he might not get all of his money back.

In assessing the case, the Ombudsman placed particular reliance on the documentation provided by each of the parties. The Bank had conducted a financial review and as part of this review they conducted an attitude to risk. The Bank alleged that the Complainant described himself as a growth investor. However the Ombudsman, having reviewed the file, noted that the Complainant had no other investments whatsoever nor did he own any property. This would seem to indicate that the Complainant was a somewhat inexperienced investor, to say the least. The Complainant had said that he was never given the option of any other type of investment product. There was a 30 day cooling-off period which the Complainant had not availed of.

The Ombudsman came to the conclusion that the Complainant had indeed understood from the outset that the product included some element of risk to his funds. However, the Ombudsman was not satisfied that all measures were taken by the Bank to adequately explain to the Complainant the extent of the risk that he would be undertaking, particularly having regard to the fact that this was his only capital. The Ombudsman found that the Complainant must accept some responsibility for having agreed to the investment. Nevertheless the Bank must bear the major share of responsibility and he directed that the sum of €6,660 be paid to the Complainant by the Bank for the inappropriate sale which had occurred.

€100,000 Investment Bond complaint not upheld

A customer claimed that he was pressurised by his Bank into investing €100,000 in an investment bond. He lost money on the bond which did not do well. He complained to the Ombudsman that his original investment ought to be returned to him because he had not been given a copy of the Terms & Conditions of the investment, that he was not informed of any cooling-off period and that the Bank had taken the initiative in introducing him to the bond. The Bank stated that at a meeting the documents in question were handed over to the Complainant. The Complainant said “*that never happened*”. However after considering the evidence, the Ombudsman came to a different conclusion in that the Complainant was mistaken and that the Bank’s advisor did give him a copy of the Terms & Conditions of the investment, including the cooling-off period and that the decision to invest was not made on foot of improper pressure applied by the Bank’s advisor. The complaint was found not to be substantiated.

Bank account of deceased could not be released to a brother

A Complainant whose sister had died sought to have the funds in her Bank account at the Bank released to him. The Bank refused. The Complainant brought a complaint to the Ombudsman claiming that the Bank was acting wrongfully in not releasing the funds to him as he was her legal representative. However, the basis for the Bank’s refusal was that the customer had left a Will and the Complainant was not the Executor thereof.

The Ombudsman found that the Bank was correct in its contention that the Executor is the only person to whom the Bank could release funds. The Executor’s powers derive directly from the Will and the provisions of the Will, including the appointed Executor, are deemed to be evidence of the intentions of the deceased person (apart from a situation where the entire value of the estate is less than €25,000 where a bank can pay out without a Grant of Probate or Letters of Administration being taken out). Otherwise where a valid Will exists the funds can only be released to the Executor named in the Will.

The Ombudsman pointed out that if the Complainant was entitled to succeed under the Will of his late sister then the appropriate course of action was for him to apply to the Executor named in the Will and have the appropriate funds released to him. The Ombudsman was satisfied that the Bank had acted correctly in this case and the complaint therefore was not upheld.

Six month notice period introduced for cashing in investment policy cost investor €5,000

The Complainant invested €40,000 in a unit-linked policy with an Insurance Company in January 2004. In March 2008, the Complainant attempted to withdraw his investment and completed a savings withdrawal form. However, in January 2008, the Company had introduced a six month delay (notice period) for cashing in or switching from the plan, i.e. six months' notice had to be given to the Company before the withdrawal could be carried out. Therefore when the withdrawal took place in September 2008 the Complainant received €64,000 which was €5,000 less than he would have received in March. He also argued that, at the sale of the policy, he had not been made aware that a notice period could have been introduced and had lost money as a result.

The Ombudsman concluded that the policy documentation and sales process clearly referred to a possible six month delay notice period being applied to withdrawals and noted that the Company wrote to the Complainant in January 2008 when the notice period was being applied. The Ombudsman noted that the application of this delay notice period was to protect the investors who remained in the fund for the long term and the Company had justified its application. The Ombudsman did not uphold the complaint.

Concerns about motor insurance policies cancelled over the phone - €800 award

The Complainant had a motor insurance policy with the Company and on 1 August 2006 was involved in a single vehicle accident. He advised the Ombudsman that he subsequently phoned the Company to inform them of this and to “stop” his car insurance from the time of the accident, until he got a new vehicle and could transfer

cover to the new vehicle. A claim was submitted to the Company for the damage caused to his vehicle. The Complainant requested that cover be transferred to the new vehicle three weeks later but was informed that this could not be done, as the policy had been cancelled as opposed to suspended. He was advised that a new policy would have to be set up. The Complainant attempted to resolve the dispute over a period of four months but during this time spoke to many different Representatives of the Company who provided him with inconsistent advice in regard to his motor insurance policy. The Complainant also disputed the deduction of the remaining instalment payments under the policy from the settlement amount of his claim. The Company was of the view that it is confirmed in policy documentation that the Company has the right to take any premium owed from any claim it may pay. The Company apologised to the Complainant on account of his dissatisfaction with the information provided to him by its Representatives.

As regards the Complainant's allegations that he received different advice from different Company Representatives, the Ombudsman found it impossible to decide on as the names of Company Representatives were never provided, so that the Ombudsman could obtain statements. The Ombudsman was satisfied that the policy clearly and unambiguously confirmed that if a policyholder was paying a premium via instalments, the full yearly premium became payable in the event of the submission of a claim under the policy during the relevant period of cover.

However, the Ombudsman was conscious that the substantive element of this dispute surrounded what was advised to the Complainant when he contacted the Company via telephone to notify it of his accident. The Complainant argued that his motor insurance policy should have been suspended as opposed to cancelled. The Company argued that it had details of the Complainant's request to "*cancel*" his policy made on 10 August 2006. Therefore the Ombudsman requested from the Company a copy of the Complainant's written request to cancel his motor insurance policy with the Company, as well as a copy of the letter issued from the Company to the Complainant confirming the cancellation of this policy. In February 2009 the Company informed the Ombudsman that it did not receive a written request from the Complainant to cancel his policy. In addition it advised that it was not until October 2006 that it

issued a letter to the Complainant confirming that it had cancelled his motor insurance policy with effect from 1 August 2006.

Regardless of whether the Complainant's insured vehicle was roadworthy after 1 August 2006, the Ombudsman found it unacceptable that the Company would cancel a policy via telephone when the policy conditions specifically require cancellation in writing. The Ombudsman also expressed his concerns that the Company did not notify the Complainant in writing of the cancellation of his policy for approximately two months. The Ombudsman felt that had the Complainant made his request in writing, this element of the dispute would not have arisen and he also noted that the Company could not provide any audio, cd or transcripts of the relevant telephone conversations. The Ombudsman accordingly requested the Company to make an award of €800 for the inconvenience and confusion caused to the Complainant.

The Ombudsman also asked the Company to review its policy of not recording phone calls and referred this aspect to the Financial Regulator. The Financial Regulator indicated in May 2009 that a consultation would shortly take place about recording and maintaining phone and other electronic communications in the context of MIFIDS regulations but are not at this time requiring other firms to do so. The motor insurance issue may be considered in the context of a proposed review of the Consumer Protection Code in due course.

Accountancy firm's role in 'execution only' €500,000 investment was somewhat confusing

In 2003 the Complainant attended a presentation given by a staff member of a firm of financial advisors/accountants. The presentation gave information regarding an investment product which was being offered by a financial institution in Europe. The Complainant subsequently invested in the product on an '*execution only*' basis, investing a sum of over €500,000. The investment product performed poorly and the Complainant complained to the Ombudsman about the information and service received from the firm of financial advisors.

In investigating the complaint the Ombudsman requested all documentation issued by the firm of financial advisors and requested clarification as to the firm's status

regarding the sale of the investment product. The Ombudsman also noted the contract between the Complainant and the financial institution with which the investment was held. He pointed out that the investment was carried out on an 'execution only' basis and that the Complainant acknowledged he was never a client of the firm of financial advisors which carried out the presentation.

The Ombudsman found that the complaint against the firm of financial advisors could not be upheld as the Complainant was never a client of the firm. He also found that the information provided at the presentation was clear as to the nature of the investment product being purchased by the Complainant.

However, the Ombudsman raised serious concerns he had regarding how the firm of financial advisors referred to itself on its documentation. He noted that some documentation referred to the firm as giving financial advice, whereas other documentation referred to wealth management. The firm has since taken steps to ensure that this matter was resolved.

He also noted that as the firm was an accountancy firm it was authorised as an investment intermediary under an approved body authorisation (not subject to Ombudsman's remit) as well as having a separate investment intermediary company which was subject to the Ombudsman's remit. The Ombudsman pointed out that confusion may arise in this regard when consumers sought investment advice and referred the matter to the Financial Regulator as he considers that where a complaint about any investment advice arises it should be subject to the Ombudsman's remit so as to have a level playing field for everyone.

€200 awarded for delay in paying travel insurance claim

The Complainant incepted a travel insurance policy with the Company to cover his trip to Austria for two weeks in February 2007. Whilst on holiday in Austria, the Complainant had an accident whilst snowboarding and required treatment in hospital. Upon his return home he submitted a claim to the Company. The Complainant argued that although he was asked if he wanted the Company's Claims Administrators to pay the hospital directly two weeks after he submitted the claim, a few weeks later

the payment had still not been made and he subsequently received a cheque for the incorrect amount in the post from the Company's Claims Administrators. He pointed out that this occurred despite the hospital's specific requirement that payment be made within 10 days.

The Complainant corresponded with the Company's Claims Administrators regularly following the submission of his claim and requested regular updates. Despite this, in July 2007 the Complainant received a letter from the hospital in Austria advising that it would be taking legal action to recover the outstanding payment which had still not been received by it. The Complainant was particularly aggrieved to have received same. In response to the Ombudsman, the Company accepted that there was a delay of fifteen working days from when it received the bank details for the hospital to making the actual payment. It advised that this was considered outside its normal procedures and it apologized for any inconvenience caused. The Company confirmed that payment in full had since been made to the hospital and forwarded evidence of same to the Complainant and the Ombudsman.

The Ombudsman found that it was clear from the evidence submitted that there was some confusion during the assessment of the claim and delays were incurred as a result. He was also concerned about the Claims Administrators' level of communication with the Complainant during the assessment of the claim and found that this could have been better. In view of all of the customer service issues raised the Ombudsman found that the Company was to pay the Complainant €200 for the stress and inconvenience caused to the Complainant.

Hair transplant eyebrow treatment health insurance claim not upheld

The Complainant was a staff member of a Health Insurance Company. He had an excision of a malignant lesion to his medial eyebrow area. The Company paid the Complainant the benefit payable under the policy for this procedure.

The Complainant subsequently sought cover for a hair transplant procedure to be carried out on his eyebrow. The Complainant felt that this treatment should be covered in the same way breast reconstruction following cancer is covered. The

Company declined to cover on the grounds that the proposed surgery was not eligible for benefit under the Terms and Conditions of membership. The matter was then referred to the Ombudsman by the Complainant.

The Ombudsman found that while there were many benefits covered under the Complainant's medical expenses insurance plan and that the limitations thereto were clearly defined he found that hair transplantation was not one of the procedures for which benefit was payable under the plan. The Complaint was not upheld.

Joe Meade

Financial Services Ombudsman

14 July 2009