MFSA

MALTA FINANCIAL SERVICES AUTHORITY

Consumer Complaints Unit
Annual Report 2009

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Chairman's Statement

The 2009 Consumer Complaints Unit Annual Report is the main publication detailing the MFSA's work on consumer related issues throughout the year.

Various investors have been affected by the financial turmoil which hit the markets during the last quarter of 2008. Some losses have been temporary or only on paper, with expectations for an upturn of the market. However, some investors have had some holdings partially or completely wiped out following major corporate defaults.

During the course of the year, the Unit received a considerable number of complaints related to investments. The majority of these complaints concerned allegations of mis-selling and bad advice, while others touched aspects relating to non-performance of investment products.

While offering its assistance to these investors, the Unit became aware of a number of instances where what was discussed verbally during the investment recommendation stage somewhat departed from what was effectively set on the relative signed documentation. Investigating cases relating to alleged mis-selling and bad advice takes time and although the Unit has endeavoured to hasten the pace of its reviews into these complaints, it never lost sight of its impartial role and adversarial obligations.

For these past six years, the Unit has consistently encouraged investors to diversify their portfolios in order to minimise risk. Many investors who have been mostly effected were those whose savings were tied up in one product or investments which were similar. In this respect, the Unit intensified its ever-present commitment to financial education, taking as examples the same cases that it handled. Additionally, an ongoing effort is being made to make consumers aware of the legislative framework which is meant to protect and safeguard their interests.

During the fourth quarter of the year, the Consumer Complaints Unit launched a new website branded 'mymoneybox' with the aim of providing impartial information to consumers about financial products and services. The information provided on the website is updated regularly and the website is continually enhanced with additional material to cater for all financial services consumers.

I wish to express my gratitude to all the staff within the Unit for their dedication.

J V Bannister

Overview

STATUTORY POWERS AND DUTIES

The Consumer Complaints Manager is empowered by law to investigate complaints from private individuals relating to any financial services transaction in a fair and impartial manner.

Article 20 of the Malta Financial Services Authority Act (Cap. 330) provides the statutory framework and lays out the responsibilities of the Consumer Complaints Manager.

The Office of the Consumer Complaints Manager cannot give advice to consumers or act on behalf of consumers in any dispute with a licensed person. Its main responsibility is to liaise between consumers and licence holders with a view to assisting in the solution of any consumer dispute that may arise between them.

OTHER ROLES AND RESPONSIBILITIES

The Consumer Complaints Manager heads a Unit which is not only responsible for investigating complaints but is also entrusted with answering queries from the public on financial services and financial products on the market.

The Unit has two core and complementary functions – an "investigative" and an "educational" role. In this latter role, the Unit handles hundreds of different queries from the public on various aspects relating to financial services.

The Consumer Complaints Manager provides administrative support to and is also the secretary of the Compensation Schemes Management Committee – which administers the Depositor Compensation Scheme and the Investor Compensation Scheme. The Consumer Complaints Manager is also the secretary of the Protection and Compensation Fund.

THE LEGAL BASIS IN PRACTICE

The Office of the Consumer Complaints Manager was set up in 2002 with the coming into force of the Malta Financial Services Authority Act. In essence, the Manager's role is that of a conciliator or mediator in respect of disputes relating to financial services transactions. Statistically, the Consumer Complaints Manager is only involved in a fraction of the disputes that occur on a daily basis and which are handled by the financial entities themselves. Not all disputes are referred to the MFSA for its consideration.

The fact that a consumer may refer his / her complaint to MFSA does not hinder him / her of the right to refer the same issue to arbitration or to the courts. The type of complaints which are usually referred to the Unit may not necessarily require judicial intervention to be resolved. At EU level, the European Commission is promoting the setting up of out of court mechanisms, similar to the MFSA's Consumer Complaints Manager, which encourage dispute resolution to financial services consumers without the need to resort to the Courts. On the other hand, the access to such mechanism, does not prejudice the consumers' right to refer the case to court or to arbitration.

The MFSA may only issue a recommendation in respect of a complaint which has been investigated by the Office of the Consumer Complaints Manager. Effectively this means that the consumer and the financial entity may choose not to follow the MFSA's recommendation. In such a case the issue is either dropped or proceeds to Court (usually on the consumer's initiative). During the year, there were a number of instances where the Unit's mediatory role was not successful as its recommendation was not accepted by the financial entity concerned, particularly when the Unit's considerations went beyond a rigid legal interpretation and were based on moral or compassionate grounds.

The law also provides for a mechanism whereby the Consumer Complaints Manager may refer cases to the MFSA's Supervisory Council for its consideration.

During the year under review, the Unit had to refer cases to the Supervisory Council not only because of the particular merits attached to them but also as a result of a large amount of complaints relating to one product and/or licence holder. The number of outstanding

The Consumer Complaints Manager's role is that of conciliator or mediator in respect of financial services disputes.

complaints at the end of the year was relatively high, compared to previous years. The majority of these complaints were against a rather limited number of financial licence holders.

The MFSA Act also enables the Consumer Complaints Manager to communicate to a consumer whose complaint is being investigated, any information concerning matters which may have come to the Unit's cognizance in the course or as a result of the investigation. This article of the law cannot be looked at in isolation. The Consumer Complaints Manager is empowered to request any information from financial entities which is relevant for the investigation into a complaint and the financial entity may not keep back any information requested by the Manager. However, some entities – aware that a case against them might end up in court – may become quite economical with information they give to the Consumer Complaints Manager as they believe it might prejudice their position should such information be passed on to the complainant. This has become a double-edged sword and the Consumer Complaints Manager is quite aware of such legitimate concerns. The situation could become more sensitive if after a lengthy review process the mediation role fails. Where the Consumer Complaints Manager would have expressed views about the case in detail to the licence holder and in the meantime gathered supporting evidence.

The final letter which the complainant is entitled to receive from the Consumer Complaints Manager might not have "all" the information which the consumer might expect. In reality, the conveyance of information to the complainant might be such that it would not reflect the hard work which would have gone into the review of the complaint. A balance has to be struck with regards to what information needs to be conveyed to the complainants and what has to be withheld so as not to prejudice the rights of either of the parties. However, there is ample opportunity to revisit this section of the law in light of concerns for legitimate disclosure of information when there is evidence that a licence holder's procedures or actions might have been of financial detriment to the complainant.

Over the course of the years, some licence holders (usually banks and insurance companies) have appointed an official within their ranks to handle complaints and act as liaison between the firm and the Consumer Complaints Unit. Smaller firms might not need to have a person specifically appointed for this purpose. However, the Unit has noticed that some firms' officials who originally investigated the customer's contentions would also be involved in discussions with the Unit during the latter's review of the complaint. In some cases, it may be more productive if another person represents the licence holder as this would be an opportunity for the latter to have a different perspective on the issue. The Unit is determined to identify weaknesses in the system, perhaps even requesting the larger firms to have some complaints referred to other officials, such as compliance or audit officials.

EEA Framework

The Consumer Complaints Manager is a member of FIN-NET, the European out-of-court network for the resolution of disputes between consumers and financial services providers.

FIN-NET is a network established by the European Commission in February 2001. It links 50 out-of-court Alternative Dispute Resolution (ADR) schemes that deal with complaints in the area of financial services and covers the European Union, Norway, Iceland and Liechtenstein (European Economic Area – EEA). The rationale for the creation of FIN-NET is to provide customers with easier access to out-of-court complaint procedures in cross-border cases, thus facilitating the market in cross-border financial services.

Members of FIN-NET are linked through a Memorandum of Understanding which outlines the mechanisms and other conditions to which members shall abide in order to facilitate out-of-court settlement of cross-border disputes. All FIN-NET members are required to comply with the principles applicable to the bodies responsible for out of court settlement: these are set out in Commission Recommendation 98/257/EC of 30 March 1998. Adherence to this recommendation is particularly important since the structure, nature and competence of different FIN-NET members vary.

FIN-NET needs to be put in the broader context of the level of cross-border transactions in the financial services sector. Where a financial services provider sets up a network of branches in different countries, normally the consumer will be contracting with a local branch and this will not be a cross border transaction. Studies have indicated that the level of cross border transactions which fall within the scope of FIN-NET is small, normally less than 1% of total transactions.

FIN-NET provides its members with an appropriate mechanism for sharing experiences and exchanging information, which also has a positive effect on the complaints handling procedure. This is primarily based on the two semi-annual meetings that allow networking among FIN-NET members but also provide information on recent developments at the European and national level. The networking of ADRs is an important benefit for the Consumer Complaints Unit because it is evident that a number of complaints made by Maltese consumers are fairly similar to those made by other European counterparts.

PRINCIPLES OF COMPLAINTS HANDLING

In the execution of its functions, the Consumer Complaints Unit is committed to follow the following principles:

1. Independence
The Unit seeks to provide an impartial service which is accessible and freely available to the general public having complaints against financial entities and their services;

2. Transparency
The Unit ensures that consumers have all the information necessary about the procedures for handling their complaints on financial services transactions;

3. Adversorial
The Consumer Complaints Unit ensures that the complainant, the financial entity and any other party interested in the complaint are given an opportunity to make representations. The Consumer Complaints Manager has to inform the parties about the progress achieved;

4. Effectiveness
The Unit ensures that private consumers will benefit from the advantages of the consumer complaints handling procedures, i.e.:

i) access without being obliged to seek professional advice;
ii) a service which is free of charge;
iii) a procedure which ensures minimum bureaucracy, no undue delays and which does not deprive the consumer of the protection afforded by consumer protection legislation or to bring an action before the courts for the settlement of the dispute;

5. Legality
The Unit ensures that the recommendation of the Consumer Complaints Manager does not result in the consumer being deprived of the protection afforded by the mandatory provisions of national legislation;

6. Liberty
The Consumer Complaints Manager ensures that any recommendation made by same is not binding on either the complainant or the financial entity. Therefore the parties to the complaint are not prohibited from resorting to court action for the settlement of the dispute;

7. Representation
The Unit ensures that the parties to the complaint have a right to be represented or assisted by a third party during all stages of the complaint review process.

Operational Aspects

SETUP

The Consumer Complaints Unit is composed of the Deputy Director/Consumer Complaints Manager, two managers and an officer. The Unit is independent from the MFSA's regulatory and supervisory structures.

DEALING WITH COMPLAINTS

Financial services are based on trust. However, one must distinguish between trusting blindly and trusting cautiously. It is easy but unfair to generalise on the way many financial products or services are offered to local consumers. Similarly it is not fair to take the number of complaints received by the MFSA as representative of the way financial transactions are conducted in specific areas of financial services.

The fact that many financial products are sold, rather than bought, is not far from the truth. The same can be said for the fact that many consumers do not read the contracts which they sign. As long as things do not go wrong, there is no cause to complain. Furthermore, it would be foolish to presume that a financial entity deliberately sells a product knowing that, in future, the process of sale or even the product itself, will eventually lead to a complaint. On the other hand, one cannot deny the fact that many consumers may be disgruntled by the performance of a financial product or delivery of service of a financial entity and that is why all licensed entities are required to have in place easily accessible complaint handling procedures available to consumers. This is not a formality created to dissuade consumers from making a complaint, rather, it is a necessary requisite of proper consumer-entity relationship, especially when things may unexpectedly go wrong.

It is expected that many consumers are sometimes reluctant to send a formal complaint in writing to their licence holders. The Office of the Consumer Complaints Manager meets consumers from all walks of life, including those who believe that formalities should be done away with. In reality, some complaints expose the true reason why some consumers may be dissuaded from complaining. Very often consumers are not comfortable with filling forms or writing a letter, even if such a situation may be resolved by having the form compiled

Many consumers do not read the contracts which they sign.

by a trusted person of the complainant. It is also never simple to understand how many consumers ended up being sold financial products which should have never been offered to them in the first place. Regrettably, such consumers blindly entrust their hard-earned savings to mere sales staff, only to face a bitter situation some months or years later when it is too late to remedy the situation. Although a prospective investor should be aware of his/her responsibilities prior to committing his/her savings into any financial product, undeniably some documentation is difficult to understand due to the language jargon, description of the product or both and many investors simply rely on the explanation which is relayed to them.

Many consumers are aware of the MFSA's existence and there have been several occasions where consumers came to the Authority's offices to lodge a complaint without first complaining to their financial entity. The Unit is taking a very firm stand on this and no complaint is registered with the Unit if the financial entity is not given the opportunity to state its case (which a complainant then has every right to refuse). There are some cases however, especially for insurance complaints, where complainants (including third party claimants) are left in limbo by some companies as to the progress of their claim. In these particular instances, the Unit will accept to register a complaint from a third party claimant, if it perceives that there are unreasonable delays or that the insurer had not been in touch with the claimant for an abnormally long time.

Normally, a licence holder would include a reference in the final letter to the complainant stating that, should the latter refuse the conclusions of the complaint, the matter could be referred to the MFSA's Consumer Complaints Unit. There is a trend – which manifested itself more during the year under review when compared to previous years – where licensed entities actually made us aware that a client of theirs would be calling or filing a complaint with the Unit against them. Unusually, this occurs in the event of an impasse between the entity and the complainant despite several attempts by the former to explain a situation or a circumstance over which the former might not have had control. The Consumer Complaints Unit is noticing this trend in the case of some complaints which for example relate to the performance of investment portfolios or valuations relating to cash surrender values of life insurance products.

The MFSA Act specifies that the Office of the Consumer Complaints Manager may only handle complaints from private consumers. However, there are occasions where small companies too may have complaints against financial providers which do not necessarily require all the formalities of the Courts to be resolved but rather a low-key out-of-court system, such as the MFSA's complaints handling mechanism. Technically, the Unit would not be acting wrongly if it outrightly refuses to handle complaints from directors of small companies. Thus for the sake of practicality, in the case where the matter appears prima facie to be straightforward to conclude, the Unit may initially accept to carry out preliminary reviews of complaints from such entities (for example, if the Unit had similar complaints from private consumers). If on the other hand, the matter referred to the Unit appears to be complicated, the complainant will be informed to refer the case to other redress mechanisms.

INVESTIGATING CASES

There are cases which may not require a lot of time to be reviewed. This may happen if, for example, the complaint might have been reviewed previously and therefore it is likely that the outcome of the new case would be similar. Some examples of these cases relate to complaints on charges (banking and investment services related complaints) and motor claims (such as delay in filing a claim or the right of a consumer to avail himself/herself of a courtesy car).

However, many cases have become fairly complicated to resolve within a very short time. In the year under review, several cases remained pending from 2008. These cases were all relating to investments or investment portfolios which have failed following the collapse of financial markets during the second half of 2008. The data of outstanding complaints as at end 2009 only gives a partial picture of the quantitative amount of complaints remaining outstanding. The data does not however indicate the qualitative value of the underlying reason behind the complaints and the continuing process to investigate them.

In addition, many complaints straddle regulatory concerns which may take longer to resolve and this may not be easily understood by complainants. Moreover, for the first time, the Unit had been faced with a mass complaint relating to specific investment products, which exposed features of the way such products might have been sold. The review process of these complaints will continue in earnest in 2010.

In handling a complaint, the Office of the Consumer Complaints Manager considers all legislative aspects, industry practice and other cases previously reviewed. In this respect, the Unit issues its recommendations on the basis of what it believes to be fair and reasonable. In doing so, the Unit takes into account the law, rules and good practice in the industry. In fact, in the majority of cases, the Unit's approach is largely based on what a formal judicial setup is likely to do in similar circumstances. In some other cases, the complainant may not have legal grounds to have his/her case upheld. However, the Unit may put forward arguments for the financial entity to compensate a complainant purely on moral or compassionate grounds. Depending on the circumstances of the case and the disposition of the financial entity, such recommendations may be accepted and compensation awarded (purely on an ex-gratia basis). In some areas, good industry practice has developed separately from the law.

LEGISLATIVE UPDATES

Directive 1 issued by the Central Bank of Malta (CBM) on The Provision and Use of Payment Services transposes Titles III and IV of Directive 2007/64/EC of the European Parliament and of the EU Council of 13 November 2007 on payment services in the internal market. It lays down rules concerning transparency of conditions and information requirements for payment services and the respective rights and obligations of payment service users and payment service providers in relation to the provision of payment services as a regular business activity.

Paragraph 58 of the CBM Directive lays down the framework for the MFSA's Consumer Complaints Manager to handle complaints in respect of rights and obligations arising therefrom. By virtue of this framework, the Office of the Consumer Complaints Manager may handle complaints from private individuals relating to transactions falling within the remit of this Directive.

It is envisaged that these additional responsibilities will be outlined formally through amendments in the Financial Institutions Act during 2010.

OTHER INITIATIVES

Local commercial banks adopted a Code of Common Principles for Bank Account Switching, pursuant to the publication of these Principles by the European Banking Industry Committee (EBIC), and their endorsement by the European Commission.

The Common Principles ensure that switching of domestic personal current accounts is not onerous to consumers and that their mobility shall not be constrained by any unnecessary delay or cost, or by lack of support from their banks. The Common Principles also increase customers' awareness of the switching-related services they can expect, and aim at reducing consumers' apprehensions with respect to bank account switching.

Consumers who have a complaint about participating banks' compliance with these Principles may refer their case to the Office of the Consumer Complaints Manager.

CONSUMER EDUCATION INITIATIVES

The MFSA invests substantial time and financial resources to ensure that consumers are continuously kept informed and educated about their rights and on various subjects relating to financial services.

Over these past seven years, the MFSA has built a reputation for providing clear, concise and unbiased information to financial services consumers. Although bi-lingual publications are given importance by the Authority as a way to circulate information to consumers, the use and influence which may be exercised via television and radio air-time constitutes an essential and effective way to disseminate information to as wide and broad audience as possible. TV and radio not only serve to educate consumers but are also an effective means for officials of the Unit to interact with consumers. Indeed, the Unit tends to prefer participating in live programmes where consumers are allowed to air their views and ask questions. During the year, the Unit participated on average in at least two radio and two television programmes a week.

This does not mean that the Unit is reaching all categories of audiences at any given time. For instance, young adults - whose viewer and listening habits differ substantially from their parents - are not being adequately targeted by the Unit. It may be true that the Unit's media efforts are being targeted at mature audiences and specific members of the household, but on the other hand, youngsters may turn to such members of their household for help and advice. However, youngsters are possibly a vulnerable age group when it comes to spending money. Even if the internet may be a valuable source of information (compared to the print media or television), it may also be a tempting medium for card fraud or potentially silly transactions (such as purchasing cars over the internet). The Unit hopes to address this aspect in the coming months through innovative educational initiatives.

NEW WEBSITE FOR CONSUMERS OF FINANCIAL SERVICES

The Consumer Complaints Unit launched a new website for consumers, branded "Mymoneybox", which has the aim of providing impartial information about financial products and services.

Compared to the previous website, Mymoneybox is definitely more informative and aims at consolidating all the information which has been imparted to consumers since the creation of the Office of the Consumer Complaints Manager. It is also more user-friendly and provides the consumer with interactive tools through which he/she may learn about his/her rights.

The website provides comprehensive information on issues relating to banking, investments and insurance. This information is updated regularly to keep financial services consumers abreast on their rights and responsibilities, such as those arising from the Payment Services Directive which came into force on 1 November 2009.

Furthermore, consumers have also been provided with two new facilities namely that of a budget calculator and a net worth calculator. More calculators will be added in due course, including an Annual Percentage Rate of Charge (APR) and a home loan calculator.

The on-line survey of tariffs/charges of a number of financial products and services offered in Malta has also been enhanced. Consumers can now compare tariffs of any four financial entities in respect of the product/service selected. The list of tariffs and charges on Mymoneybox is also updated regularly. The Unit will be adding new tariff categories during the first quarter of 2010 and is also exploring the possibility of comparing specific insurance products available in Malta. Statistically, the on-line survey of tariffs and charges is the most visited compared to the other pages of the website.

Mymoneybox also contains information about lodging a complaint with the Office of the Consumer Complaints Manager against a financial service provider in Malta. During the first quarter of 2010, consumers will be able to lodge their complaint on-line in a secure environment.

The website can be accessed on http://mymoneybox.mfsa.com.mt

Mymoneybox homepage

Complaint Trends

TABLE 1: ANALYSIS OF COMPLAINTS AGAINST LICENCE HOLDERS AND QUERIES HANDLED IN 2008 AND 2009

	FORMAL COMPLAINTS						VERBAL COMPLAINTS		QUERIES	
	Cases Received		Cases Closed*		Pending Cases					
COMPLAINTS RELATED TO	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Banking	77	59	64	49	15	26	29	62	166	174
insurance	171	167	143	187	57	29	40	91	111	222
investments	49	90	40	41	17	65	23	39	177	147
Others	6	8	9	6	4	3	16	66	114	70
TOTAL	303	324	256	283	93	123	108	258	568	613

* Includes cases received in the preceding year.

The Consumer Complaints Manager distinguishes between 'formal' complaints, where the complainant submits a complaint in writing, and 'verbal' complaints which are normally received over the telephone. If the issue raised verbally by the complainant requires contacting a licensed entity, the latter is contacted by e-mail or over the telephone for any comments. However, if the matter gets complicated, the complainant is requested to submit a formal complaint in writing.

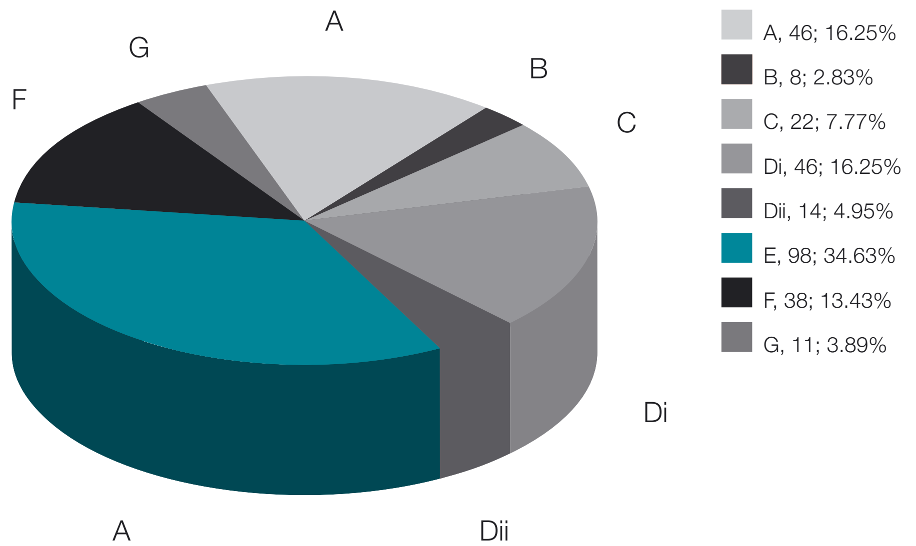
Throughout the year, data was collected with regards to the number of queries received from consumers on a wide range of issues relating to financial services. Comments or replies on these queries were given immediately over the telephone, without the need to contact the licensed entity concerned.

A detailed breakdown of Tables 1 and 2 is available in Appendices 1 and 2.

TABLE 2: FORMAL CASES CLOSED IN 2009 BY CLASSIFICATION

A		46	Outside MFSA jurisdiction (in such instances and following any investigation undertaken, the complaint is requested to seek redress with the appropriate authority as applicable).
B		8	Customer withdrew complaint.
C		22	Referred to entity or consumer - no feedback
D	i	46	Entity has not treated the customer's complaint fairly - complaint upheld by Consumer Complaints Manager. Entity accepts recommendation.
	ii	14	Entity has not treated the customer's complaint fairly - complaint upheld by Consumer Complaiants Manager. Entity did not accept recommendation.
E		98	Entity has treated the customer's complaint fairly - complaint not upheld by Consumer Complaints Manager.
F		38	Entity has generally treated the customer's complaint fairly but it still agrees to a goodwill payment or improved settlement.
G		11	General query - provided information/ clarification.

FIGURE 1: FORMAL CASES CLOSED IN 2009 BY CLASSIFICATION



Frequently Asked Questions

A key role of the Office of the Consumer Complaints Manager is that of answering consumer queries on a wide range of issues relating to financial services and other aspects which may fall under the responsibility of the Authority. When compared to the previous years, the year under review has seen a remarkable increase in the number and diversity of queries received.

The financial crisis which was triggered during the second half of the year and which lingered on in the first half of 2009 led many consumers to ask a variety of questions about the state of their investments and also about the levels of guarantees available for their deposits.

As much as the Unit may wish to assist consumers with all their queries, there may be instances where the Unit might simply not have an answer or where its answer might not be what the consumer expects to hear. For example, the Unit received a number of queries relating to the status of their product guarantee following the closure of a number of retailers. Although the Unit may be able to give factual information about the status of a company, as long as its filings with the registry of companies are in order, it is certainly not in a position to recommend or provide information about the actual guarantee given (the relevant governmental consumer department may be able to handle such queries). The volume of consumers' queries is indicative that there is a keen interest by consumers to be informed. No question is ever considered frivolous. On the other hand, there were cases where consumers' expectations went beyond the Unit's (or even the Authority's) statutory remit.

A selection of frequently asked questions, with answers, is being reported hereunder.

FEES AND CHARGES

Typical query: Some years ago, I had purchased funds from a local financial entity. I agreed with its representative that payment of any interest distributed by the fund is paid by cheque. A week or so ago, I received a letter from my financial entity requiring me to have interest credited in my account at €1.50 for each transaction. This is unfair because, in the past, I was never charged for receiving my dividends. I would like to continue receiving payment by cheque but if I do so, the financial entity will charge me €10 and will aggregate the amount of interest annually (rather than quarterly). I firmly believe that this is rather unfair as I have never authorised the financial entity to arbitrarily change its fees. Can I contest the financial entity's decision?

Typical query: For these last few years, I have used my bank's internet banking service gratuitously. Recently I was informed that the bank will start imposing a tariff for the service. This leaves me with no option but to either accept the charge or alternatively stop using the service and move my accounts with another bank (which may not be a practical solution). Can a bank introduce or change a fee while it is providing such service?

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

There are two issues which underpin questions of this type. The quantum of the charge and the contractual obligation attached to the entity's decision.

Any financial entity may introduce or vary its charges as long as it is contractually allowed to do so. Whenever a consumer accepts to avail himself/herself of an entity's service, there is usually a specific clause which states that the customer agrees to pay those fees and charges which the company may establish from time to time. This is subject to prior

notification of such changes to the customer, usually, (but not exclusively) within 30 days of the changes coming into force. In most of the cases considered by the Unit, this clause featured under the terms and conditions of service. Furthermore, the financial entity would have provided the Unit with a specimen copy of the terms which the consumer was likely to have been required to sign before the taking up of the service or product. Alternatively, the financial entity would have provided a copy of the actual terms signed by the customer.

With such general clauses, the entity would cover its legal and contractual responsibility towards its customer should there be any changes to its fee structure. This means that a financial entity may exercise its right to amend its fee structure because the customer had originally agreed to it.

Whether the application or increase of a charge is ethically incorrect is another subject altogether. There might be sufficient and commercially justified reasons for varying a fee structure. In the first question, for example, it is clear that the company preferred to use electronic payments to distribute interest to its investors. Such a practice is quite normal and is promoted because cheques are considered to be an inefficient way of payment. The processing of a cheque is laborious and does not give value to the customer upon presentation. Electronic direct-to-account payments are increasingly becoming a preferred means of payment and provide the consumer with value as soon as the funds are credited. Therefore, it is normal for financial entities to apply a high charge to process payments by cheque – at least to provide an incentive to the customer to switch. After all, even the Treasury and many other government departments are doing away with cheques to resort to electronic direct-to-account payments. Customers may have to learn to ride along with the system and adapt themselves subject to proper and intensive educational initiatives.

With regards to the second question, one may argue that while there might be serious commercial justifications to apply a tariff for the use of such electronic banking facilities, it is evident that consumers – who may have been lured to take up the service because it had been offered for free or at very low cost – received a cold shower when a charge became applicable unexpectedly. Attracting a captive mass of customers on the pretext of a free service and then rolling out a charge on a take-it-or-leave it basis may not be in breach of any contract but may surely be interpreted as being unfair.

LOAN ACCOUNT CLOSURE FEE

Typical question: *Last year I took out a home loan with one of the local banks. Recently, I approached another bank which offered me a better package for my current home loan. I decided to take up the offer of this bank but when I went to my other bank, besides the multiple efforts to convince me not to extinguish the loan, I was charged a hefty fine for closing the account "prematurely" Can the bank do so?*

Typical question: *In 2000, I took out a loan with one of the local banks. Recently, I popped in another bank and was offered a very good rate for my current balance with the other bank. I decided to take up their offer and went to close my loan account with the other bank. When I informed my present bank that I would be refinancing my loan, the bank slapped a charge of €800 – had I closed my loan account from proceeds not coming from another bank (such as from inheritance), they would have charged me €100 only. I think this is grossly unfair and uncompetitive.*

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

With regards to the first question, there is really nothing one can do because a bank may impose an Early Payment Charge if a loan is paid in full or in part before the time established by the agreement. The actual charge and the period until when it is applicable would be clearly indicated on the sanction letter or any other credit agreement.

The Consumer Credit Regulations establish the creditor's obligation to provide the consumer with pre-contractual information that includes a list of related cost elements, such as administrative costs, insurance costs, legal costs, the costs of intermediaries and whether there is a possibility of early repayment (if so, at which conditions).

These Regulations also provide that in any home loan agreement, the creditor (or rather the bank) is obliged to ensure that the agreement includes the consumer's right to a reduction if he/she pays credit before it is due. In fact, if costs directly arising from the credit agreement have been specified in the agreement and such costs are fair and reasonable, taking into account all relevant circumstances, the creditor may recover such costs from a consumer who has exercised his right of early repayment. The Regulations also state that the creditor shall inform the consumer of the costs he would incur if early repayment is made and where such costs cannot be established when the credit agreement is signed, the creditor shall inform the consumer of the method of calculation to be used to establish such costs.

Even if a sanction letter gives legal right to a bank to apply the charge, a bank might be able to reconsider its decision (effectively waiving its right to charge). Some banks for instance, do not apply an early repayment charge at all.

On the other hand, it is very questionable – perhaps also anti-competitive – if a bank charges a different fee purely on the basis of the way the loan account has been closed before maturity date. If this charge did not form part of the list of charges when the sanction letter was drawn up, the matter may be in breach of the contractual agreement apart from being in breach of consumer protection legislation. If the charge is an item on the list of charges on a sanction letter and the consumer accepted it, it remains to be seen whether that too may be in breach of consumer and competition legislation as it is unlikely that a bank incurs differentiated charges depending on the way the customer closes his loan account.

Charging a higher fee for refinancing (obtaining a loan from another bank), but applying a lower fee if proceeds come from other sources (such as inheritance or sale of property) may be tantamount to anti-competitive practices which may deprive the customer to shop around for the best offers. That is why it is important for the customer to read the sanction letter before committing his/her signature of acceptance, and be firm with a bank which might be adopting differentiated closure fees.

LIFE INSURANCE

Typical question: In 1988, I took out a loan with one of the local banks. I was required to issue a life insurance policy and, between the various options available, I took out an endowment policy. I was led to believe that the policy would be paying me a rather handsome sum of money upon maturity in 20 years time. However, at no point, during the purchase of the policy, it was mentioned (verbally or in writing) that the maturity value can be less than that

declared. I happened to be reading an article which stated that insurance policies may not pay up the declared maturity value and, upon enquiring with my insurance company, I was told that the maturity value of the policy may vary as this depends on profits made. I was told that the documentation I had been provided at the time did not state that values are guaranteed but, rather, that the values were being quoted as estimates. I believe this is deceiving and constitutes a breach of my rights because I was forced into buying a product which is not likely to deliver on its promises. What are my rights?

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

In 2009, the Unit received multiple queries and complaints similar to the abovementioned. Many policyholders questioned the resilience of their life insurance companies in the wake of the financial turmoil that left many investors worldwide uncertain of the future.

As is customary with our procedures, we would have discussed the complainant's contentions with the insurance company which had issued the policy and examined the documentation at the time of sale of such policy. It is pertinent to point out that regulation and consumer protection regulations have evolved since 1988 and this is reflected in the quality of the documentation which is available today, as compared to 20 years ago. This does not mean that the documentation used at the time was deceiving or incomplete – one would say that there might not have been as much detailed disclosure as there is today. For sure, the type of illustrations which were given at the time of sale might have been reflective of the typical returns rewarded by life insurance policies at the time. One cannot deny the fact that these same returns now appear to be 'historic' due to unsettled economic times. The policy wording would not normally express any guarantee with respect to the value at maturity. The policy quotations, which would normally serve as basis to proceed with a policy, would have indicated the potential returns likely to be achieved over its lifetime. The terms normally used on the quotation would be "estimated maturity value(s)" which cannot be taken as guaranteed amounts.

A life insurance quotation would not normally express any guarantee with respect to the value at maturity but would indicate the potential returns likely to be achieved over its lifetime.

It is a fact that bonus rates (mostly relevant to endownment policies) are dictated by financial conditions at the time in which they are declared. Depending on the insurer, quotations may show three indicative bonus rates, such as 3%, 5% and 7%. Although the last two scenarios may sound very generous by today's rates, they might have been realistic at the time.

In respect of the penalties applicable if policyholders cash in their policy prior to maturity date, it is pertinent to point out that a life policy is a long term insurance contract and therefore will penalize those considering an early release. A policy can increase in value if declared bonuses remain bouyant or improve. However, declared bonuses might also be less than those in previous years - which is a major cause of concern for many policyholders. For this reason, it is premature to complain of bonus returns at this stage.

Finally, one must also keep in mind that, during this time, the policy was also giving the complainant life protection. This means that had the complainant died after payment of the first premium given the policy was not pledged in favour of the bank, his/her family would have been paid the value of the sum assured. This means that one's death would not have left a financial burden on the family following payment of the sum assured, this aspect is most often misunderstood or forgotten by policyholders.

DEPOSITOR COMPENSATION SCHEME

Typical question: I have been noticing multiple adverts on newspapers and TV advertising very good rates for fixed deposit account by banks which I had never been aware of. All these adverts claim that my deposit is protected under the Depositor Compensation Scheme but I want to make sure that none of these adverts is misleading – such as for example, enticing me to deposit my hard-earned savings with them on the basis that my deposit is covered by the scheme, when in actual fact it is not.

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

All banks licensed by the MFSA are required to be members of the Depositor Compensation Scheme. The Scheme provides a level of coverage of up to €100,000 for each depositor in the event that a bank becomes insolvent and therefore is unable to honour its obligations towards such depositors.

In light of the new regulations which came into force in August 2009, all banks are required to indicate clearly that they are members of the Depositor Compensation Scheme in Malta. Very shortly, all banks will also be providing information to their depositors – on demand or through their websites – relating to the scheme including the circumstances under which the scheme would pay compensation. This information is already available on the Depositor Compensation Scheme's website (www.compensationschemes.org.mt) but banks are now also required to provide this information to depositors to enable them to understand better how the scheme works and whether and to what extent their deposits are covered.

In brief, the scheme covers deposits made by individuals and small companies which are allowed to draw up abridged balance sheets in terms of the Companies Act. The scheme covers deposits in the currencies of all EU and EEA (European Economic Area). Other non - EU currencies are excluded. There is no closing date as to the limit of €100,000 (as many depositors continue to think). The limit is per person, per bank so for example, if two banks

are unable to honour their obligations at the same time, a depositor is covered for up to that limit for each insolvent bank.

As with diversification, there is absolutely no harm for a depositor to diversify and distribute his/her savings between different banks.

THE PROVISION OF THE POLICY CONDITIONS

Typical question: On-line shopping is so convenient, even when renewing my insurance policy. When I purchase an insurance policy online, is the insurance company obliged to send me the policy documentation and other related documents by mail?

Typical question: I will be joining a tour next August and I preferred to purchase my travel insurance from my travel agent. Actually, I was told that the whole group will be insured under one policy. I was given a receipt for the premium and also a document which lists the benefits from the policy if I claim. Is that all the insurance documentation I need?

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

It stands to reason, that a policyholder should be provided not only with the benefits which the insurance policy may award in the event of a claim, but also the contractual terms binding on both the insurer and the insured, i.e. the policy document. At inception, the insurance policy would generally be provided to the policyholder. There is no obligation for the insurer to provide the same contract to the insured if the policy is renewed with the same insurer – however, the insurer may amend any policy conditions prior to renewal by means of an endorsement, which is usually attached to the renewal notice.

There may however be some instances in which the policy document may not be given – not because the insurer is not willing to do so but rather as a result of the contractual nature between the insurer, the insured and the beneficiaries of the policy. This may usually occur when the policy is issued to a group of people, such as a group health scheme or a group travel policy. In the former case, for example, the contracting party is normally the organization which pays for the policy and the beneficiaries of the policy are the staff of such organization. The contract between the insurer and the insured (i.e. the organisation) may not only contain the "standard terms and conditions" of a health insurance policy but also other contractual clauses of a commercial nature which may not necessarily be of interest to the beneficiaries. Given the commercial nature of the transaction, it may not be appropriate for the organisation's staff to have access to the whole document. However, there is nothing which precludes the organisation from making available the section of the contract relating to the coverage and conditions which allow the beneficiary to know about his obligations in the event of a claim.

In terms of Insurance Rule 3 issued under the Insurance Business Act, it is evident that it is incumbent on the insurer to ensure that the contractual information to the policyholder is not only given but that, if required to do so, the insurer has to prove that it has actually provided it to the potential policyholder. Any disclosure is required to be communicated to the potential policyholder or policyholder either (a) on paper or in some other "durable medium" that is accessible to such person; and (b) in a clear and accurate manner, comprehensible to such person.

The Rule defines a "durable medium" as "… any instrument which enables the potential policyholder or policyholder to store information addressed personally to such person in a way accessible for future reference for a period of time adequate to the purposes of the information and which allows the unchanged reproduction of the information stored. In particular, durable medium covers floppy disks, CD-ROMs, DVDs and hard drives of personal computers on which electronic mail is stored, but it excludes Internet sites, unless such sites meet the criteria specified [herein]."

The same applies to many group travel policies which are issued yearly. The Unit has come across many instances where claimants had no idea whatsoever of the terms and conditions binding on them in the event of a claim, precisely because they were only provided with a copy of the cover note and the summary of benefits (which would not include details required of the insured for a claim to be valid). It may be true that some cover notes or summaries contain a reference stating that the terms and conditions could be downloaded from the insurer's website – perhaps this is more convenient for the insurer (in terms of costs rationalization). However, this is unacceptable because the onus of making the beneficiary aware of the policy conditions cannot be shifted on the consumer merely by "informing" the consumer of a web link on any of the two documents mentioned earlier. Moreover, there is no guarantee that the policy conditions on the website (which is not the actual contract but a specimen) will remain unchanged (even if this might be remote).

In this sense, the rules emphasize that the provision of the contractual terms should be in a format which would not allow information to be changed. Technology is also making it easier for consumers to purchase or renew insurance policies on-line. While the internet has brought choice and convenience for consumers even in financial services, one should also keep in mind that the price paid for a policy should not "make or break" the customer's decision. Not only local insurance companies are competing for business, but also foreign companies which enable Maltese customers to purchase their policies (for example, travel policies) on-line. Competition is healthy and should be encouraged – (not only where the price of the policy is concerned but also in the level of service which the insurer is expected to deliver in the event of a claim). However this may prove tricky if the insurer, which may be located abroad, does not have a claims representative in Malta. The problem is that the insured may only get to know this, in the event of a claim (unless he has read the policy on-line before purchasing).

This recurring theme – the importance of reading the insurance contract (actually, any binding contract) – features prominently in a number of travel complaints and queries, especially from consumers who had travel insurance as part of a package with their premium credit and debit cards (such as gold cards). The problem with these cardholders is that many of them completely forget to check their travel policy prior to travelling, with the consequence that many find that they are under-insured or failed to follow carefully the policy conditions. In reality, these are not situations particular to such policyholders only. However, given that cardholders may not have to utilise their travel policy until the time they are abroad, there is the risk that the cardholder may take scant interest in it.

Typical question: I have just returned from a trip in Europe and unfortunately, my video camera and other personal items were stolen from me. It all happened within seconds. I claimed under the travel insurance policy which came with my gold card. However, the insurance company is coming up with quite a number of conditions before it pays what I believe is my due. For example, when I claimed for my video camera, the company not only asked for proof that I actually had a video camera (such as the box, spare battery, guarantee and perhaps

even proof of purchase) but for the company to pay, I have to provide the fiscal receipt of a new camera identical or similar to the one I had. I think this is absolutely unacceptable and the company should not oblige me to purchase a new camera to honour my claim.

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

Generally speaking, the insurance contract would give sufficient leeway to the insurance company as to how and under which circumstances it should pay in the event of a claim. An insurance company may choose to settle a claim by paying cash, or by substituting the stolen or damaged possession itself. It may also choose to direct the claimant to a particular merchant from where the claimant could choose the item on which a claim had been submitted. In some instances, it may also choose to repair an item (for example, in the event of a torn piece of luggage).

The Unit finds nothing untoward if the insurer asks for proof that, prior to loss, the claimant actually had a video camera. This is likely to be a procedure to reduce the incidence of fraudulent claims being made to insurers. At the same time, there seems to be a growing practice that an insurer would choose to settle a claim if the insured provides a receipt for a similar or identical item for which a claim is being made. This may not always be the case but it seems that the decision by the insurer applies for valuable items – such as a video camera, jewellery or designer objects. At first glance, this may appear to be of inconvenience to the insured (who may prefer to have the loss paid in cash). Upon closer examination, this procedure too may be part of an insurer's procedure to address potential fraudulent claims (for example, it may not be difficult to source any accessories which comes accompanied with a video camera from third parties). The Unit finds nothing inconvenient with this procedure as long as the insurer provides the claimant in writing with the amount that it is prepared to settle for the claim and a reasonable time period for when the object needs to be replaced.

Technology is also making it easier for consumers to purchase or renew insurance policies on-line.

OPENING OF BANK ACCOUNTS

Typical question: *I would like to bring to your attention a problem many parents may be encountering. Once our children are 16 years of age they are told that they can have their own accounts. Knowing my children well, I went over to the bank to request information about my son's account because I wanted to be certain that he is depositing his pocket-money. However, I was told that I could not be given such access as the account belongs to my son. I informed them that I was the parent and that legally he is still under-age and that my husband and I are still legally responsible for him. However the reply was that this was the practice in banking services and that the parents are consulted only if a request for a loan is made. I find this to be very wrong. At that young age many of them are still irresponsible and still need some guidance from the parents.*

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

Article 188 of the Maltese Civil Code (Of Majority, Interdiction And Incapacitation) states that "Majority is fixed at the completion of the eighteenth year of age". On the other hand, Article 971A of the Civil Code providing with the ability of children over sixteen years to open and operate bank account provides that "Notwithstanding any provision of this Code, a child who has attained the age of sixteen years may deposit money in an account opened by the child in his or her own name with any bank, and any money deposited in any such account may only be withdrawn by such child notwithstanding that such money may be subject to the administration, usufruct or authority of any other person. For all purposes of law the child shall with regard to the opening and operation of any such account be considered a major."

In this respect, paternal authority ceases as soon as a child opens a bank account in his/her name.

Facilities may only be granted to a minor who has attained the age of sixteen years and such minor shall be deemed to be major with regard to obligations contracted by him/her for purposes of trade, if (i) he/she has previously been authorized to that effect by the parent to whose authority he/she is subject, by means of a public deed registered in the Civil Court or, where both parents are dead, interdicted or absent, he has been authorized by the judge of the Civil Court and (ii) a summary of the deed of authorization or of the decree aforementioned has been published by means of a notice in the Government Gazette and in another newspaper.

In this regard, minors who are traders authorized as aforesaid can by reason of their trade charge, hypothecate and even alienate their property, without any of the formalities prescribed by the civil law. It is important to note that in these instances facilities may only be provided to minors in relation to their trade (business loan) and not for personal purposes (home loan).

For instance, banks would not issue a credit card to young adults under 18 years of age. They may only do so if the primary cardholder is either the parent or legal guardian – in that case, the supplementary cardholder may be the young adult. Any debts incurred by such supplementary cardholder would be under the responsibility of the primary cardholder.

MOTOR INSURANCE - FAILURE TO LODGE A CLAIM

The Annual Reports for the years 2007 and 2008 addressed a number of situations which the Unit came across with regards to complaints and queries relating to motor insurance. During the year under review, motor insurance complaints continued to be predominant, compared to other complaints, but not as pronounced as in previous years. This may be the result of a number of factors. The information provided in the Unit's annual reports has given insurers and claimants common ground as to where each of the parties' responsibilities lie. Indeed, it is positive to note the stance taken collectively by insurers through their Association to address, by way of a Code of Practice, how third party motor claims should be handled. Even if there are some aspects which the Unit may not necessarily be in agreement with, the Code of Practice (which is available from the Malta Insurance Association Website: www.maltainsurance.org) addresses some very important aspects which third party claimants may encounter in the event of a claim – such as failure of a party to open a claim, loss of use, uninsured events, replacement parts etc. Insurers, through the Unit's reports, know where the Unit stands in respect of complaints which it is asked to review. Complainants, on the other hand, use these reports when discussing their claim with the relevant insurer.

In many instances, cases are resolved expeditiously. There were complainants who have however asked us to intervene because they felt that their rights at law were being prejudiced, especially as they were not at fault following a car collision. Some even resorted to vent their frustration in newspapers.

There are two issues to the recurring problem – delays in the claim process and the rights of the third party when the latter is clearly not at fault. Despite the advantages which may accrue to those who have comprehensive insurance cover, many policyholders either seem to have lost confidence in being fully insured or else are inhibited by the cost of comprehensive cover (which they feel might be uneconomic considering the dwindling market values of many car models particularly over the past year). Comprehensive insurance might have become unattractive to policy holders due to the bad reputation which the industry might have accumulated as a result of the different methodologies adopted. The lack of adequate communication with policyholders as to changing vehicle market values at renewal and at claims stage (where in the latter stage, claimants seem always at the mercy of changing market force) is also increasing the frustrations of policyholders.

Typical question: I was lately involved in a traffic collision. Both my insurance and the other party's insurance told me that I am not to blame. As I am insured on Third Party basis, my insurance company was not able to handle my claim and I had to contact the other insurer myself. It has been more than 3 weeks now, and the other party has not filed a claim. The other party's insurer advised me to send an official letter to the third party giving him 10 days to open the claim. I was told that, if in those ten days, its client fails to open a claim, his insurer would pay me the expenses (around €1000). Apart from the inconvenience of not being able to use my car for the past three weeks, I had to seek legal advice to send this letter. I was talking to friends of mine and it transpires that this letter might not solve all the problems. Do you think this is fair? What exactly are the rights of a victim in a traffic accident? I am really tired of suffering all these unnecessary consequences led by a combination of incompetent drivers on our roads protected by lack of laws.

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

The third party insurer is contacted and asked for a detailed reply to the complainant's contentions. A reply may normally be given within a few days, depending on the insurer's attitude and the complications arising from the issue concerned. Regrettably, there are a handful of insurers which may take too long to reply to the Unit's requests, and even when they do, it may not necessarily be helpful especially if they cannot trace their client or their client has still not contacted them (thereby exacerbating the inconvenience for the innocent third party).

There are some processes or procedures which have become the norm, and accepted to be so by the industry. However, one cannot continue to accept situations where some insurers simply disregard the word and spirit of the law and the Code of Practice to which they adhere, allowing their insured to flout their (policy) obligations to the detriment of innocent third parties. It is simply incomprehensible that, as a result of such intransigence, some third parties have had to wait for weeks (and even months) simply because the insurer took a laissez-faire approach in regard to their errant policyholder. What is unacceptable is the attitude and/or practice of some insurance companies in situations where no claim is lodged by their insured and who instruct the innocent third party to sue their client "if you want to pursue your rights". Of course, each case is different – it is a right for a party not to accept liability and for the relevant insurer to refer the case to arbitration so that fault can be independently determined. That is perfectly in order and for the due process of natural justice to take place.

The Unit would generally provide this preliminary information to the complainant pending specific details from the insurer of the third party:

a. Etars Reports (i.e. the wardens' report) are sent to insurance companies after 3 or 4 working days. This is standard procedure and over which insurers have little control.

b. The insurer of the party who is likely to be at fault will treat any notification received as a claim. The insurer would not normally accept liability before it can discuss the circumstances of the accident with its insured. That is the reason why the insurer would send a surveyor to inspect the victim's vehicle on a "without prejudice basis". The insurer would also normally discuss the case with the innocent party. One has to appreciate that it is a basic principle of natural justice that both sides should, at least, be given an opportunity to be heard within a reasonable time.

c. There are instances where the party who allegedly is at fault queries the accuracy of the Etars Report and refuse to accept liability. At that point, the insurer can do either of two things – inform his policyholder that he may have a point and suggest that the case is submitted to arbitration (an issue which was discussed in last year's annual report), or alternatively recommend that, on the basis of their experience, should the matter be referred to arbitration, the likelihood of their policyholder not being found liable is so minimal that refusing to admit liability at that stage would be uneconomical.

d. Whichever way the recommendation is given, the third party cannot refuse to lodge a claim. If the errant third party refuses to take the insurer's suggestion to accept liability, there is yet another process to go through. Presumed innocent third parties

may complain about this fact - however, whilst every insured is bound to lodge a claim, they have a legal right not to accept liability. An insurer cannot legally accept liability against the policyholder's wish.

e. Some insurers recommend to the presumed innocent party to send a legal letter so that there would be a formal claim registered from him. Although there is nothing which should preclude the third party from doing so (especially if he wants to expedite matters), this may be an additional (and in some cases unrecoverable) expense because the insurer is aware that, in terms of law, such legal or judicial letter should be sent by the insurer and not the third party. A legal letter may not be necessary if the insurer intends to process the claim. It is only necessary if the policyholder disagrees (in writing) with his insurer's opinion that he is to blame. If the third party wants to start legal proceedings he has a choice as to whether to proceed directly against the insurer or the responsible party.

f. A legal letter or some similar form of written communication is the minimum necessary to prove to the third party's insurer that there is a claim by the third party.

   The law is quite clear on this aspect. Article 15 of Chapter 104 of the Laws of Malta provides that a registered or judicial letter be sent by the third party insurer to their client granting him notice of the claim and the intention to accept liability. Only after the requisite 10-day period has lapsed can the insurer proceed to pay the innocent third party. It is to be noted that the law (and the handbook issued by the Malta Insurance Association) requires that the insured be given an indication of the amount to be paid - which would, strictly speaking require the third party to submit bills regarding repairs or an approximate indication of the total amount due as resulting from the survey report.

g As soon as the insured is notified with the insurer's registered or judicial letter sent in terms of law, the 10 days required according to law would start running, and should the insured fail to lodge an objection within that time-frame, the insurer shall be entitled, according to law, to pay the innocent third party.

If a vehicle has been declared beyond economic repair, this means that it is not financially feasible for the insurer to repair it as in doing so might very well exceed the vehicle's market value.

h The time that may run from the date of accident might as well run into a few days or couple of weeks.

Whilst one naturally sympathises with third parties who are involved in accidents and suffer unnecessarily, one must also appreciate that the law must be respected.

Finally, there is also another important aspect which should be borne in mind. The innocent third party might argue that his vehicle is not in a good state to be road worthy as a result of the accident (until it is repaired). Thus he/she is deprived from its use during the time until a decision is taken by the insurer to accept liability and authorise repairs. One must remember that it may be possible for temporary repairs to be undertaken so that the vehicle may be driven without the risk of contravening any traffic regulations. Such situations may however complicate themselves if the financial outlay for repair works is high. This too might appear as an additional financial burden for the innocent third party, but repair works would nevertheless have to be carried out sometime or other, whether reimbursable or not (especially if the case is referred to arbitration and the presumption of innocence is not upheld).

MOTOR INSURANCE - THE VALUE OF MY VEHICLE'S WRECKAGE

Typical question: I am insured on a third party fire and theft basis. I was involved in an accident and my car has been declared beyond economic repair. When the insurer of the party admitting liability told me the market value for my vehicle, I thought he was joking. He declared a value which was less than half I had last insured it with my insurer. Moreover, he told me to keep the wreck and he gave me less than the amount he declared. The wreckage is of no use to me and I want my car back. To add insult to injury they took ages to decide whether my car should be repaired or not. Am I entitled to a rented vehicle? What are my rights?

The Office of the Consumer Complaints Manager usually answers such questions in the following manner:

The query touches various facets of many queries such as that posed above.

1. The value of the vehicle: A third party insurer – the insurance company of the third party who has admitted liability and agreed to pay you financial compensation for the loss suffered – would not normally be obliged to refer to the value of your vehicle's sum assured (that is, the value you had last renewed your insurance policy with your insurer). This is so because there is no contractual obligation between you and this insurer. That stated, the insurer is duty bound to indemnify you – this means putting you back into the same financial position you were in prior to the accident. Through its appointed surveyor, a market value of the damaged vehicle would be established – this is normally referred to as the pre-accident value and is shown on the surveyor's report. Although surveyors are normally guided by the vehicle values guide book published by the Malta Insurance Association, to establish the market value, they will take into consideration the actual condition of the vehicle, the mileage and other factors that may have affected its market value on the second hand vehicle market. It is not unusual that you may find that your vehicle's value is much lower than your expectations. The market value should not be mixed up with the value you would have been willing to sell your car for (and for which you might have found a buyer). If you disagree with the market value, it may be appropriate to obtain an opinion from another surveyor (perhaps your own insurer may suggest one) to ascertain an independent

view. Ultimately you would need to have in hand professional evidence that the pre-accident market value of the vehicle was higher than that determined by the insurer.

2. The value of the wreck: If a vehicle has been declared beyond economic repair, this means that it is not financially feasible for the insurer to repair it as in doing so might very well exceed the vehicle's market value. The surveyor will establish an estimate of the value of the wreck – this is the price the wreck would fetch if it is sold, for example, to a repairer. It may be true that the wreck might be worthless to you and you expect the insurer to dispose of it in normal circumstances. However this depends on the approach and attitude of the insurer. Some insurers might suggest that they keep the wreck and you will be given the market value established (as long as you agree with this estimate, in which case you might have to bargain for a better offer or else commence arbitration proceedings). Sometimes the value of the wreck established by the surveyor would differ from that which may actually prevail on the market. As some insurers would not be willing to dispose of the wreck, it would be in the owner's interest to find a buyer for the wreck before accepting the insurer's offer. The Unit believes that it would be preferable, however, if the insurer would arrange for the wreck to be disposed or sold, and the owner given the full market value. After all, the owner should not be burdened unnecessarily with these situations. If the owner accepts to take the wreck, the insurer would pay the difference between the market value and the value of the wreck.

3. The right to hire of replacement vehicle is not automatic although, irrespective of whether there is an insurance company involved or not, nothing precludes a person from hiring a vehicle and then asking for reimbursement of expenses from the party who has caused the accident and his insurer. It is important to keep in mind that when claiming reimbursement one has to prove that it was necessary to hire the replacement car and that the cost was kept to a minimum. Insurers would not compensate for a hired vehicle when a vehicle is declared beyond economic repair. This means therefore that, even if one may be entitled for reimbursement of a hired vehicle until the insurer declares whether to repair or scrap, as soon as it is declared beyond repair, one will not be entitled to any expenses incurred for hiring a vehicle. The rights of a third party to claim back expenses relating to the hire of a replacement vehicle were discussed in detail in the Consumer Complaints Unit Annual Report of 2006.

Case Studies

A substantial number of complaints which remain outstanding at year end relate to cases of investments going awry as a result of the financial turmoil which spilled into 2009 and whose effects continue to reverberate in 2010. Some of these cases were filed during the last two months of 2008. Many others were filed during the year under review.

It may be appropriate to comment generally on why the Unit has not yet completed its review of these complaints.

For the first time, the Unit has been faced with a mass of complaints relating to identical or very similar products against a handful of financial intermediaries. Although each case is treated on its own merits, the outcome of one case might have repercussions on the outcome of other cases. In some instances, the cause of the complaint was either the decrease in value of the investment or the restrictions put by the fund manager to disincentivise investors from redeeming their units which might have prejudiced the value of the entire fund and therefore the position of those unit holders who did not wish to redeem their investment.

The cause of many complaints was also the allegations put forward by complainants that the product had been "verbally" misrepresented to them. As the onus of responsibility is on the financial intermediary to prove that it has acted honestly and did not mis-sell these products, the intermediary is obliged to ensure that the sale process is sufficiently documented for both the customer and itself to bind themselves by a common set of contractual obligations. It is never too easy, therefore, to determine exactly what had been stated and how the products had been explained verbally. On the other hand, whenever there is documented evidence – with signatures of the customers and the financial intermediary – which clearly and unequivocally indicate the characteristics of the product, it becomes difficult for the Unit to assess diametrically opposing situations whereby what is declared in writing is completely different from what has been allegedly stated verbally. It becomes even more complicated when such complainants seem to have similar (and sometimes even identical) allegations being made against the financial intermediary or any of its members of staff who sold the product.

The Unit is also processing a number of complaints where there are allegations of bad advice. In this case, the allegations are being made in respect of particular investment securities which have turned sour following collapse of their issuer, some of which considered of high repute before the turmoil. In a sense, a financial intermediary can only judge the credit worthiness of a holding on the basis of information which it has in its possession at the time it is sold or recommended – with such obligation being a constant obligation. One may not reasonably expect a financial intermediary to predict that an issuer is expected to go bankrupt, or will be failing from honouring its commitments. On the other hand, it is quite reasonable to expect financial intermediaries to assist investors to diversify risk between holdings and market sectors. When one considers the effort that has been made by the Authority to educate investors on the importance of diversification, it becomes difficult to understand the reasoning behind the advice given by intermediaries which recommended portfolios concentrated in securities issued by one sector (such as financial institutions) or junk holdings (BB and under), for example.

In last year's annual report, the Unit had dedicated a special section on the effect of the financial turmoil on investors and their investments. The report had this to say about a particular category of products and the practice of some intermediaries which promoted them as widely as possible: *The Consumer Complaints Unit has also noticed a prevalent increase in the promotion of investment products where the underlying assets are illiquid,*

such as property or life insurance products. Given their inherent characteristics and risks, the Unit is concerned to see retail investors being offered such products, which should only be targeted for experienced investors.

The practice by some financial intermediaries to offer such products to the general public may be attributed to the "innovative" nature of the products themselves and the perceived appetite for higher returns by the investing public in light of the very poor interest rates on bank accounts. The problem may not necessarily be the product itself but rather the way it is promoted and sold to the public. One fails to understand how, for example, property funds have been sold to the general retail public rather than actual experienced investors – meaning, investors who can truly understand the risks inherent of the product and who are able to decide for themselves whether the product is suitable for their circumstances or not. Some of these products have been sold via retail bank branches – hardly the place for sophisticated investors to visit but certainly a captive environment for retail customers. Moreover, it is inconceivable how one can accept as morally justified the sale of these funds on an "execution only" basis. On the other hand, it is simply incredulous how investors continue to blindly trust some very enterprising financial executives without considering the risks involved and the extent of diversification of their portfolios.

It is evident that some financial firms might have taken lightly the Unit's concerns about funds investing in highly illiquid assets such as life insurance policies (termed asset-backed securities by people in the trade). The fact that these products – hardly easy to understand – have been promoted as an "alternative" to traditional or conventional investments to the mainstream retail investing public speaks volumes about the perception that "anything goes" for the Maltese investors as long as they are offered promising returns, whatever the risk.

The Unit felt it was its duty to remind consumers to be extremely vigilant before committing their monies to these investments and should make sure that they have read and understood the product documentation given to them prior to any potential investment. Investors, who are unable to understand the documentation, should not buy these investments.

In this respect, the Unit issued a warning to investors about these "innovative" breed of asset-backed securities and why they were unsuitable for particular retail investors. The Authority is determined to express itself further if investment promotions of this nature crop up in future.

Coupled with this issue, it was also disturbing to note the "innovative" practices by certain financial intermediaries who advised some of their clients to take out loans on their life insurance policy (with a profits element, such as an endowment policy), and to invest proceeds from these loans into particular investments involving substantial risks. The problem is that many of the investors which chose (or rather, were recommended) to take out a policy loan were not aware that such a loan bears an annual interest and that it has the effect of diminishing the value of that same policy with the risk of wiping out any cash surrender value until such time that it is repaid. Moreover, the financial benefit for the policy owner would only be minimal because of the marginal difference between the promised annual return and the actual interest payable on the loan. In addition, the interest on the loan would still have to be paid, even if the promised interest on the investment is lower or not paid at all. Timely regulatory action to stall such practices was indeed welcome. As indeed was the positive outcome of a complaint where, an inexperienced investor who totally relied on his intermediary and had no idea of what he was investing in, was reinstated in full as the

proceeds from a policy loan were invested in a product which was totally unsuitable for his particular circumstances.

Unravelling such situations takes time, not least because a fair review process is required.

Besides investments-related complaints the Unit handled a number of other complex cases. In general, the Unit endeavours to resolve complaints without undue delay. However, some cases may take some time to resolve. In some instances, this may be the result of the workload, the exchanges between the licence holder and the Unit, and any other complications which may arise purely as a result of the merits of the case being reviewed.

This section provides a short summary of a selection of cases dealt with by the Unit in the year reviewed. Names and situations have been altered to preserve confidentiality.

HEALTH INSURANCE - WHEN A MEDICAL PRACTITIONER IS NOT A SPECIALIST (COMPLAINT UPHELD)

Mr A was covered by a group medical insurance policy. He was generally aware that treatment must be undertaken on referral of a General Practitioner and given by a medical specialist. Mr A's wife, who was also covered by insurance, was complaining of a foot ailment and went to their GP for advice. Their GP referred them to a podologist within the same clinic, which incidentally had an agreement with the health insurer for bills to be settled directly. The podologist advised the patient to take an X-Ray for further examination. When Mr A filed a claim with the insurer for payment, the insurer declined to pay on the basis that the expenses related to the podologist, and his referrals for an X-Ray, were excluded from the policy. Mr A complained to the insurer, which stood firm by its decision and, as a result, referred the matter to the Office of the Consumer Complaints Manager.

The insurer told the Unit that "as the local competent medical board had not approved the list of practitioners complimentary to medicine, in this case a podologist as compared to specialists, who are granted the right of direct referral to investigative radiological procedures, the claim could not be considered as eligible for reimbursement". The Unit sought further clarification from the insurer as to how a claimant could have reasonably be expected to know the difference between a "specialist" and a "podologist" and who is competent to do what and when.

In its reply, the insurer stated that as the list of specialists is published by the relevant medical council to clarify and specify those practitioners who may actually practice as specialists, it reasonably expected policyholders to know who these specialists are. It stated that the list is available publicly on a website which consumers are generally expected to be aware of and refer to so that they would be able to know when a medical practitioner is a specialist and when he is a practitioner. In this case, a podologist – according to the insurer – is not a specialist in terms of its policy even if it does not specifically exclude services provided by podologists.

The Unit disagreed completely with the insurer's response for various reasons. It stated that Mr A was never in a position to double guess his GP when he was referred to a podologist. In addition, as the policy did not exclude podologists, Mr A could not make an informed decision about the exclusion or otherwise of such medical practitioner from being covered by the policy. In this respect, Mr A could not have known that a podologist was a practitioner

but not a specialist – and in that respect, it would be unreasonable to make policyholders double-guess the status of a medical professional purely to satisfy the insurer's decision to exclude some of them under a health insurance policy.

The insurer counter-argued that a patient should not go to a doctor under the impression that he is a specialist when in fact he is not. On the other hand, the Unit sustained that it is unreasonable for a lay-person to know of these situations unless the policy specifically and unequivocally lays down what category of medical persons are covered and excluded. In the absence of this information, it should not be left to the patient to establish such facts on his own.

At the end, the insurer agreed to pay the claimant in full as a gesture of goodwill.

UNAUTHORISED WITHDRAWAL - CARD STOLEN (COMPLAINT NOT UPHELD)

The apartment of Mr B was burgled in July 2009. Mr B's credit card and a particular file which contained various statements and correspondence relative to his Visa Gold Card were stolen. Seven unauthorized drawings were made with the credit card from an ATM.

In his complaint, Mr B stated that the burglars could have traced the PIN from the file that was located in his desk. He rejected the bank's contention that he had contributed to the loss as a result of any negligence since he was quite certain that the PIN was not in the same place where he usually kept the card.

The bank claimed that it was not in a position to refund the amounts withdrawn on the grounds that the transactions were effected using the card and the PIN. The bank was clear on its position – the card was used by means of the PIN which in accordance with the Terms and Conditions regulating usage of the card had to be destroyed upon receipt. The bank however could not produce the original card agreement which had been entered into a long time ago.

Banks are likely to require cardholders to keep their PIN secret at all times and also to change their PIN should this become known to third parties.

In principle, the Unit stated that the bank was perfectly in line with the Central Bank of Malta Directive 4 on Electronic Payment Services which stated that the terms of a card agreement shall include "(b) a description of the holder's and issuer's respective obligations and liabilities; this is to include a description of the reasonable steps that the holder must take to keep safe the electronic payment instrument and the means (such as a personal identification number or other code) which enable it to be used". Furthermore, Directive 4 also states that "the holder shall …. not record his personal identification number or other code in any easily recognisable form, in particular on the electronic payment instrument or on any item which he keeps or carries with the electronic payment instrument."

The fact that the Bank included a clause in its terms and conditions requiring a cardholder to immediately destroy the PIN upon receipt does not appear to go contrary to the requirements imposed by this directive. However, the Unit was not in a position to presume that the cardholder was aware of this.

Among the facts taken into consideration was that Mr B's card was chip-and-pin. These new cards were rolled out by the bank during these past 12/14 months and all cardholders received documentation about the use of these cards. All cardholders received a new PIN. When the Unit raised this issue with the bank, it produced a specimen letter which it had sent to all cardholders in 2009 announcing the roll-out of the chip-and-pin cards. The letter reminded its cardholders about their obligations to keep their PIN secret at all times and also to change their PIN should this become known to third parties.

In conclusion, it was evident that withdrawal of cash by Mr B's gold card could only have been done with the card and PIN being present at the same time, and whoever withdrew cash had access to both of them.

Given the unfortunate way in which Mr B's card had been misused, the Unit tried convincing the bank to offer a partial amount in commiseration. However, it declined the Unit's suggestion.

LIFE INSURANCE - FUNERAL BENEFIT (COMPLAINT NOT UPHELD)

Mrs X, widow of Mr Y, contested the interpretation of funeral expenses benefit under her deceased husband's life insurance policy. She claimed that the payment of such benefit should be over and above the amount of the policy account (which, given the length of time her husband had been paying the premiums, exceeded the sum assured). Mrs X claimed that, when her husband took out the life policy, he was told by the official who sold him the policy that the funeral benefit (around €2500) was over and above the amount payable on death or maturity. She claimed that she was present at that meeting and she still remembered her husband saying that the amount was quite generous, given that it was payable over and above the amount payable by way of the policy.

The life insurance company stated that what Mrs X was claiming was not what the policy stated. According to the relevant clause in the policy document, the company could consider advancing the funeral expenses up to the amount stated in the schedule. It stated that the payment was not automatic and, if the company agreed to advance such payment, it would consider such payment to be on account of the sum assured / death benefit and before the company would be in a position to admit liability under the policy. It also stated that, any

advanced payment in respect of a funeral benefit would not bind the company whether to pay the sum assured/policy account to the beneficiaries in terms of its obligations under the policy and would not be recoverable because the clause binds it to do so before it accepts to pay for the claim.

In the Unit's opinion, the relevant clause in the policy was quite clear as to when the funeral benefit is actually made payable. However, the Unit was also mindful of the claim made by the complainant as to how the benefit had allegedly been explained at policy inception. The Unit asked the representative to provide the Unit with a declaration as to what was likely to have been his explanation to prospective policyholders at the time. The representative declared that, with regards to the funeral expenses, he had always explained to his clients that funeral expenses are paid out as a pre-payment, either of the sum assured or the policy account. He was certain that, under no circumstances, had he ever in any way or form stated that funeral expenses were paid out in addition to the sum assured or policy account. Indeed, he stated that he had many other clients who had the same policy and who passed away, and none of the beneficiaries claimed what Mrs X had alleged.

The Unit held the view that, although there were differing views about what might have been stated at the time the policy was issued, on a basis of probabilities it was unlikely that the policy was incepted purely on the funeral expenses benefit and – most importantly – the policy conditions were clear enough in this respect.

TRAVEL CLAIM - CANCELLATION (COMPLAINT UPHELD)

Mr C wrote to the Office of the Consumer Complaints Manager in connection with a claim he put forward to his provider of travel insurance. Mr C and his children were planning to travel but had to cancel the trip in view of the sudden death of his aged mother. He cancelled the journey only a week before the trip had to commence and the travel insurance provider refused to pay claiming that Mr. C and his children knew of the circumstances surrounding the sudden death of the aged lady at the time they took the policy.

Mr. C submitted a medical report issued by his deceased mother's consultant which attested that the cause of death of his mother was totally unrelated to the condition for which she was taking medication. However, the insurer was not satisfied with the report and repeatedly asked Mr C to provide a declaration to search hospital records relating to the deceased.

The Unit was of the opinion that what the insurer was requesting went beyond the remit of the policy, if not data protection and confidentiality issues. On this aspect, the Unit contacted the Data Protection Commissioner who was of the opinion that the complainant was only required to produce evidence (such as death certificate/burial certificate) establishing cause of death. The Unit agreed with the Commissioner's recommendations.

The insurer finally accepted to pay the amount of the claim in full.

Appendices

APPENDIX I

FORMAL COMPLAINTS BY CLASSIFICATION

BANKING COMPLAINTS	A	B	C	D i	D ii	E	F	G	TOTAL
Bank commercial decision			1			1	1		3
Bank mistake	3		1	1		3	1	1	10
Charges			1	1		8	1	1	12
Cheque encashment	1			1					2
Delays			1						1
Determination of Interest Rate		1							1
Loans and advances				1		1			2
Provided information or general query	2							1	3
Refusal to give information			1			1			2
Transfers	2		1	2		1			6
Unauthorised card transaction		1				2	1		4
Use of exchange rate			1			1		1	3

INSURANCE COMPLAINTS									
Foreign company passporting in Malta	1								1
Health-related	1				1	3			5
Home insurance-related			1			3	2		6
Increase in premium				2		1			3
Insurer concerned	1		1			1			3
Life-related	1			3		8			12
Local company passporting in EU	2					2			4
Marine cargo Insurance	1								1
Motor - own policy - claims	1	1		2	1	5	1		11
Motor - own policy - liability	1	1				2		1	5
Motor - own policy - loss of use				1		2			3
Motor - own policy - market value	1				1				2
Motor - own policy - NCD				1	1				2
Motor - own policy - use of spare parts					2	1			3
Motor - Third party - Delay in claim/payment	6		4	4	1	4	2	1	22
Motor - Third party - failure to open claim	5	1	1	10	1	3	4		25
Motor - Third party - liability	12	1	2	9			1		25
Motor - Third party - loss of use	1		1	2	5	3	1		13
Motor - Third party - market value	1				2	1	2		6
Motor - Third party - use of spare parts				1			2		3
Personal accident insurance						1			1
Provided information or general query	1					1			2
Travel-related			2	2		16	10		30

INVESTMENT COMPLAINTS	A	B	C	D I	D II	E	F	G	TOTAL
Bad advice allegation						3			3
Calculation of interest/ yield/ price						2	3	1	6
Capital guaranteed-related							1		1
Charges			1		1	3	1	1	7
Delay in submission of payments/ documents			1			1		2	4
Intermediary mistake		1		1		2			4
Mis-selling allegation	1			1		6		1	9
Other						3	3		6
Information provided or general query		1				1			2
Use of exchange rate				1					1
OTHERS									
Scam/ fraud	1								1
Trust - Mismanagement			1	1					2
TOTAL	46	8	22	46	14	98	38	11	283

CLASSIFICATION	
A	Outside MFSA jurisdiction (in such instances and following any investigation undertaken, the complaint is requested to seek redress with the appropriate authority as applicable).
B	Customer withdrew complaint.
C	Referred to entity or consumer - no feedback
DI	Entity has not treated the customer's complaint fairly - complaint upheld by Consumer Complaints Manager. Entity accepts recommendation.
DII	Entity has not treated the customer's complaint fairly - complaint upheld by Consumer Complaiants Manager. Entity did not accept recommendation.
E	Entity has treated the customer's complaint fairly - complaint not upheld by Consumer Complaints Manager.
F	Entity has generally treated the customer's complaint fairly but it still agrees to a goodwill payment or improved settlement.
G	General query - provided information/ clarification.

APPENDIX II

VERBAL COMPLAINTS AND QUERIES

BANKING	QUERIES	VERBAL COMPLAINTS
Charges	28	16
Cheque encashment	2	7
Delays	2	1
Use of exchange rate	9	-
Transfers	3	3
Bank Mistake	2	3
Refusal to give information	-	3
Unauthorised card transactions	12	3
Cross Border banking	31	6
Depositor Compensation Scheme	31	1
Interest rates	3	2
Bank commercial decision	14	4
Provided info or General query	37	30
TOTAL	174	79

INVESTMENTS		
Bad advice allegation	5	5
Calculation of interest/ yield/ price	2	2
Capital guaranteed-related	6	2
Charges	5	1
Intermediary mistake	2	1
Mis-selling allegation	22	10
Suitability of product	6	2
Other	8	1
Delays (payments and other docs))	-	3
Financial Turmoil + Lehman	6	-
Provided info or General query	85	28
TOTAL	147	55

INSURANCE	QUERIES	VERBAL COMPLAINTS
Cannot find insurance	1	2
Health-related	6	5
Home insurance-related	10	3
Increase in premium	2	3
Life-related	10	12
Travel-related	48	20
Motor - own policy - NCD	4	1
Motor - own policy - Claims	24	1
Motor - own policy - Liability	7	1
Motor - own policy - Loss of use	7	3
Motor - own policy - Market Value	6	7
Motor - own policy - Use of spare parts	11	1
Motor - Third party - Failure to open claim	9	3
Motor - Third party - Liability	7	5
Motor - Third party - Loss of use	6	2
Motor - Third party - Market Value	7	6
Motor - Third party - Use of spare parts	4	4
Refusal to give information	1	-
Intermediary-related	-	1
Motor - Third party - Loss of Profit	-	1
Motor - Third party - Delay in handling claim/ payment	7	13
Motor - Third party - Choice of garage	-	1
Independent Insurance - related	-	1
Provided info or General query	45	17
TOTAL	222	113

OTHER		
Scam	34	4
Listed Company on the MSE	-	1
Others	22	-
Outside MFSA Jurisdiction	13	6
TOTAL	69	11

TRUSTS AND TRUSTEE SERVICES		
Provided info or General query	1	-
TOTAL	1	-

Notes

MFSA

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