Office of the Financial Services Ombudsman

Annual Report 2007

An Agency created under the auspices of the Central Bank of Trinidad and Tobago

Office of the Financial Services Ombudsman

Annual Report 2007

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FOREWORD

by the Governor of the Central Bank

Ewart S. Williams

As the Office of the Financial Services Ombudsman celebrates its fifth year of existence, I am convinced that it has made a difference to the financial landscape of Trinidad and Tobago.

The number of complaints about banking services received by the Office declined from one hundred and fifty four (154) in 2003 to twenty six (26) in 2007. I think that part of the explanation is that the Ombudsman's Scheme has provided the impetus for all the banks to be more diligent in providing better and improved service even as they compete aggressively for customers. I am also very pleased that the commercial banks have established mechanisms to deal effectively with customer complaints.

The insurance scheme has been in existence for three years and for the first time in 2007, there was a decline in the number of complaints received. This was partly due to the closure of two companies that faced liquidity and solvency problems. In addition, several insurance companies have upgraded their dispute resolution mechanisms and improved their customer service. It is worth noting that 70 percent of all complaints relate to 5, out of the total of 30 operating companies. The Central Bank's Financial Institutions Supervision Department as well as the Ombudsman Office will continue to work with these companies to improve customer service and market conduct.

I am particularly happy to note the positive response and support given by the banks and insurance companies to Central Bank's National Financial Literacy Programme. In addition to providing funding, both banks and insurance companies have been conducting their own financial education programmes.

I would like to take this opportunity to publicly express my sincere thanks and appreciation to Mrs. Judy Chang who demits office as the Financial Services Ombudsman on April 30, 2008. Mrs. Chang helped in setting up the Office and presided over its expansion to cover insurance companies as well as banks. Through her diligence, resourcefulness and impartiality, she has succeeded in bringing tremendous credibility to the Office.

Mrs. Chang will be succeeded by Ms. Ann Marie Narine who has considerable experience in financial sector matters, having worked for many years in the Supervision Department of the Central Bank. I am certain that Ms. Narine will provide the same high level of service as her predecessor.

Ewart S. Williams
Governor
April 2008

PREFACE

By the Financial Services Ombudsman

Judy Y. Chang

I am pleased to report that the number of complaints received by our Office for the year ended December 31, 2007 for both banks and insurance companies declined compared with the previous year.

The complaints against the banks fell by thirty five per cent (35 per cent) from the previous year, and this continued the trend established since the inception of the Scheme. The number of insurance complaints received has also declined by twenty nine per cent (29 per cent). This may be attributed to the diligence exhibited by some insurance companies in their handling of complaints and the genuine efforts made to do so in a timely fashion. However, the same cannot be said for all insurance companies. There is still some reluctance on the part of one or two companies to co-operate fully with the office. As was observed in the past, the complaints arising from motor vehicle accident claims account for over 90 per cent of the complaints handled. There were very few in the areas of general and life insurance.

During the year two new banks began operations in Trinidad and Tobago - the Bank of Baroda (Trinidad and Tobago) Limited and FirstCaribbean International Bank (Trinidad and Tobago) Limited. I am happy to welcome these institutions as members of the Scheme.

In the 2007 Budget Speech the Minister of Finance announced plans for the creation of a Motor Accident Vehicle Fund to assist those victims of motor vehicular accidents who cannot get any financial redress. This type of fund is similar to that of the Motor Insurance Bureau of the United Kingdom. Since the announcement, a study has been completed and this was partly financed by ATTIC. Further research into the feasibility of such a programme is in progress.

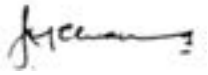
Judy Y Chang, Financial Services Ombudsman in the centre, flanked by her resolution officers. From left to right: Selwyn Trim (senior), Natalie Abraham-Syriac, Nicola Robinson and Karen Thompson-Morris

The Office of the Financial Services Ombudsman (OFSO) is pleased to be associated with the National Financial Literacy Programme initiated by the Central Bank to lift the level of financial literacy among the citizens. When I assumed duty at this office five years ago, it was very clear that there is a pressing need for basic information on banking and insurance practices and procedures to be disseminated to the general public.

The OFSO produced a booklet with banking tips entitled "Dollars & $ense" and this was well received. This booklet is used widely in the National Financial Literacy programme. Work is presently underway to produce a similar booklet containing basic information and tips on insurance and this will be published shortly. I am happy to note that the banks and some insurance companies have taken steps to support the Central Bank's initiative by conducting similar programmes to educate the public on financial matters.

I attended the annual Conference of International Ombudsmen in London, England in September 2007. I was privileged to be one of the members of a panel of speakers who discussed the advantages and disadvantages of a small Ombudsman scheme. At that conference a network of international ombudsmen was formed and Trinidad and Tobago is one of the founding members. We now have access to that body or any particular member within the group to have a discussion or exchange ideas on any matters of mutual interest.

I am very pleased to have been given the opportunity to serve as Ombudsman for the past five years. As I demit Office on April 30, 2008, I wish to say how very much I enjoyed my tenure and to thank the Governor for his confidence in me and for providing me with his full support. The staff of the OFSO has always been dedicated and loyal and respects the tenets of the Office - to provide service to the users of the financial services sector who may have a complaint. While the job of Ombudsman has been challenging at times, I have been able to perform my duty successfully with the co-operation and support provided by members of both the banking and insurance sectors.



Judy Y Chang
April 2008

REPORT OF THE BANKING COMPLAINTS

For the year ended December 31, 2007

Introduction

The establishment of the Office of the Financial Services Ombudsman and its predecessor, the Banking Services Ombudsman, in May 2003 was the impetus for the banking sector to institute measures within their organisations to handle complaints from the public and to strengthen their customer service. This has prompted all banks to set up dispute resolution centres at their head offices to handle complaints that are not resolved at the branch level and to be the liaison with our Office. As a result, in the fifth year of operations of the Ombudsman's Office, the number of complaints received has continued its steady decline when compared with previous years.

Complaints Received

During the year ended December 31, 2007, a total of 26 complaints were received compared with an average of 106 over the four (4) preceding years. The number of complaints declined steadily from a high of 154 in the first year to 40 in 2006. As with the previous year, complaints were received only from the four (4) larger commercial banks. Among the complaints received in 2007, twelve (12) met all the requirements under the operating terms of reference. The other fourteen (14) complaints fell outside of these requirements and were deemed non-qualifying. This compares with seventeen (17) and twenty three (23) respectively for 2006. From the inception of the scheme the practice has been to send even non-qualifying complaints to the banks and they were well received.

Analysis of Statistics

Almost all of the banking complaints considered during 2007 were resolved. A total of six (6) banking complaints were brought forward from 2006; twenty-six (26) were received and thirty (30) resolved in 2007, while two (2) were carried forward to 2008.

TABLE 1:
Number of Complaints Processed

	Jan – Dec 2007	Mar 2003 – Dec 2007
Brought forward	6	0
Received	26	450
Subtotal	32	450
Resolved	-30	-448
Carried forward	2	2

Statistical Overview of Banking Complaints

TABLE 2:
Complaints Received by Type

/Number/

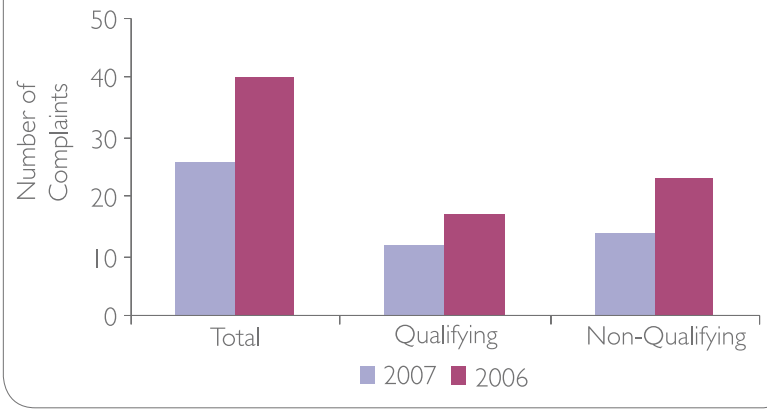
	Total		Qualifying		Non-Qualifying	
	2007	2006	2007	2006	2007	2006
Account & Transactions	15	16	9	6	6	10
Card Services	2	6	2	5	0	1
Fees and Charges	0	2	0	1	0	1
Loans and Credit	2	3	0	2	2	1
Privacy and Confidentiality	1	0	0	0	1	0
Service and Advice	2	3	0	1	2	2
Mutual Funds	0	1	0	0	0	1
General Interest rate level	0	0	0	0	0	0
Credit policies and decision	3	4	0	0	3	4
Other	1	5	1	2	0	3
Total	**26**	**40**	**12**	**17**	**14**	**23**

/Percent/

	Total		Qualifying		Non-Qualifying	
	2007	2006	2007	2006	2007	2006
Account & Transactions	57	40	75	35	43	44
Card Services	8	15	17	29	0	4
Fees and Charges	0	5	0	6	0	4
Loans and Credit	8	7	0	12	14	4
Privacy and Confidentiality	4	0	0	0	7	0
Service and Advice	8	7	0	6	14	9
Mutual Funds	0	3	0	0	0	4
General Interest rate level	0	0	0	0	0	0
Credit policies and decision	11	10	0	0	22	18
Other	4	13	8	12	0	13
Total	**100**	**100**	**100**	**100**	**100**	**100**

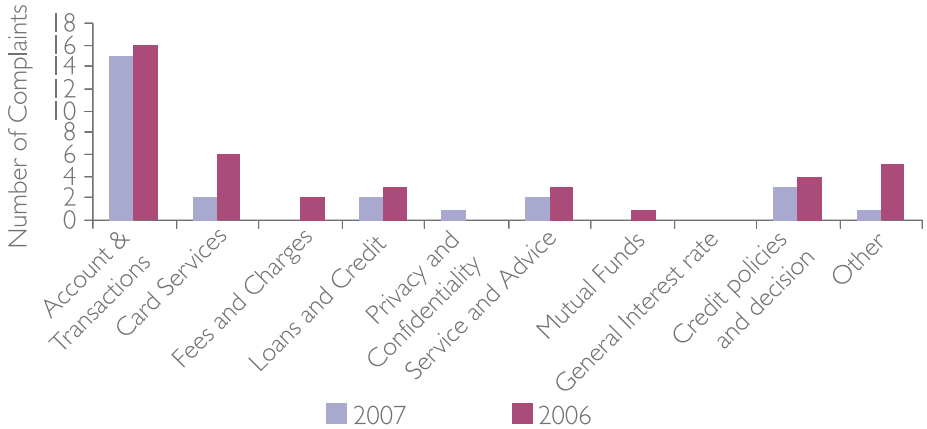
Type of Complaints

FIGURE 1:
Total Complaints



In 2007 there was a 35 per cent decline in the number of complaints received. Similarly, there were declines in both qualifying (29%) and non-qualifying (39%) complaints. Complaints about Accounts and Transactions accounted for 58 per cent of all complaints received in 2007 compared with 40 per cent in 2006. This category also represented 75 per cent of qualifying complaints and 43 per cent of non-qualifying complaints in 2007 compared with 35 per cent and 43 per cent respectively for 2006. Card Services also recorded a decline from 15 per cent to 8 per cent in 2007. The other categories of complaints remained close to the 2006 levels. As with previous years, the number of complaints received from each bank was in proportion to the relative size of each bank to each other.

FIGURE 2:
Types of Complaints



Reporting of Complaints Handled by the Banks

During the year, the OFSO requested the four (4) larger banks to provide information at the end of each quarter about the complaints handled at their banks. The data received was consolidated and fed back to each of the banks in summary form for the industry, with a comparison of the statistics for the individual bank compared to the industry and a report of any emerging trend. The number of complaints reported was more or less proportional to the size of the banks. With one exception, the largest number of complaints is in the area of unsatisfactory service, an area where the banks have some more work to do in order to satisfy their customers.

REPORT OF THE INSURANCE COMPLAINTS

For the year ended December 31, 2007

Complaints Received

During 2007, the third year of operations for the insurance industry and the fifth for the Office of the Financial Services Ombudsman (OFSO), the OFSO received a total of three hundred and forty one (341) complaints from the public against insurance companies. This represents a reduction of 139 or 29 per cent fewer complaints than for the corresponding period in 2006. Two (2) of these were complaints from small businesses.

Thirty nine (39) of these complaints in 2007, including two (2) against Citizen Insurance Company Limited (in compulsory liquidation), were referred to the Market Conduct Unit of the Financial Institution Supervision Department (FISD) for handling, since the Terms of Reference of the Scheme did not permit the OFSO to treat with these complaints. In 2006, seventy three (73) such cases were referred to that unit.

The 29 per cent decline in the number of complaints received may be attributed to the closure of Goodwill General Insurance Company Limited and Citizen Insurance Company Limited in 2006. Twenty one (21) of the complaints that were lodged with the OFSO against these two companies were redirected to the judicial managers of these respective companies in 2007 and ninety six (96) in 2006. Both companies were since placed into compulsory liquidation.

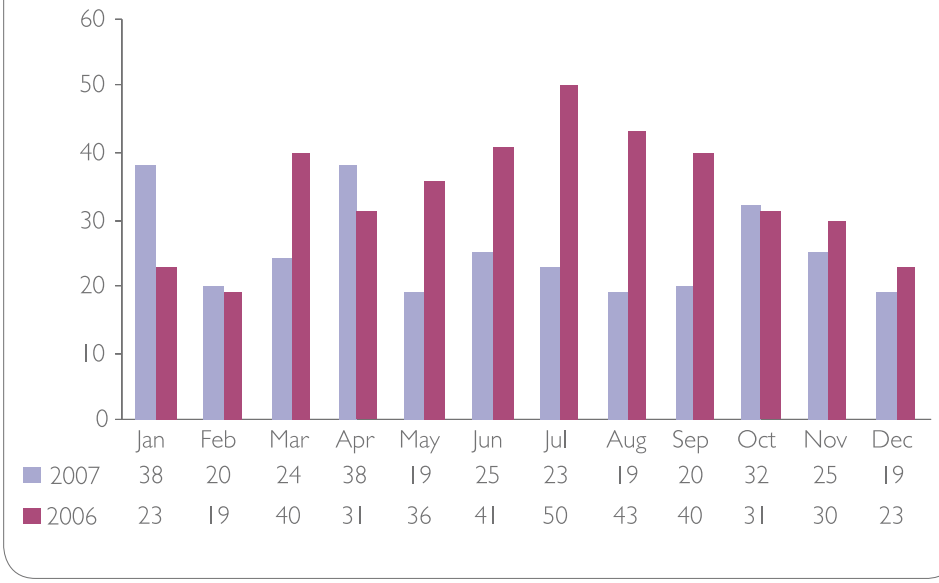
TABLE 3:
Number Of Complaints Processed

	2007	2006
Brought Forward	97	87
Received during the year	341	480
Transferred to FISD	-39	-73
Subtotal	**302**	**407**
Subtotal	**399**	**494**
Transferred to Liquidator	-21	-96
Resolved/Closed	-314	-301
Subtotal	**-335**	**-397**
Carried Forward	**64**	**97**

Distribution of Complaints Throughout the Year

The data show that there is no seasonal pattern in the distribution of the number of complaints that were lodged during the year. Complaints received were evenly distributed throughout the twelve month period and this was similar to the trend of the previous year except for the period from March to September 2006 when a greater number of complaints were received. This spike in complaints can be attributed to the announcement that the two companies were placed into receivership. (See Figure 3)

FIGURE 3:
Distribution of Complaints Handled by the OFSO



Types of Complaints

The vast majority of complaints continue to be about issues pertaining to the settlement of claims arising from motor vehicle accidents. Of the three hundred and two (302) complaints that were processed by the OFSO, two hundred and eighty-four (284) complaints, or 94 per cent, relate to motor claims; only three (3) or 1 per cent, were made in relation to dissatisfaction with the payment of claims for property damage. Fifteen (15) or 5 per cent of the complaints were against life insurance companies. (See Figure 4 and Table 4)

FIGURE 4:
Types of Complaints

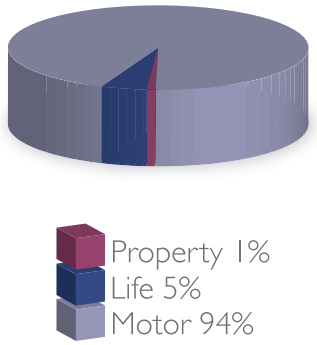


TABLE 4:
Types of Complaints Received and Handled

	2007		2006	
	No. of Complaints	% of Total	No. of Complaints	% of Total
Motor	284	94	387	95
Property	3	1	3	1
Life	15	5	17	4
Total	302	100	407	100

Distribution of Complaints Among Insurance Companies

Most of the complaints that were received and handled by the OFSO in 2007 were against five companies. These totaled two hundred and forty one (241) and represent 70 per cent of the complaints handled. (See Figure 5 and Table 5)

FIGURE 5:
Distribution of Complaints by Companies

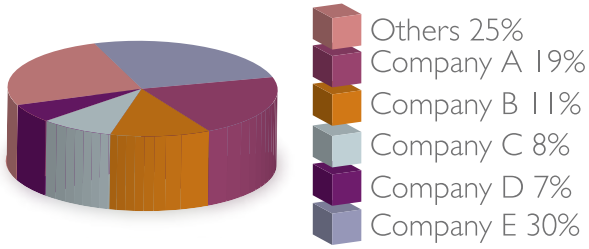


TABLE 5:
Complaints Received and Handled for 2007

COMPANY	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Sub-Total	FISD	Total	% Of Complaints Handled by OFSO
Company A	17	24	12	21	74	9	83	25
Company B	15	14	14	16	59	7	66	19
Company C	13	8	5	7	33	1	34	11
Company D	4	8	8	5	25	10	35	8
Company E	13	8	0	0	21	2	23	7
SUB TOTAL	**62**	**62**	**39**	**49**	**212**	**29**	**241**	**70**
Other Companies	20	20	23	27	90	10	100	30
2007 TOTAL	**82**	**82**	**62**	**76**	**302**	**39**	**341**	**100**
2006 TOTAL	**82**	**108**	**133**	**84**	**407**	**73**	**480**	

Categories of Complaints

The majority of the complaints handled by the OFSO were lodged as a result of the delays experienced by the public in the settlement of their claims by the insurance companies. A significant number of complainants were also dissatisfied with the amounts being offered for settlement. In a few instances, the subject matter of the complaints was the denial of liability by the insurers and their refusal to pay compensation. The proportion of complaints for each category for January – December 2007 was similar to the distribution for the same period in 2006 except for those for "undue delays". (See Figure 6 and Table 6)

FIGURE 6:
Categories of Complaints

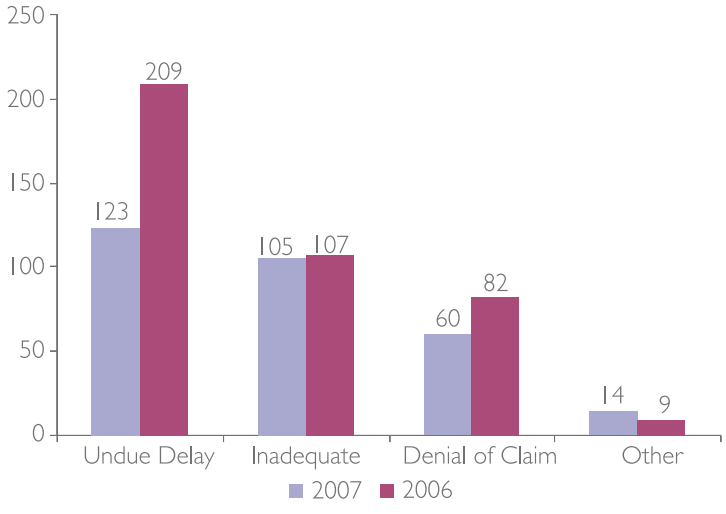


TABLE 6:
Categories of Complaints

Categories of Complaints	No. of Complaints		% of Total	
	2007	2006	2007	2006
Undue Delay	123	209	40	52
Inadequate	105	107	35	26
Denial of Claim	60	82	20	20
Other	14	9	5	2
Total	**302**	**407**	**100**	**100**

Resolution of Complaints

During the year 2007, three hundred and thirty five (335) complaints were resolved. Two hundred and fourteen (214) of these complaints were resolved by agreement between the complainants and the respective insurers. Twenty one (21) complaints were forwarded to the Judicial Managers of the two companies in receivership. Ninety two (92) complaints were withdrawn by the OFSO for various reasons. They were deemed to be without merit or the complainants failed to provide sufficient information or evidence to support their cases against the companies after they had denied liability for the payment of the claims. Six (6) complainants opted to withdraw their complaints and one (1) was referred to the court.

In May 2007, the Financial Services Ombudsman, after diligent consideration of all the information submitted by both parties, was constrained to make an award for the resolution of a complaint against one of the insurance companies. The terms of the award required that the company settle a long outstanding claim by the payment of compensation to the claimant. The insurer did comply with the award, albeit reluctantly. See Table 7 for details and a comparison with 2006.

Nevertheless, a greater percentage of the complaints have been resolved by agreement. Two hundred and fourteen (214) or 64 per cent were resolved by agreement versus one hundred and eighty eight (188) or 47 per cent in 2006. The increase may be attributed to a greater acceptance of the role of the OFSO by the insurance companies.

TABLE 7:
Resolution of Complaints

	2007		2006	
	No. of Complaints	% of Total	No. of Complaints	% of Total
By Agreement	214	64	188	47
Recommendation			1	1
Award	1	1		
OFSO Withdrawals	92	27	105	26
To Liquidator	21	6	96	24
Customer Withdrawal	6	1	6	1
Court Referral	1	1	1	1
Total	**335**	**100**	**397**	**100**

Time Taken to Resolve Complaints

Sixteen per cent (16%) of the complaints were resolved within 30 days compared to thirteen per cent (13%) in 2006 and this represents a marginal improvement. Those that were resolved in 60 and 90 days were about the same as last year but those within and over 120 days have not improved.

As much as thirty six percent (36%) of the complaints were closed after more than 120 days of receipt. It would appear that many insurers, particularly the "top" five companies with the highest number of complaints against them, have no great interest in having outstanding matters settled and continue to procrastinate on the settlement of claims. The timeliness of the responses by some companies to many letters of enquiry and other correspondence leaves a lot to be desired. In an effort to hasten the resolution process, the OFSO visited some of these companies from time to time but while there was some minimal improvement in one or two companies, the same cannot be said for all. (See Table 8.)

TABLE 8:
Time Taken to Resolve Complaints

	2007		2006	
Resolved within	No. of Complaints	% of Total	No. of Complaints	% of Total
30 days of receipt	55	16	51	13
60 days of receipt	67	20	78	20
90 days of receipt	67	20	78	20
120 days of receipt	27	8	44	11
More than 120 days of receipt	119	36	146	36
Total	**335**	**100**	**397**	**100**

Conclusion

We are of the view that the OFSO is making a difference to the lives of genuine complainants who come to our Office for assistance. We have been receiving tremendous support from the majority of the insurance companies who respond positively to our interventions but there is still some resistance by some companies.

BANKING CASE 1

Never disclose your PIN to anyone, not even to a bank official

Mr. G attempted to use his debit card at an ATM machine on a Saturday morning. There was no one else in the vestibule at the time. However, when he inserted his card into the ATM, it became stuck in the machine which then displayed a message reading 'out of service'.

While Mr. G was attempting to retrieve his card, a well-dressed young lady entered the vestibule and offered to assist him. She offered to place a call to the bank's customer service hotline using her mobile phone. Mr. G then spoke with the person on the line, whom he believed to be a representative of the bank. He was told that in order to have his card ejected from the machine he should press 'CLEAR', then 'ENTER', followed by his PIN three times.

Mr. G followed these instructions carefully with the "good Samaritan" looking on all the while. Needless to say, the card remained stuck in the machine and the person on the telephone advised him to contact his bank on Monday. He then returned home and related the events to a family member who advised him that it sounded suspicious and he should report the matter to the Police. Mr. G did so the following day. He also reported the matter to his bank on the following Monday when he discovered that practically all the funds in his account had been withdrawn.

The customer then lodged a complaint at his bank seeking reimbursement of the unauthorized funds. This request was denied by the bank on the basis that Mr. G had breached the terms and conditions of the agreement under which the card was issued as he admitted to disclosing his PIN, albeit unknowingly. Mr. G then sought the assistance of the Ombudsman Office seeking redress.

Investigations made on behalf of Mr. G revealed that the terms and conditions of the agreement between the Bank and the cardholder had indeed been breached. The customer had voluntarily disclosed his PIN to someone else, even though unknowingly. The Office agreed with the decision taken by the bank.

The Bank, through the use of promotional flyers in the vestibule of the ATM machine and in their bank halls, reinforces the proper use of the ATM cards with their customers and advises them that they should safeguard their PIN at all times. It also reminds their customers that if at any time during a transaction, they should feel uneasy due to the presence of other persons they should cancel the transaction and return at another time or choose another location where they feel safer.

Unfortunately, Mr. G had disclosed his PIN to a fraudster who appeared to be a "good Samaritan". In doing so, he breached the terms of the agreement thereby relieving the Bank of any liability with respect to his missing funds.

BANKING CASE 2

DO NOT keep your PIN where others can have access

While using the Bank's telephone banking system, Mrs. M discovered that $1,000.00 had been withdrawn from her savings account, without her knowledge or authorization. Since she always kept her ATM card secure at home and she was not aware that it had been stolen or missing, she reported the matter to her Bank the following day.

An investigation was conducted by the Bank and they produced records which show the date and location of the alleged "unauthorized" withdrawal, using Mrs. M's debit card and the associated Personal Identification Number (PIN). The Bank also provided video footage obtained from the branch where the transaction took place but Mrs. M could not readily identify the person shown to be withdrawing funds at that time.

Upon further questioning, Mrs. M disclosed that she kept her PIN written down together with her ATM card. This act constitutes a breach of the cardholder's agreement with the Bank. Mrs. M then brought her case to the OFSO. After making enquires on the complainant's behalf, the Ombudsman's Office concluded as follows:

- Funds cannot be withdrawn from the ATM without the use of the ATM card and the associated PIN.
- The fact that Mrs. M did not report the card as either lost or stolen suggests that the withdrawal was made by someone who had access to both the customer's card and the PIN (both being kept together).
- The Bank cannot be held liable for the reimbursement of Mrs. M's funds because she was in breach of the terms and conditions of the cardholder's agreement and her actions made it easy for anyone to gain access to her account and the funds therein.

The Office of the Financial Services Ombudsman therefore agreed with the Bank's decision not to reimburse the unauthorized funds to Mrs. M.

BANKING CASE 3

Beware of the spread between the buying and selling rates of foreign currencies

Ms. J lived abroad and planned to visit Trinidad on a regular basis to attend to family business and so she decided to open a bank account to have funds readily available to her. She intended to deposit both Canadian (CAN) and American (US) dollars by wire transfer from her home in North America. She was assured by the bank's representative that she could access funds from her account in Canadian dollars if she so desired. She need only fax her request and, after the indemnity usually required for faxes, the money would be deposited in her Canadian bank account. She then made a large deposit, in Canadian dollars, to her account.

Some time later, Ms. J tried to access the funds from her account, in CAN dollars. She discovered, much to her surprise, that when the first deposit was made to her account, it was converted to TT dollars at the bank's current buying rate. In order to have the money sent to her Canadian account, the bank would then convert the TT dollars back to CAN dollars but at the bank's selling rate. Given the fluctuations in the conversion rate from TT dollars to CAN dollars and the spread between the buying and selling rates, there would be an exchange rate loss each time Ms. J tried to reconvert her funds from TT dollars.

Ms. J then complained to the bank, claiming that the bank's representative never advised her that the money would be converted to TT dollars when a deposit was made. Further, she stated that had she been made aware of this she would have opened a US dollar account rather than a TT dollar account and she would have traded solely using US dollars. The complainant then approached the Office of the Financial Services Ombudsman to assist her in recovering the difference in the buying and selling rates of the initial deposit made in CAN dollars.

An investigation was conducted by the bank and they responded to this Office stating that they were satisfied that Ms. J had been provided with adequate information when the account was opened. At that time, had she indicated that she wished to access funds from the account, in CAN dollars, the bank's representative would have advised her to open a foreign currency account. Notwithstanding the above, the bank agreed to reimburse the complainant using a preferred rate such that Ms. J recovered most of the difference in rates of her initial deposit.

Had the customer disclosed her intentions regarding the use of the account, she would have received proper guidance from the bank's representative and she would have been better able to choose a product that suited her needs.

BANKING CASE 4

A bank customer must keep proper supporting documents and keep records on a correct basis; a bank is not expected to keep records indefinitely.

Mr. B approached his bank in late 2006 to notify them that he was missing his passbooks for an account that he had opened some twenty years earlier. To the best of his knowledge the last transaction occurred sometime between 1983 – 1985. However, he was advised by one of the bank's tellers that she could not find any record of an account in his name. At this point, Mr. B became quite distressed and immediately requested an interview with the manager or someone in authority. After several attempts, Mr. B was finally able to speak with the manager.

Unfortunately for Mr B, the manager confirmed the information that he had received earlier, i.e. the bank could not find any record of an account in Mr. B's name. He was advised that he would be required to provide some documentary evidence such as a bank statement or account number to confirm the existence of the account under query.

Further efforts by Mr. B to have his complaint resolved by the bank proved unsuccessful as he remained unable to provide any details that he was an accountholder with the bank. In frustration, Mr. B sought the assistance of the Office of the Financial Services Ombudsman.

After review of the case and the bank's response to his enquiries, the Ombudsman's office concurred with the bank's position. The consumer could not, at any time during the complaint, provide any evidence that the account existed except his assertions about the 'lost passbook'. The bank had, on more than one occasion, thoroughly checked their records but could not find the missing account in Mr. B's name, both among the accounts of the current account-holders or the dormant accounts that were sent to the Central Bank. They remained co-operative throughout the entire complaint process, both with the customer and the Ombudsman's Office to try and resolve the matter.

The Ombudsman found that the bank had tried their best to satisfy the customer and that they had met the statutory requirements for the retention of records. The Ombudsman's Office was left with no option but to withdraw the complaint and close their files. The case has no merit whatsoever since the customer could not support his claim.

BANKING CASE 5

Customers owe a duty to themselves to keep their records up-to-date

Mr. B visited his bank in early 2006 to find out the status of four accounts he held there and presented his passbooks. To the best of his knowledge the accounts had not been closed and according to the balances shown in the passbooks, each account still contained funds which he intended to withdraw.

Mr. B was surprised to discover that his accounts had been classified as dormant accounts, since there had been no activity in any of the accounts for more than two years. In fact, closer examination of the passbooks showed that the last transaction dated back to the 1990's in two cases and as far back as 1980 for another. He was further advised by the bank's representative that after the accounts became dormant, monthly service charges would continue to be deducted so the balances would have been reduced. If the balances in the accounts reached a nil balance, they would be closed. Very unhappy about the bank's explanation regarding his accounts, Mr. B sought the assistance of the Office of the Financial Services Ombudsman.

The bank responded quickly to the Ombudsman's request for information and confirmed that Mr. B was their customer and held several different types of accounts with them, all of which were still active. However, the accounts under query were opened at Bank A and only became part of the bank's portfolio when they bought over Bank A. At that time, all accounts with balances were transferred to the bank. Three of these accounts then became dormant. The bank would have notified Mr. B of this inactivity by sending a letter to his last address in their files. If there is no response by the customer, the account is advertised in the daily newspapers after which the funds are transferred to the Central Bank. However, the names of the accounts and the balances transferred, remain with the bank but there were no such accounts in his name.

Mr. B first visited his bank looking for information in 2006 but his accounts had been closed off during the period 1995 – 2002. Unfortunately, detailed records on his accounts were no longer available as Mr. B's queries dated back beyond the bank's stipulated policy for the retention of records.

It is in the customer's best interest to always maintain current up-to-date balances of their accounts held at banks. Had Mr. B updated his records on a continuous basis, his account would not have become dormant.

BANKING CASE 6

Banks must seek approval from account-holders before deducting funds

Mrs. H was a joint account holder with her husband and they had enjoyed a relationship of more than fifty years with her bank. Every month, Mr. H received a pension from the National Insurance Board (NIB). This was paid directly into their bank account on the 15th of the month for the following month. Mr. H died in the second half of the month after his pension payment was deposited to his account in the usual manner for the following month. Mrs. H notified the bank and the NIB of her husband's death. The NIB requested a refund of the pension that had been paid in advance. She promptly did so expecting that the matter was now settled. Unbeknownst to her, the NIB had also written to her bankers seeking a refund of the overpayment. In keeping with their normal practice, the bank debited Mrs. H's account for the amount requested without seeking her authority. Since there were insufficient funds, after the second sum was debited, her account was placed into overdraft and the usual penalty and other additional charges were applied. When Mrs. H became aware of the situation, that is, that her account was now in the red through no fault of her own, she brought it to the attention of the bank and the Ombudsman's Office at the same time. Our Office made enquiries of the bank on behalf of the complainant and concluded as follows:

- This type of situation occurred frequently when persons died and the monthly pension had already been deposited to their accounts.
- The bank followed a procedure set up with the NIB where by the overpayment was charged directly to the account upon request by the NIB without authority of the account-holder. In this instance however, both the widow and the bank were asked for the refund simultaneously and they both complied.
- Naturally, Mrs. H felt that she should have been notified by her bankers that they intended to remove funds from her account, before it was done.
- The bank had debited Mrs H's account even though the charge resulted in her account going into overdraft, and even though the account did not have any overdraft facilities.
- Once funds are credited into an account, the account holder is the only person to authorize any withdrawals. No such authorization was given by Mrs. H and therefore, the bank acted outside of their jurisdiction.
- The Ombudsman's Office found in favor of the Complainant. Mrs H was refunded the full amount withdrawn and all associated charges related to her overdrawn account.
- Furthermore; the bank agreed to amend their procedures so that account holders must give their approval before any funds are withdrawn from their accounts.

INSURANCE CASE 1

Incorrect accident coding

The complainant, Mr. M was involved in an accident with another vehicle. He filed a third party claim with the insurance company that insured the other vehicle, seeking repairs to his vehicle. However, his claim was denied by the insurance company based on the statement given to them by their insured and the report submitted by their investigator. This report stated that the accident had been caused by the complainant's own negligence and that the police had coded the accident against him. Not happy with this decision, the complainant visited the police station to obtain a copy of their report and was told that the accident coding had been changed and was now coded against the other driver. Mr. M then resubmitted this new report to the insurance company, hoping that they would now settle his claim. The claim was denied again, this time on the basis that the information given on the police report was inconsistent. Now quite frustrated, the complainant sought the assistance of the Office of the Financial Services Ombudsman to resolve the matter.

The Ombudsman's office reviewed the case and conducted its own enquiries which included having an independent investigator visit the police station to obtain an accident report. This showed that, when the report was first entered into the police records, the complainant was shown as the negligent party, hence the reason for the denial of the claim by the insurance company. However, when the police completed their investigations, the initial coding was changed.

After some negotiation, the insurance company agreed to settle the claim on a contributory negligence basis. The complainant was paid for 50% of his damages as the other driver maintained that he was not liable and had the initial police report to support him.

Lesson of the case:

Given the information provided to the police and the circumstances surrounding the accident, it was not absolutely clear which driver was liable in the accident. Hence, the reason for the two police reports with conflicting accident codes. The complainant did not accept the first decision given by the insurer and by obtaining independently an updated police report in support of his claim; he was able to recover part of his damages.

INSURANCE CASE 2

Greater duty of care must be exercised when entering lane of traffic

Mr. A was plying his maxi taxi for hire on the Priority Bus Route (PBR) when his vehicle was struck by a car that moved suddenly into his path from the shoulder of the road. He submitted a third party claim to the other driver's insurance company stating that their insured was liable and seeking repairs to his vehicle. However, his claim was denied by the company because their insured driver maintained that he was not liable for the accident. He stated that he was at a standstill when the complainant collided with him.

Mr. A did not accept this decision given by the company and submitted a police report asking that they reconsider. The company responded saying that they were maintaining their position despite the fact that the police had coded the accident against their insured. It was their policy to consider not only the police coding but the circumstances surrounding the accident and the statement given by their insured. Furthermore, it was their view that the complainant could have avoided the accident had he been more attentive to the traffic to his side and the road conditions ahead. Mr. A then sought the assistance of the Office of the Financial Services Ombudsman to help him resolve the matter.

The Ombudsman's office reviewed the case and wrote to the company on behalf of Mr. A indicating that the position taken by the company did not seem reasonable. By denying liability, they were essentially saying that the complainant should anticipate the actions of both the drivers travelling ahead of him and those who may be parked alongside him. The Ombudsman felt that, contrary to what the company had said, their insured was the one who attempted to join a line of moving traffic and as such, had a greater burden of care to ensure that it was safe to do so before pulling off. Mr. A was travelling in his proper lane, as he was expected to do, when he was struck on the front left corner of his vehicle.

After some negotiation, the company reversed their decision and agreed to settle Mr. A's claim for the full value of his adjusted repairs.

Lesson of the case:

The Highway Code is clear about circumstances such as these as it states that "you should change lanes only when you have given the appropriate signal and it is safe to perform this manoeuvre". The insurance company reversed their decision as their insured was the one who was moving from a parked position into the moving traffic and a greater duty of care lay with him to ensure that he could do safely.

INSURANCE CASE 3

Comprehensive cover cancelled after one accident

Ms. W, a new driver, purchased a vehicle and insured it under a comprehensive policy in November 2006. Unfortunately, two months later she was involved in an accident when her car tyre blew out causing her to collide with a bridge. She submitted a claim to her insurers seeking repairs to her vehicle. They responded saying that her claim would be treated on a Constructive Total Loss basis and the insurance policy would be cancelled. This means that, even though she would be compensated for her loss (market value at the time of the loss less deductibles), the cost of repairs is considered to be more than the settlement value and the car must be taken off the roads.

Ms. W protested, saying that her vehicle was repairable and that she was willing to accept the funds to repair her car and she wished to have her insurance policy run till the end of the cover period. The company refused to move from their position and insisted that the claim would be dealt with on a 'write-off' basis. Not happy with this decision, Ms. W lodged a complaint against the insurance company with the Office of the Financial Services Ombudsman.

The Ombudsman's Office reviewed her case and was able to advise Ms. W that the comprehensive policy under which she was insured entitled the company to deal with her claim on a Total Loss basis. The consequences of such a decision meant that they would have to report to the Licensing Authority that the car was a total write-off and then remove it from their books. In addition, the policy would be cancelled forthwith. However, they could only do so if the cost to repair the vehicle exceeded the current market value of the car, less any salvage. In this case, it did not.

The Ombudsman's Office wrote to the company advising them of the above and asked that they treat with the claim on a 'repairs basis' instead since they were not adhering to the terms and conditions of the policy. They responded, agreeing to the request by the Office to pay their insured to repair her car. However, they no longer wished to insure Ms. W. During their own investigations they discovered that the insurance premium that was charged to Ms W was inadequate to meet the risk she presented. Now that an accident had taken place so soon into the life of the policy they wished to discontinue the relationship with her. The complainant accepted the company's offer and had her vehicle insured elsewhere.

Lesson of the case:

Customers need to be aware of the terms and conditions of their insurance policy to avoid unnecessary problems at the time of a claim. An insurer is within their rights to cancel a policy if they believe that the risk presented is not adequately covered; however, they are required, by legislation to inform the insured, in writing of this decision. This is necessary as the insured must return the insurance certificate within seven days of receiving the cancellation notice.

INSURANCE CASE 4

Unauthorized driver

Mrs. J, a long standing customer with her insurance company had her vehicle damaged in an accident in February 2007. At the time of the accident, Mrs J was not feeling well so she asked her son, who was under 25 years of age and had recently received his driving permit, to go to collect her daughter from school. On his way to collect his sister, he had an accident, ran off the road and was injured. The car was considered a total loss.

Mrs J was insured under a comprehensive policy with her insurance company. She submitted a claim to recover her loss with her insurer. In keeping with normal claims handling practices, an investigation was conducted by her company, the findings of which led to the denial of her claim. She tried, unsuccessfully, to get her company to review her case and reverse their position. However, they remained steadfast. Mrs. J then sought the assistance of the Office of the Financial Services Ombudsman to resolve her matter.

The Ombudsman's office reviewed the complaint submitted by Mrs. J and on the face of it, there appeared not much that could be done to assist the complainant. However, the Office decided to try to mediate some type of settlement for her, most likely in the form of an ex-gratia payment.

The insurance company responded in a timely fashion to the Ombudsman's request for information regarding Mrs. J's complaint. In their response they detailed, quite clearly the reasons for the denial of the customer's claim and included documents to support their position. Upon review of the information submitted the Ombudsman was forced to concur with the position taken by the company and withdraw the complaint.

Mrs. J's policy, though comprehensive, did not cover for the use of the vehicle by drivers under the age of 25 or without the required two years driving experience. At the time of the accident, the vehicle was being driven by Mrs. J's son who did not meet the age requirement. Furthermore, Mrs. J stated on her Proposal Form that the vehicle would only be driven by persons who met the above criteria. So despite the fact that Mrs. J had given her son permission to drive the vehicle, on this occasion, he was not authorized to do so and therefore, was not covered by the policy at the time of the accident. The company chose to exercise their right to deny Mrs. J's claim as she had breached the terms of her policy.

Lesson of the case:

Despite the fact that the complainant acknowledged that she was in breach of the policy, she appealed the company's decision on the grounds that extenuating circumstances led to her giving her son permission to drive the vehicle. She further stated that this was an isolated event when unfortunately for her, tragedy struck. According to the policy contract, the company was within their rights to deny Mrs. J's claim as she was in breach of her contract. The fact that it may have been a one time occurrence is not applicable because the customer, by her own act, relieved the insurance company of any liability for her loss.

INSURANCE CASE 5

No compensation for a blown tyre

Mr. S, who was insured under a comprehensive policy, was on his way to work one day when his front right tyre blew out causing him to lose control of his vehicle. He collided with another car travelling in the opposite direction resulting in both parties being hospitalized due to their injuries.

When he was discharged from the hospital, Mr. S immediately made his way to the relevant police station and gave a statement on the accident to the officers there. Similarly, he made his way to his insurance company to report that he had been involved in an accident and to pay the applicable policy excess. He was advised by his company's representative to return with additional documents to have his claim processed and also, that he should inform the driver of the other vehicle to claim for damages as well.

Mr. S complied with the instructions given and was told by the company that his claim would be settled within two weeks and he would be contacted by someone from their Claims department. More than a month passed by without any word from his insurers, so Mr. S visited the company to query the status of his claim. He was then asked to submit additional information to support his claim, namely a claims history and any applicable discounts from his previous insurer. Again, Mr. S did as requested and waited on his insurers to settle his claim.

The complainant was then quite surprised to be told by the company that his claim was denied on the basis that at the time of the accident, the car was being driven with 'defective tyres'. Mr. S queried this decision by the company and even submitted the report of the officer from the Licensing Department who verified that he had inspected the car after the accident and found the tyres to be in 'good condition'. The officer went on to say that the blown tyre was as a result of cut or crack on the inner wall where the complainant could not have seen it. Furthermore, this could have been developed during the normal operation of the vehicle such as driving into a hole in the road or over a sharp stone or piece of glass. However, the company remained firm in their decision that the tyres were defective and directed their insured to seek recovery from either the manufacturer or distributor of the tyre. Unable to resolve the matter, Mr. S turned to the Office of the Financial Services Ombudsman for help.

After reviewing the complainant's case, the Ombudsman's Office wrote to the insurance company to try and negotiate a settlement on Mr. S's behalf. In the letter, the Ombudsman's Office stated that the reason given for the denial of liability, that is, a defective tyre, was quite harsh, given the report prepared by the Transport official on the condition of the car immediately after the accident. Further, it seemed to the Ombudsman's Office to be 'beyond the bounds of expectation' that their insured could have known that the tyre was damaged due to the location of the crack nor was it reasonable to pinpoint this defect as being caused by negligence on the part of the manufacturer. In the end, after some negotiation the company finally agreed to settle Mr. S's claim for approximately half of what he was seeking.

Lesson of the case:

An insured person is expected to maintain his or her vehicle in such a manner as to allow for its safe operation on the roads and to satisfy the risk underwritten by the insurer. This includes ensuring that the tyres are in good condition and fit for driving because an insurer will not pay for damages arising out of any accident caused by a car driven on 'smooth' tyres. However, this was not the case with Mr. S. His car was well maintained and through no fault of his own or any other party he suffered a loss. He was therefore, able to be compensated by his insurer.

INSURANCE CASE 6

Policy voided because of false declaration made by proposer

Mr. H took out a policy of insurance on his life and named his wife, Mrs. H as the beneficiary. Three years later, while overseas, he died and Mrs. H filed a death benefit claim with his insurance company in October 2006. In keeping with normal claims handling practices, the insurer launched an investigation and told the widow that she would be notified of their decision pending the outcome of the inquiries. More than eight months went by and Mrs. H was unable to get any definitive answer from the company regarding the status of her claim this despite repeated calls and visits to their offices. Frustrated at the delay in her claim settlement, Mrs. H lodged a complaint against the insurer with the Office of the Financial Services Ombudsman.

After reviewing Mrs. H's complaint, the Ombudsman's Office wrote to the company enquiring as to the reason for the delay in settling the claim. The company responded saying that their investigations had revealed that the insured, Mr. H, had made a false declaration on his Proposal Form and they would be denying his claim.

To support this position, they submitted to the Ombudsman's Office, copies of the said Proposal Form and other relevant documents.

In the circumstances, under the terms and conditions of the policy contract between Mr. H and the company, they were entitled to void the policy since the insured had made a false statement. No benefits were payable under the policy. Mrs. H would only receive a refund of the premiums paid without interest.

Mrs H contended that the contestability period of two years had passed so the insurance company was not entitled to cancel the policy. However, since Mr H had diabetes at the time of completing the proposal form and did not disclose this fact, the contestability period clause did not apply. He made a false statement by not disclosing a pre-existing condition. The insurance company is therefore entitled to void the contract.

Having examined both sides of the case carefully, the Ombudsman's Office upheld the decision given by the company and notified the complainant accordingly.

Lesson of the case:

When applying for insurance, the burden of truth is upon the applicant (or proposer). Prospective insured persons are required to disclose all material facts that may affect an underwriter's decision and must be honest and truthful in answering the questions listed on the proposal form. This insurance principle is called 'utmost good faith' and a greater burden to 'tell all that he knows' rests with the proposer. Failure to do so can cause the policy to be voided at the time of a claim, should the insurer discover otherwise..

INSURANCE CASE 7

Accidental death not covered if in breach of conditions of contract.

Mr. R took out a policy of insurance on his life and named his wife, Mrs. R as the beneficiary. Unfortunately, he was later killed in a vehicular accident and Mrs. R filed a death claim with his insurers seeking payment of both the basic sum insured and an additional amount under the Accidental Death and Dismemberment (AD&D) rider on the policy. The insurance company launched an investigation into the claim. Even though Mrs. R received a cheque for the amount payable under the life benefit of the policy, the accidental death benefit remained outstanding.

Almost one year went by from the time that Mrs. R filed her claim but she was still unable to receive payment under the accidental death benefit of the policy. She frequently visited and called the company trying to expedite her settlement but to no avail. Quite upset, Mrs. R lodged a complaint against the insurer with the Office of the Financial Services Ombudsman, claiming undue delay.

The Ombudsman's Office reviewed the case submitted by the complainant and wrote to the insurance company asking for the reason for the delay in settlement. The company responded, confirming that a partial settlement had been made to Mrs. R but given the nature of the AD&D benefit, further investigations were required as part of their due diligence process.

As it turned out, the results of the autopsy on Mr. R indicated that at the time of the accident, his blood alcohol levels had exceeded the minimum established values of intoxication. In other words, he was drunk at the time of the accident and therefore, not fit to operate a vehicle. The insurance policy excluded payment of the AD&D benefit if it was determined that the insured was under the influence of alcohol or the use of drugs or narcotics other than prescribed by a licensed physician. Unfortunately for Mrs. R, her claim was denied.

Having examined the company's position, the Ombudsman's Office upheld the decision given by the company and explained same to the complainant, advising her that the company was within their rights to avoid payment under the policy.

Lesson of the case:

Although Mr. H's life was insured in the event that he died by accident, the policy contained an exclusion clause to rule out payment if such accident occurred due to the actions of the insured as noted above. An insurance policy is essentially a tool to transfer the risk of a potential loss, from one entity (proposer) to another (insurer), in exchange for a reasonable fee (premium). It takes the form of a legal contract between the parties and is subject to conditions which must be met. By driving under the influence of alcohol, the insured has contravened one of the conditions stated in the contract and increased the level of risk faced by the insurer. By his own actions, the insured relieved the insurance company of any liability for any loss incurred under those circumstances.

ESTABLISHMENT AND OBJECTIVES OF THE OFFICE

The Office of the Financial Services Ombudsman (OFSO) opened its doors to receive complaints from customers of the banking industry in May 2003 and of the insurance industry in May 2005.

The Office was established by an agreement between the Central Bank of Trinidad and Tobago and the banking and insurance companies. The names of the institutions are printed to the back of the report.

The objectives, processes and procedures for resolution of complaints for the commercial banks are the same as for the insurance companies. A summary of the terms of agreement follow:

The main objectives of the OFSO are:

(a) to receive complaints arising from the provision of financial services to individuals and small businesses*; and
(b) to facilitate the settlement of these complaints.

* A small business is defined as any business with assets valued up to TT$1,500,000.00 (excluding the value of land and buildings) at the time the subject of the complaint originated.

The aim is to provide independent and prompt resolution of complaints using the criteria of best practice in the financial services sector and fairness in all circumstances.

The Office provides a legitimate and independent channel through which complainants (individuals and small businesses) not satisfied with the treatment received from any of the participating financial institutions concerning any financial service or product, may file a complaint with the Office and seek redress.

A complainant must first seek resolution at the financial institution where the problem arose. If the matter is not resolved satisfactorily at that level, the complainant can then lodge a complaint with the Ombudsman.

THE COMPLAINTS PROCESS AT THE OFSO

Complaints should be submitted to the OFSO in writing and on the prescribed complaint form. The documents should summarise the nature of the complaint. Copies of all correspondence as well as copies of all relevant documents and notes of conversations should be included with the complaint form to allow our officers to assess and determine the case.

The complaint form explains the process and authorises the financial institution to exchange information with the OFSO. If the complainant is disabled or requires the assistance of a representative – a family member, friend, broker or even an attorney-at-law – both the complainant and the representative will be required to co-sign the form as an indication that approval is given for confidential matters to be discussed with the representative.

The OFSO stipulates that all documentation and any material related to the dispute resolution process must not be used in any subsequent legal or regulatory proceedings. In addition, the parties concerned must agree that the Ombudsman and staff of the OFSO and its advisors will not be called upon to testify in any legal proceedings.

Conclusions by the OFSO are based on the following criteria:

- overall fairness and equity
- best practice in the industry
- the accepted industry standards and practice
- standards established by industry regulatory bodies, professional associations or the individual financial institution where the customer does business, and
- due regard to the law.

The process is not binding on the complainant who may exercise the option of taking the case to the courts at any time during the process. The OFSO will consider the matter closed at that stage.

COMPLAINTS OUTSIDE OF THE JURISDICTION OF THE OMBUDSMAN

Certain complaints are not investigated since they are specifically excluded under the terms of reference. These include competitive issues which are better left to the dictates of market forces.

The areas outside of the jurisdiction of the OFSO are:

(i) Those specifically excluded:

- Premium rates and/or underwriting decisions
- Actuarial tables, surrender values, paid-up values, bonuses or investment rates as they apply to life and long-term insurance policies
- Pensions under Group Pension Plans and Deposit Administration Schemes
- Alleged false or misleading marketing practices
- Unacceptable service except where it relates to service of a monetary nature
- Third party personal injury claims arising out of a motor accident
- Matters barred by law
- **A claim where the amount is more than TT$500,000 in respect of first** party matters and TT$25,000 in respect of third party property damage under a motor policy

(ii) Matters that are currently or have been before the courts or an arbitration body or other dispute resolution process.

(iii) Matters that have occurred before January 1, 2003, in the case of a banking complaint and before January 1, 2004 in the case of an insurance complaint, except where the complainant only became aware, and cannot be expected to become aware, of the matter after those dates respectively.

Complainants retain their legal rights and are free to pursue the matter in court if they are not satisfied with the decision of the OFSO. However, if a complainant decides to go to the court or an arbitration body first, the option of bringing the matter to the OFSO is not available since both of these processes are final and binding.

SETTLEMENT OPTIONS AVAILABLE TO THE OMBUDSMAN

The options available for resolving financial complaints at the OFSO are as follows:

1. **Settlement by agreement**
2. **Recommendation by the Ombudsman and**
3. **Award by the Ombudsman**

1. Settlement by agreement

This involves mediation between the financial institution and the complainant to arrive at an agreed position. The majority of the complaints are resolved in this manner.

2. Recommendation by the Ombudsman

If no agreement is reached between the financial institution and the complainant, either party may request the Ombudsman to make a recommendation for settlement or withdrawal of the complaint. Once the recommendation of the Ombudsman is accepted by the complainant and the financial institution in full and final settlement, the matter is resolved at this stage.

If any one of the parties, the complainant or the financial institution, does not accept the recommendation made by the Ombudsman, the matter may be taken to the final stage.

3. Award by the Ombudsman

If the complaint is not settled by agreement or recommendation, the Ombudsman may make an Award. The Award is limited to $500,000 and must not be greater than the amount required to compensate the complainant for direct loss or damage suffered by reason of acts or omissions of the institution.

If accepted by the complainant, the Award is binding on the financial institution. If not accepted by the financial institution, the Ombudsman is obligated to report the noncompliance to the Governor of the Central Bank. Although the Ombudsman has the power to make recommendations and awards, the preferred route is that of reaching agreement via mediation to find a solution acceptable to all parties and this has been the case thus far.

KUDOS RECEIVED FOR THE YEAR 2007

- Just a note to say thank you so much

- I wish to express my profound gratitude for the timely and efficient manner in which your office dealt with my matter. Without your input and intervention, I would still have been awaiting a response from the above mentioned insurance company with regards to my claim.

- I take this opportunity to thank you and your staff sincerely for your hard work and sympathy. If not for your efficient service, I know I would still be 'battling' with this insurance company. I hope that some action would be taken against them if they do not improve.

  From the time I called your office, I received all relevant information from a very efficient young lady and she immediately sent the necessary documents to me for completion. I apologize for not remembering her name.

  Almost a week after your intervention my claim was settled.

  It was a pleasure to deal with you and once again I say thank you.

- Thanks for your services rendered. I'm grateful that there are offices like yours to provide information and protection to us consumers.

- With reference to your correspondence on the above caption, I wish to state my appreciation and the support given by your office.

  Please be advised that I have reached an amicable settlement with the insurance company concerned.

STAFF OF THE OFFICE OF THE FINANCIAL SERVICES OMBUDSMAN

From left to right: Selwyn Trim (Senior Resolution Officer), Karen Thompson-Morris, Susan Morris, Nicola Robinson, Judy Y Chang (Financial Services Ombudsman), Natalie Abraham-Syriac, Cbar Thompson and Andrew Kowlesar (Outgoing Resolution Officer). Susan Morris and Cbar Thompson are Administrative Assistants.

THE NEW INCOMING OMBUDSMAN

Ann Marie Narine, Incoming Financial Services Ombudsman with Judy Y Chang, Outgoing Ombudsman

LIST OF PARTICIPATORS

COMMERCIAL BANKS

- Bank of Baroda (Trinidad and Tobago) Ltd.
- Citibank (Trinidad and Tobago) Ltd.
- First Caribbean International Bank (Trinidad and Tobago) Ltd.
- First Citizens Bank Ltd.
- Intercommercial Bank Ltd.
- RBTT Bank Ltd.
- Republic Bank Ltd.
- Scotiabank Trinidad and Tobago Ltd.

INSURANCE COMPANIES

- American Life and General Insurance Company (Trinidad and Tobago) Ltd.
- Bancassurance Caribbean Ltd.
- Bankers Insurance Company of Trinidad and Tobago Ltd.
- British American Insurance Company (Trinidad) Ltd.
- Capital Insurance Ltd.
- Colonial Fire and General Insurance Company Ltd.
- Colonial Life Insurance Company (Trinidad) Ltd.
- Cuna Caribbean Insurance Society Ltd.
- Furness Anchorage General Insurance Ltd.
- Guardian General Insurance Ltd.
- Guardian Life of the Caribbean Ltd.
- Gulf Insurance Ltd.
- GTM Insurance Company Ltd.
- Maritime General Insurance Company Ltd.
- Maritime Life Caribbean Ltd.
- Mega Insurance Company Ltd.
- Motor and General Insurance Ltd.
- Motor One Insurance Company Ltd.
- Sagicor General Inc.
- Sagicor Life Inc.
- ScotiaLife Trinidad and Tobago Ltd.
- Tatil Life Assurance Ltd.
- The Beacon Insurance Company Ltd.
- The Demerara Life Assurance Company of Trinidad and Tobago Ltd.
- The Great Northern Insurance Company Ltd.
- The New India Assurance Company Ltd.
- The Presidential Insurance Company Ltd.
- The Reinsurance Company of Trinidad and Tobago Ltd.
- Trinidad and Tobago Insurance Ltd.
- United Insurance Company Ltd.

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