FSO

Office of the
Financial Services Ombudsman

Annual Report 2005

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

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"JUST WANTED YOU TO KNOW THAT THE GOOD WORK THAT WAS DONE ON MY BEHALF, HAS NOT GONE UNNOTICED. MUCH THANKS."

FOREWORD

BY THE GOVERNOR OF THE CENTRAL BANK

On May 2, 2005, the Office of the Banking Services Ombudsman became the Office of the Financial Services Ombudsman when it assumed responsibility for handling complaints related to the insurance industry. This evolution was a natural consequence of the extension of the Central Bank's regulatory authority to encompass the insurance industry and private pension funds, with effect from May 2004.

The addition of the insurance industry to the remit of the Ombudsman's office was a major challenge, firstly because it immediately added twenty-eight (28) insurance companies to the six (6) banks that the Office was required to serve; and secondly, because it came at a time when the industry was struggling to re-establish its reputation for efficient customer service and good governance.

To meet the expanded mandate the Ombudsman's office had to make several adaptations. It had to expand its staff complement; it had to acquire new competencies in part through intensive training and it had to modify its systems to accommodate the new clients. Most importantly, it had to establish its credibility with the insurance industry which did not have a long history of relations with the Central Bank.

Despite the several challenges, I am pleased to report that the transition from Banking to Financial Services Ombudsman has been a seamless one. The Office has been able to develop considerable credibility with the insurance industry even while it continued to consolidate its working relationship with the banking system. With the aid of some technical experts on contract, the Office has been able to handle a sizable number of

insurance complaints promptly and, for the most part, to the satisfaction of all the parties concerned.

The sharp reduction in the number of banking complaints could be traced, in part on the impact that the Ombudsman's office has had on the quality of service offered by the banks, including the upgrading of their own complaints resolution mechanisms. It is hoped, that over time the Ombudsman's office would have insurance companies bringing much needed respect and credibility to the industry.

I take this opportunity to thank the banks, the insurance companies and the entire public for facilitating the work of the Office of the Financial Services Ombudsman.

I also sincerely congratulate the Ombudsman, Mrs. Judy Chang and her staff for their commitment and dedication.

Ewart S. Williams
Governor of the Central Bank

BANKING CASE STUDY 1

ATM CARD TRANSACTION

THE CUSTOMER ATTEMPTED TO WITHDRAW CASH ON A FRIDAY EVENING FROM AN ATM MACHINE PROVIDED BY A BRANCH OF A BANK OTHER THAN HIS OWN, VIA A LINX CONNECTION. HIS ATM CARD BECAME STUCK IN THE MACHINE. THE CUSTOMER ATTEMPTED TO RETRIEVE HIS CARD, BUT WAS UNSUCCESSFUL AND LEFT.

The customer further alleged that the following Monday, he returned to the same branch of the bank where the ATM machine was located, to report the matter. He was advised to visit his home bank to collect his card. At his home branch, he discovered that a multiplicity of transactions, some ATM cash withdrawals and some point-of-sale debit transactions, totaling over $10,000.00, was charged to his account without his authorization. The bank launched an investigation into the matter but the customer remained unsatisfied. He approached the Office of the Financial Services Ombudsman (OFSO) for assistance. The bank's lengthy investigation proved inconclusive because of the unavailability of the video surveillance footage.

After some discussions, the bank decided to refund the missing funds to the customer, having regard to the fact that he was a long-standing customer and because the incident closely resembled the 'Lebanese Loop' ATM fraud typology which was quite prevalent at the time and the customer had followed the proper reporting procedures under The Electronic Transfer of Funds Crime Act, 2000, which provides protection to customers.

Lesson of the Case: The Electronic Transfer of Funds Crime Act, 2000 provides that a card-holder does not suffer any loss in the use of his ATM card if he does not act in collusion with another party, does not reveal his PIN to anyone and reports the loss of his card within 48 hours followed by a written confirmation within 14 days, if original reporting was done orally. ■

"I GREATLY APPRECIATED THE CONSIDERATION AND ASSISTANCE IN REVIEWING THE MATTER. THANK YOU FOR YOUR KIND ATTENTION."

PREFACE

BY THE FINANCIAL SERVICES OMBUDSMAN

I am happy to report as the Financial Services Ombudsman in our third year of operations. In May 2005, our Office assumed the added responsibility of handling complaints against insurance companies from individuals and small businesses. Twenty eight (28) of the thirty-two (32) insurance companies joined the Scheme initially. However, as of the date of the report, the other four (4) companies have joined so that all insurance companies and commercial banks operating in Trinidad and Tobago are now participators of the Financial Services Ombudsman Scheme.

Our Office has expanded both in terms of physical facilities and personnel. Two additional resolution officers joined our team.

The insurance scheme is unique. Unlike other jurisdictions, third party motor vehicle property damage claims up to a limit of $25,000 are handled under the Scheme. They account for almost 90% of the claims processed by the Office.

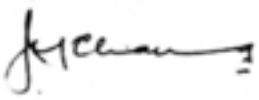
Unlike the commercial banks, the practices at the insurance companies are not uniform and vary from one company to another. The companies would do well to harmonize their practices and agree on a code of procedures and practices that are common to all.

During the latter half of the year we began publishing in the daily newspapers a series of educational material on banking, drawn from the experiences of complaints processed. The publications were well received. Similar material is being put together for insurance, for publication in the current year. The material will be published in a booklet form for distribution.

As Ombudsman, I am grateful for the tremendous support received from the banks and insurance companies alike in our quest to resolve the complaints received from the general public against the financial institutions.

I appreciate the support provided by the Governor of the Central Bank and other staff members of the Bank who provided administrative services to our Office when called upon to do so. I acknowledge the efforts of my staff who worked diligently to handle complaints in a timely manner.

I enjoyed being of service to members of the general public as they interact with the banks and insurance companies and I look forward to continuing that service as our Office strives to make a difference to the Financial Services landscape of Trinidad and Tobago.



Judy Y Chang
Financial Services Ombudsman

BANKING CASE STUDY 2

CREDIT CARD TRANSACTION

THE CUSTOMER CLAIMED THAT HE WITHDREW CASH FROM HIS ACCOUNT, USING AN ATM MACHINE, AND DEPOSITED THAT CASH, AT THE SAME ATM MACHINE, WITH A DEPOSIT SLIP GIVING INSTRUCTIONS THAT THE MONEY BE PAID TOWARDS HIS CREDIT CARD BALANCE. THE CUSTOMER DISCOVERED, SIX MONTHS LATER, THAT THE FUNDS WHICH WERE MEANT TO BE DEPOSITED TOWARDS HIS CREDIT CARD ACCOUNT, WERE CREDITED TO HIS SAVINGS ACCOUNT INSTEAD.

The customer admitted that he did not regularly check his credit card statements. Upon further investigation, it was evident to the OFSO that the customer did not fully understand the operation of an ATM when making credit card payments, nor does he understand the implications of the interest element of a credit card account. As a result, the customer had incurred accumulated interest, finance charges and late payment fees on his credit card account and requested that the bank waive these charges.

Even though the customer was tardy in reconciling his indebtedness, the OFSO felt that the customer genuinely did not fully understand the process in place for the use of the ATM for paying his credit card account and the implications of ensuing interest charges, the OFSO made an appeal to the bank on behalf of the customer to waive the accrued interest and finance charges. The bank agreed, in the interest of good customer relations, to write off all the accumulated interest and finance charges on the credit card account.

Lesson of the case: all bank transactions should be checked regularly and upon the receipt of the statements sent by the banks. Any discrepancies should be followed up right away. Credit card finance charges are exorbitant and should be avoided where possible. ■

INTRODUCTION

PARTICIPATING COMMERCIAL BANKS

Citibank (Trinidad and Tobago) Limited
First Citizens Bank Limited
Intercommercial Bank Limited
RBTT Bank Limited
Republic Bank Limited
Scotiabank Trinidad and Tobago Limited

On May 2, 2005, history was created when the Office of the Banking Services Ombudsman was expanded to include the handling of complaints from insurance companies. The name of the Office was changed from the Office of the Banking Services Ombudsman to the Office of the Financial Services Ombudsman (OFSO) in recognition of the expanded service.

Two additional resolution officers were assigned from the staff of the Central Bank to service the extra workload. Notwithstanding the additional volume of complaints, the transition was relatively smooth.

Initially twenty eight (28) of the thirty two (32) insurance companies joined the Scheme but subsequently the other four (4) companies have joined so that all the commercial banks and insurance companies in Trinidad and Tobago are participators of the Scheme.

The operations of the OFSO are conducted in accordance with the Terms of Reference of the Financial Services Ombudsman Scheme under an agreement signed by all the participators. They outline the powers and duties and the jurisdiction of the Office and are basically the same for both the banks and insurance companies. Any individual or small business, as defined, who has a grievance against a commercial bank or an insurance company about financial services provided, can lodge a complaint with the Office.

Complaints which fall outside of the remit of our Office are forwarded to the Regulation Unit of the Financial Institutions Supervision Department of the Central Bank so that appropriate action may be taken up with the respective financial institutions.

The expansion of the Office to include the insurance services was launched at a media function to which all the insurance companies and brokers were invited. The Ombudsman and her team visited several insurance companies to make presentations to senior members of their staff to explain how the system works, what we expect of them and what they could expect from us and to answer any questions that they have. The invitation remains open to all companies to repeat the session or do refreshers.

"WHEN I FIRST DECIDED TO SEEK YOUR HELP, I WAS TOLD THAT YOUR OFFICE HAS AS MUCH CLOUT AS A TOOTHLESS BULLDOG, AND THAT A CERTAIN NEWSPAPER WOULD DO ME JUSTICE. I CAN SAY THAT YOU 'MUST BEWARE OF THE DOG AT ALL TIMES' FOR THE CLAWS CAN DO EQUAL AND WORSE DAMAGE."

THE ERIC WILLIAMS FINANCIAL COMPLEX WITH THE NATIONAL MUSEUM IN THE FOREGROUND AND NICHOLAS TOWER TO ITS LEFT.

In addition, the Ombudsman appeared on television and radio talk shows and was interviewed by the newspapers.

Together with a resolution officer, the Ombudsman visited those insurance companies with complaints outstanding for an extended period of time, to discuss and bring early closure to complaints. The visits provided an opportunity for the insurance companies to appreciate the procedures we follow and the timeliness that should be applied to all complaints.

In order to encourage the insurance companies to deal with complaints in a timely manner, if a complaint is resolved within ten working days from the receipt, no fee will be charged. Otherwise, a fee of 10% of the settled sum will be charged, with a minimum of $500 and a maximum of $20,000. This has worked well with some insurance companies and encouraged quick responses. However, for others, especially where liability was not established, it has not worked in a positive manner. This will be reviewed after the first year of operation.

The number of cases settled was skewed somewhat by those companies who were not very prompt with their settlements for whatever reason.

The operations for the banking and insurance functions are shown separately in the report below. The report for the banking industry covers the third year of its operations while the report for the insurance industry spans only eight months to December 31, 2005. Since this is the inaugural report for that industry, it is presented in greater detail than for banking. ■

PARTICIPATING INSURANCE COMPANIES

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

BANKING OPERATIONS

STATISTICAL OVERVIEW OF BANKING COMPLAINTS
(ANALYSED BY TYPE OF COMPLAINTS)

FOR THE YEAR 2005 AS COMPARED TO 2004

	TOTAL		QUALIFYING		NON-QUALIFYING	
	2005	2004	2005	2004	2005	2004
ACCOUNTS AND TRANSACTIONS	32	46	13	9	19	37
CARD SERVICES	18	25	16	5	2	20
FEES AND CHARGES	4	12	1	1	3	11
LOANS AND CREDIT	3	41	1	1	2	40
PRIVACY AND CONFIDENTIALITY	0	0	0	0	0	0
SERVICE AND ADVICE	9	16	5	3	4	13
MUTUAL FUNDS	0	1	0	0	0	1
GENERAL INTEREST RATE LEVEL	1	1	0	0	1	1
CREDIT POLICIES AND DECISIONS	3	3	0	0	3	3
OTHER	3	11	0	1	3	10
TOTAL	73	156	36	20	37	136

	PERCENT					
ACCOUNTS AND TRANSACTIONS	44	29	36	45	52	27
CARD SERVICES	25	16	44	25	5	15
FEES AND CHARGES	5	8	3	5	8	8
LOANS AND CREDIT	4	26	3	5	5	29
PRIVACY AND C ONFIDENTIALITY	0	0	0	0	0	0
SERVICE AND ADVICE	13	10	14	15	11	10
MUTUAL FUNDS	0	1	0	0	0	1
GENERAL INTEREST RATE LEVEL	1	1	0	0	3	1
CREDIT POLICIES AND DECISIONS	4	2	0	0	8	2
OTHER	4	7	0	5	8	7
TOTAL	100	100	100	100	100	100

During the year ended December 31, 2005, 73 complaints were received versus 156 complaints for the year 2004, representing only 48% of the number of complaints received last year.

Of those received in 2005, 36 met all the conditions under the terms of reference while 37 fell outside of the terms of reference of the agreement under which the operations of the Office are governed. This compares to 20 and 136 respectively for 2004, the second year of operations for this Office.

Of great significance is the drop in the number of non-qualifying complaints, from 136 in 2004 to 37 in 2005. This may be attributed to the maturity of

"SINCE MAY OF THIS YEAR AFTER FUTILE EFFORTS AT GETTING THE COMPANY TO HONOUR ITS AGREEMENT, I REALIZED I HAD NO RECOURSE BUT TO PUT THEM BEFORE YOU."

the process and the structures put in place by the banks to handle the complaints that they receive as they all seek to achieve greater and greater customer satisfaction. This is borne out by the fact that during 2004 the OFSO received 55 complaints that customers have not taken to their banks as the first port of call, as against 4 during 2005. We also received in 2004, 17 complaints relating to matters that have occurred prior to January 1, 2003, the cut-off date set under the Scheme, versus 10 during 2005.

Table 1 shows the number of non-qualifying complaints received during 2004 and 2005 and the reasons for the non-qualification.

It is to be noted that even when complaints do not qualify strictly under the terms of reference, the Office still accepts and processes them. The complaints are forwarded to the banks for consideration, and all the banks treat with them as if they qualify under the Scheme.

Table 2 shows the number of complaints brought forward at the beginning of 2004 and 2005, the number received during those years, the number closed and the number carried forward.

TABLE 1: ANALYSIS OF NON-QUALIFYING COMPLAINTS

	2005	%	2004	%
MATTER AROSE PRIOR TO CUT-OFF DATE OF JANUARY 1, 2003	10	27	17	12
GENERAL LEVEL OF INTEREST RATES	0	0	0	0
CREDIT POLICIES AND CREDIT DECISIONS	4	11	14	10
OTHER OPERATING AND FINANCIAL POLICIES	4	11	16	12
FEES AND PRICING OF PRODUCTS AND SERVICES	0	0	8	6
MATTER ALREADY REFERRED TO OTHER DISPUTE RESOLUTION BODY	0	0	5	4
NON-BANK COMPLAINT	1	3	4	3
COMPLAINT DETERMINED TO BE FRIVOLOUS	3	7	1	1
NO OFFICIAL COMPLAINT MADE TO DATE	4	11	55	40
MORE THAN 180 DAYS ELAPSED SINCE BANK'S HANDLING	1	3	0	0
OTHER	10	27	16	12
TOTAL	37	100	136	100

TABLE 2: STATISTICS OF QUALIFYING AND NON-QUALIFYING COMPLAINTS

	QUALIF. 2005	NON-QUALIF. 2005	TOTAL 2005	QUALIF. 2004	NON-QUALIF. 2004	TOTAL 2004
BROUGHT FORWARD	3	16	19	8	5	13
RECEIVED DURING THE YEAR	36	37	73	20	136	156
CLOSED DURING THE YEAR	28	48	76	25	125	150
CARRIED FORWARD	11	5	16	3	16	19

Of the 25 qualifying complaints closed during 2004, 13 were considered to have been properly treated by the banks; the Ombudsman rejected 12 while the complainant himself withdrew the other complaint. During 2005, 28 qualifying complaints were closed, of which 19 were considered to have received proper treatment by the banks; the Ombudsman rejected 2 and the customer withdrew the other 7 complaints.

BANKING OPERATIONS

THE LIGHTHOUSE OF PORT OF SPAIN WITH THE ERIC WILLIAMS FINANCIAL COMPLEX IN THE BACKGROUND.

DISRIBUTION OF COMPLAINTS

No complaints were received during the year from the two smaller commercial banks. The complaints received were distributed among the other four (4) larger banks in ratio, more or less, to their respective sizes.

As shown on the table, the totals of all types of complaints decreased in 2005 over 2004. In both years, Accounts and Transactions dominate the type of complaints, followed by Card Services and Service and Advice.

Even though the total card services complaints decreased over 2004 (25 in 2004 versus 18 in 2005), there was a drastic increase in the number of qualifying complaints in 2005 in card services (5 in 2004 versus 16 in 2005) compensated by just as drastic a decrease in the number of non-qualifying cases in 2005 (20 in 2004 versus 2 in 2005).

EDUCATION PROGRAMME

In order to ensure that the general public is aware of the existence of the services provided by the Office, the Ombudsman made appearances on TV and radio programmes and started the series of advertisements entitled "Dollars & $ense" in the daily newspapers. The series has been received well. It is intended that the series will be published in booklet form for distribution to the general public and for publication on the website. A similar exercise will be done for the insurance services.

FIGURE 1: TOTAL COMPLAINTS FOR THE YEAR 2005 AS COMPARED TO 2004

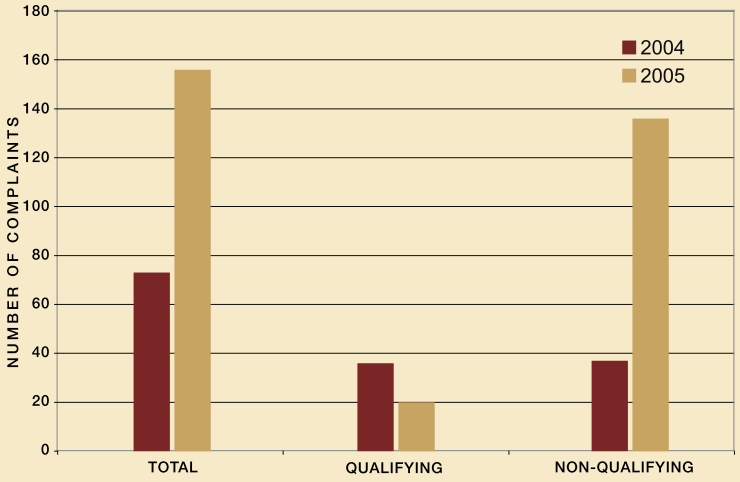
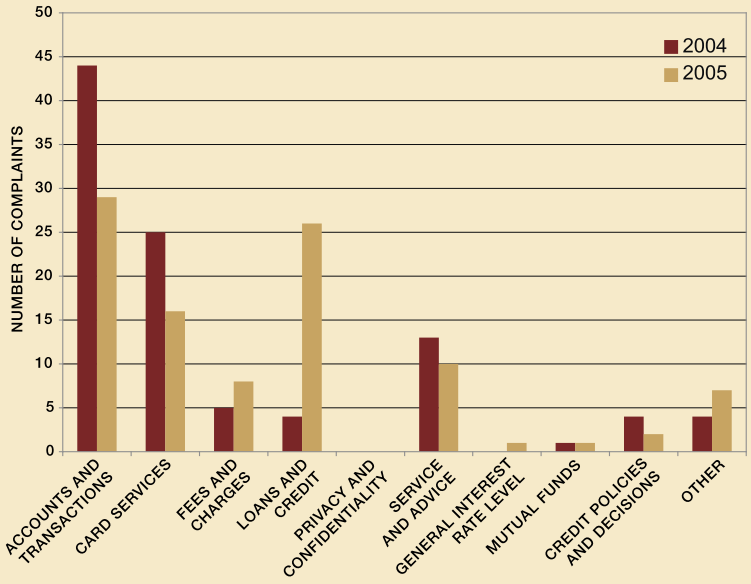


FIGURE 2: TOTAL COMPLAINTS FOR THE YEAR 2005 AS COMPARED TO 2004



INSURANCE OPERATIONS

FIGURE 3: TYPES OF COMPLAINTS

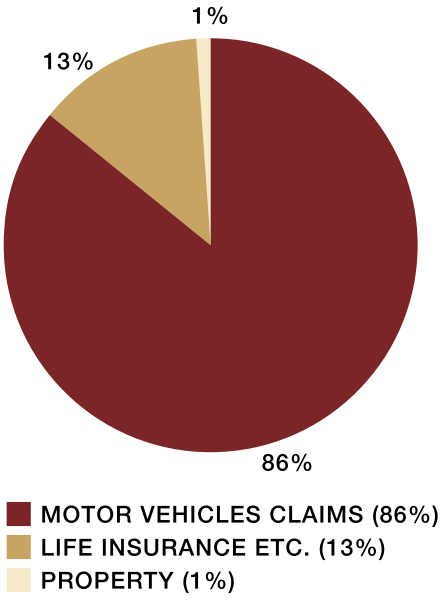
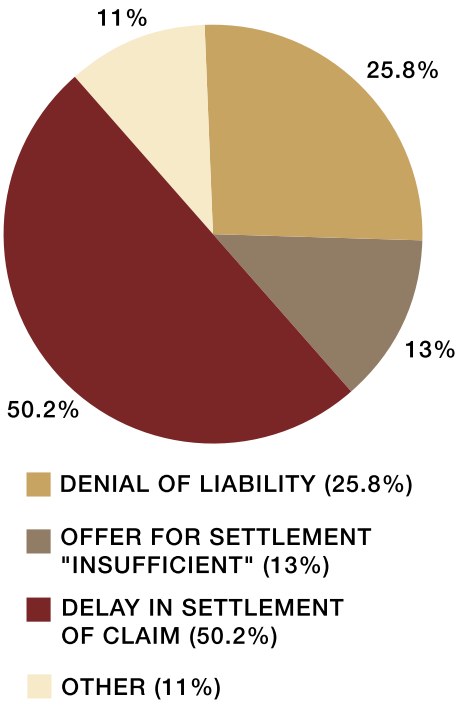


FIGURE 4: CATEGORY OF COMPLAINTS



COMPLAINTS RECEIVED

For the period May 2 – December 31, 2005, two hundred and ninety-eight (298) complaints were lodged with the Office of the Financial Services Ombudsman (OFSO), including three (3) complaints by small businesses. Of these, eighty-nine (89) complaints were re-directed to the Regulation Unit of the Financial Institution Supervision Department (FISD). Either the subject matter of these complaints did not fall within the jurisdiction of the OFSO or the insurance companies against whom the complaints were lodged, were not as yet participators of the Scheme.

Approximately one hundred and eighty (180), or 86%, of the two hundred and nine (209) complaints received and considered by the OFSO were complaints related to disputes with respect to the settlement of claims resulting from motor vehicle accidents. There were twenty-seven (27) (13%) complaints pertaining to issues of alleged discrepancies in payments on life insurance policies, annuities and other related products and only two (2) (1%) in relation to claims for compensation for property damage. See Figure 3.

The complaints lodged with, and considered by, the OFSO may be classified into the following categories:

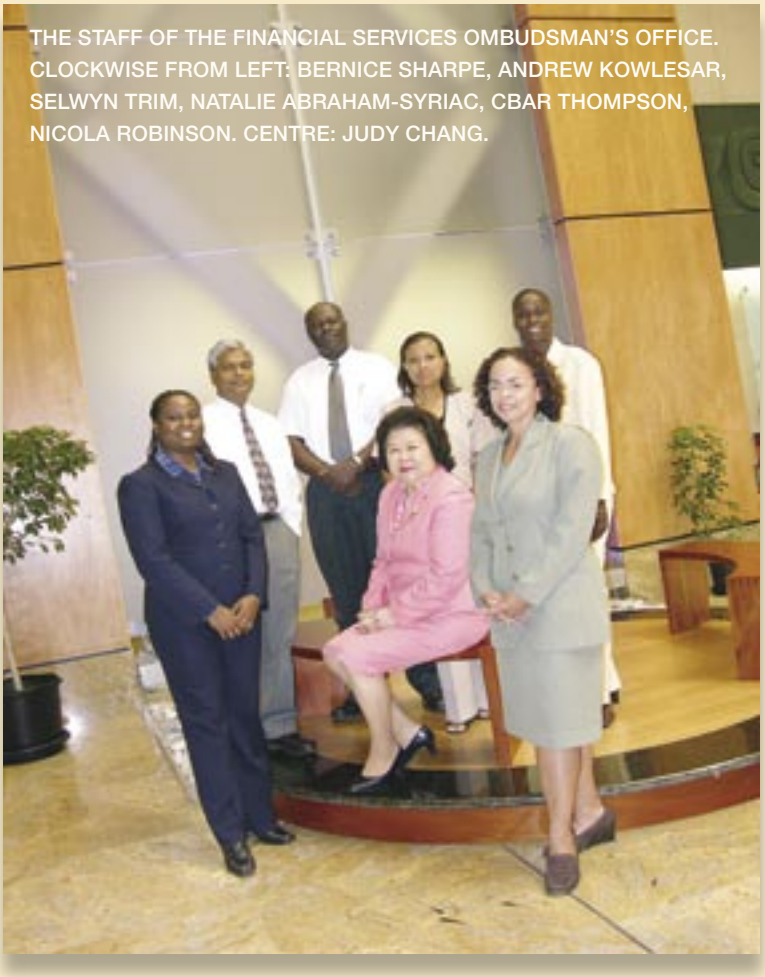
Denial of liability	54	25.8%
Offer for settlement "insufficient"	27	13.0%
Delay in settlement of claim	105	50.2%
Other	23	11.0%
	209	100.0%

See Figure 4.

HANDLING OF COMPLAINTS

In cases where the subject matters of complaints were within the jurisdiction of the OFSO, the OFSO, in accordance with the Terms of Reference of the Scheme, contacted by letters, the companies against which these complaints have been lodged. The companies were informed of the details of the complaints lodged against them and were also reminded of their responsibility to make every effort to resolve these complaints with the complainants and to do so by a stipulated deadline, failing which a transaction fee would be charged. A letter of acknowledgement was also sent to each complainant. If no response was received by the stated

"I TAKE THIS OPPORTUNITY TO EXPRESS MY IMMENSE GRATITUDE FOR THE ASSISTANCE GIVEN ME IN THE SETTLEMENT OF MY CLAIM WITH XYZ INSURANCE COMPANY LIMITED." (NOT REAL NAME OF COMPANY)



THE STAFF OF THE FINANCIAL SERVICES OMBUDSMAN'S OFFICE. CLOCKWISE FROM LEFT: BERNICE SHARPE, ANDREW KOWLESAR, SELWYN TRIM, NATALIE ABRAHAM-SYRIAC, CBAR THOMPSON, NICOLA ROBINSON. CENTRE: JUDY CHANG.

INSURANCE CASE STUDY 1

DENIAL OF LIABILITY FOR BREACH OF CONDITION

THE COMPLAINANT/OWNER LEFT HER VEHICLE WITH A RELATIVE WHO WAS AUTHORIZED TO DRIVE THE VEHICLE. THE VEHICLE WAS REPORTED STOLEN. IT WAS LATER DISCOVERED THAT THE VEHICLE, WHICH WAS ALLEGED TO HAVE BEEN STOLEN BY TWO TEENAGE RELATIVES, WAS INVOLVED IN A SINGLE-CAR ACCIDENT THAT SAME NIGHT. NO FORMAL CHARGES WERE LAID AGAINST THE TEENAGERS AS THE POLICE CONSIDERED THE MATTER A "FAMILY AFFAIR".

The complainant, having comprehensive motor vehicle insurance, filed a claim for compensation for damages to the vehicle. The insurer denied liability. The complainant requested the assistance of the OFSO in an effort to resolve the complaint.

The insurer's position is that while it is evident that, at the time of the accident, the vehicle was being driven without permission, the vehicle was not "stolen", since the identity of the person(s) who took the vehicle, was known. In addition, the insurer's perspective was that the accident was not caused as a result of the "theft" of the vehicle but because of the negligence of an unauthorized driver who was also operating the vehicle without a driver's permit.

The insurer denied the claim for damages to the vehicle due to the breaches of the conditions under which the policy was issued. The complainant could not dispute the findings of the insurer and as such the OFSO was not in a position to assist her.

Lesson of the case: The insured should adhere strictly to the conditions under which the policy is issued. To do otherwise is tantamount to driving without insurance cover. Some of the common breaches of the conditions are: a driver under age or without the required amount of driving experience; a driver not named in the policy; plying a private car for hire. ■

date, follow-up action was then taken by a Resolution Officer, usually by telephone contact, with the liaison officers of the respective companies.

RESOLUTION OF COMPLAINTS

During the period May to December 2005, the files on one hundred and eighteen (118) complaints were closed. Eighty-six (86) complaints, or approximately 73%, were resolved by the settlement of claims. From feedback received from many complainants it was evident that many of these complaints were resolved only because of the intervention of the OFSO.

Nine (9) complaints, or almost 8%, were closed because the claims related to the complaints were rejected by the respective insurers. Twenty-three (23) complaints were withdrawn by the OFSO primarily because, after careful and diligent investigation by the OFSO, they were deemed to be without merit. These were given no further consideration and the files were closed accordingly. See Figure 5.

HOW RESOLUTIONS WERE RESOLVED:

(May to December 2005)

Settled	86	73%
Rejected	9	8%
Withdrawn	23	19%
TOTAL	118	100%

In cases where complaints were resolved by the settlement of claims, almost 60% of these were resolved within sixty days of receipt of the complaints by the OFSO. See Table 3. In instances where complaints remained outstanding for periods in excess of sixty days, this was largely owing to the tardiness of the insurers in their responses to our enquiries about the complaints. In a few cases, however, complainants were requested to submit further information or evidence to support their complaints but did not provide such within the time suggested. In other cases, the complainants were either out of the country or not contactable by telephone.

"FINALLY, BY MID-OCTOBER, THE LAST OF THE PARTS WERE DELIVERED TO BEGIN THE REPAIRS TO MY VEHICLE RESTORATION OF WHICH IS STILL BEING EFFECTED. I AM SATISFIED THAT FOR YOUR INTERVENTION THE RESULT WOULD HAVE BEEN DIFFERENT."

FIGURE 5: CATEGORY OF COMPLAINTS

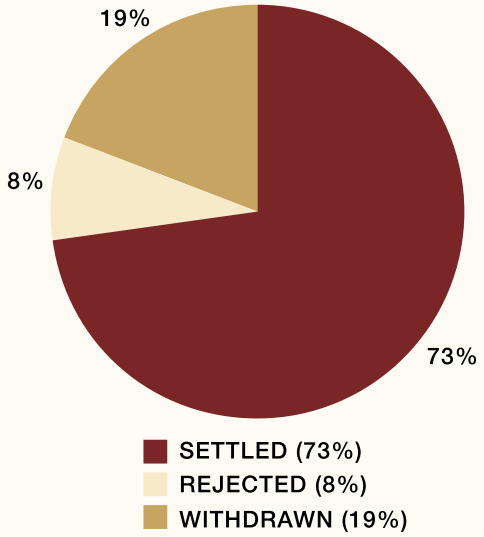


TABLE 3: RESOLUTION OF COMPLAINTS

(May to December 2005)

Resolution period –within	Complaints "resolved" by			Total complaints closed
	Settlement of claim	Rejection of claim	Withdrawal of complaint	
30 days of receipt	20	1	4	25
60 days of receipt	31	4	3	38
90 days of receipt	10	2	5	17
120 days of receipt	11	1	5	17
Over 120 days	14	1	6	21
TOTAL	86	9	23	118

FIGURE 6: DISTRIBUTION OF COMPLAINTS BY COMPANY

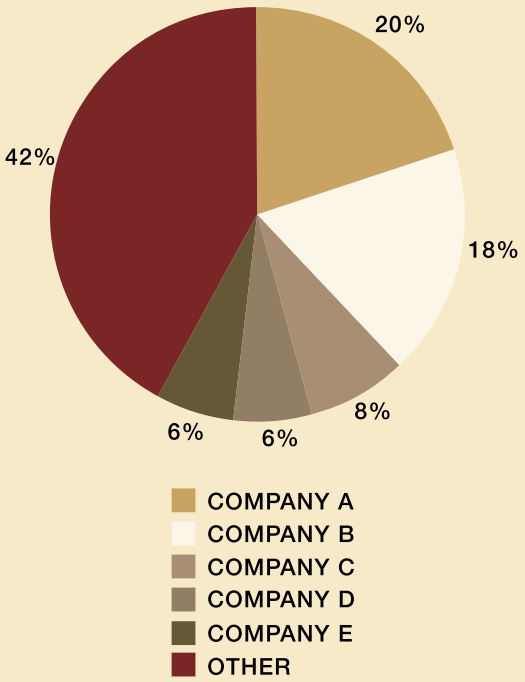


TABLE 4: COMPLAINTS RECEIVED
(May to December 2005)

	MAY-JUL	AUG-OCT	NOV-DEC	FISD	TOTAL	% OF TOTAL COMPLAINTS RECVD.
COMPANY A	24	16	10	9	59	19.8%
COMPANY B	15	20	10	9	54	18.1%
COMPANY C	7	9	2	7	25	8.4%
COMPANY D	6	9	1	3	19	6.4%
COMPANY E	2	8	3	4	17	5.7%
SUB TOTAL	54	62	26	32	174	58.4%
OTHERS	28	30	9	57	124	41.6%
TOTAL	82	92	35	89	298	100.0%

In addition to the complaints received and considered as stated above, a number of issues and disputes involving insurance matters were also reported by telephone calls from members of the public. These were also dealt with and resolved by telephone contact with the respective insurers without the "complainants" having to resort to the process of lodging a formal complaint.

DISTRIBUTION OF COMPLAINTS BY COMPANIES

The distribution of all complaints received for the period May to December 2005, according to insurance companies, is illustrated in Figure 6 and Table 4. It should be noted that the majority of these complaints were lodged against five (5) insurance companies. Complaints against these five (5) companies accounted for over fifty-eight percent (58%) of all the complaints received. No complaints were received against four (4) companies.

Over the period, there was also a noticeably declining trend in the number of new complaints received by the OFSO. Figure 6 and Table 4 show the distribution of complaints for the period May to December 2005 according to insurance companies.

CUSTOMER SATISFACTION

Overall, the level of public satisfaction with the service being offered and provided by the OFSO continues to be very good. A number of complainants have expressed their gratitude to the Office, both verbally and in writing, for its assistance in the settlement of their claims and the resolution of their complaints, even when the amounts received from the insurers were not the amounts initially requested in their claims.

There have been instances, however, where complainants have questioned the effectiveness of the OFSO to deal with the delinquency of some insurers as it relates to the timely settlement of claims. This matter is, of course, entirely outside of the scope of the Terms of Reference of the OFSO.

There were only two cases where complainants did express their extreme dissatisfaction with the OFSO's handling of their complaints. In both of these cases, the nature of their discontent was in relation to their unwillingness to accept the amounts being offered as settlement by the respective insurance companies, in spite of the Financial Services Ombudsman's view that the sums being offered were, to all appearances, fair and reasonable. Appointments were made for

INSURANCE CASE STUDY 2

DISCOUNT DUE TO AGE OF VEHICLE

THE COMPLAINANT, WHOSE VEHICLE WAS OVER TWENTY YEARS OLD, WAS INVOLVED IN AN ACCIDENT AND THE OTHER PARTY ACCEPTED LIABILITY. THE COMPLAINANT FILED A THIRD PARTY CLAIM AGAINST THE LIABLE PARTY'S INSURANCE COMPANY, WHICH ALSO HAPPENED TO BE HIS OWN INSURER.

The company, taking into consideration the age of the vehicle, its pre-accident value and the fact that parts are not readily available, made an offer to the complainant, which was not acceptable. The complainant did not agree that the cost of the parts for the repair works should be discounted even though his vehicle was over twenty years old.

The OFSO was of the opinion that the company had considered all the relevant factors in determining its offer and acknowledged that the vehicle was over twenty years old. Although the OFSO did not agree with the complainant's point of view, it was successful in negotiating an increase of 18% in the settlement offer, which was accepted by the complainant.

Lesson of the case: it is the common practice for insurers to discount the cost of the parts required to repair a vehicle depending on the age of the vehicle, on the grounds that the insured is entitled only to be put back to the same position as he or she was prior to the damage. To compensate for the full cost of new parts would be to put the insured in a better position than he was prior to the loss. ■

"I AM PLEASED TO INFORM YOU THAT MY CLAIM WITH XYZ INSURANCE COMPANY LIMITED (NOT REAL NAME OF COMPANY) WAS SETTLED AT THE END OF LAST MONTH AFTER EIGHT MONTHS."

THE TECHNICAL STAFF OF THE FINANCIAL SERVICES OMBUDSMAN'S OFFICE. LEFT TO RIGHT: ANDREW KOWLESAR, NATALIE ABRAHAM-SYRIAC, JUDY CHANG, SELWYN TRIM, NICOLA ROBINSON.

meetings with these complainants by the Financial Services Ombudsman with a view to having their complaints amicably resolved with the insurers. However they were not prepared to alter their positions and have since stated their interest in seeking alternative means for the resolution of their disputes with the companies.

GENERAL COMMENTS

Generally, the approach of most of the participating insurance companies to the treating, and the settling or resolving of disputes, with the public, has been rather encouraging. There may be some merit in concluding that this may, to some extent, be owing to the obligations imposed by the Financial Services Ombudsman Scheme on the participating insurance companies. However, a number of companies have been expressing some concern about the imposition of the fee for the tardy settlement of complaints beyond the prescribed ten-day period. Nonetheless, it can be concluded that this provision in the Scheme did provide an incentive and, it worked well in most cases to expedite the resolution of complaints.

Another contributing factor could be the outreach programmes being conducted by the Financial Services Ombudsman. These programmes include a series of visits to various insurers by the staff of the OFSO,

informing their staff of the OFSO's operations under the Agreement and providing clarification on issues where necessary.

There were three companies against which there continued to be serious public dissatisfaction with their treatment of claims resulting in large numbers of complaints being submitted to the OFSO. In the case of one of these companies, the complaints were primarily in relation to delays in payment of claims, even after agreement for settlement of these claims had been reached and signed

For most companies, the overwhelming majority of the complaints were made by third-party claimants with the subject matter of the complaints being mainly related to the insufficiency of the settlement amount offered and the denial of liability.

With the significant increase in motor vehicles on the nation's roads, and consequently the corresponding increase in claims resulting from accidents, it is reasonable to expect that the trend would be for an increase in the number of complaints being lodged with our Office.

Regrettably, a few insurers have not been cooperating with the Office as regards the providing of the expected prompt or timely responses to our letters and in the submission of information requested by our Office.

BANKING CASE STUDY 3

LATE PAYMENTS IN SERVICING A LOAN

THE CUSTOMER HAD A LOAN WITH A COMMERCIAL BANK WHICH WAS SERVICED BY A STANDING ORDER ON HER ACCOUNT AT THE SAME BANK. THE LOAN REPAYMENTS WERE DUE ON THE LAST DAY OF EACH MONTH, BUT FOR THE MONTH OF MARCH 2004, HER ACCOUNT WAS DEBITED TWICE FOR TWO LOAN REPAYMENTS, ONE FOR THE CURRENT MONTH AND ONE FOR A PRIOR MONTH.

This resulted in there being insufficient funds in her account for subsequent monthly loan repayments. As a result, there were charges of late penalty fees to her account over a period of time. The customer was also concerned about small amounts being debited to her account, throughout the month, instead of the loan repayment amount agreed upon. The customer admitted that she was not aware of these occurrences, until she attempted to pay off her loan.

The customer approached the OFSO for assistance. The bank advised the OFSO that loan repayments are automatically debited to the account on the agreed date, that is, on the last day of each month in this case. If there are not enough funds in the account to service the loan, on that date, the system will debit the account when the next available funds become available, and keep on searching for available amounts, on a daily basis, until the full loan repayment amount is paid. In addition, there would be a late payment penalty charge. The OFSO was of the opinion that the bank acted in accordance with the terms and conditions of the loan agreement, but found that if the bank had communicated with the customer about her delinquent status, the problem could have been avoided.

Lesson of the case: One should ensure that there are sufficient funds in one's bank account to meet any pre-arranged standing orders. Stiff penalties, including a late payment fee, are charged when a monthly loan payment is not paid on time and in full. ■

THE GOVERNOR OF THE CENTRAL BANK AND THE FINANCIAL SERVICES OMBUDSMAN AT A PRESENTATION TO THE AMERICAN CHAMBER OF COMMERCE.

Nevertheless, we will continue in our efforts to work closely with the insurance industry and to convince them of the need to minimise the number of disputes that may arise between themselves and the public by having these issues resolved at the earliest possible stages and to work along with us towards effectively resolving all outstanding complaints. Further efforts will be made to encourage all companies to establish complaints units, with competent staff, as required under the Agreement. We also expect to continue working closely with the Financial Institutions Supervision Department (FISD), the regulatory arm of the Central Bank, by the sharing of information and data as it becomes necessary to do so.

"A HEARTFELT THANK YOU TO YOU AND YOUR STAFF. GOD BLESS AND A HAPPY AND HEALTHY NEW YEAR TO YOU ALL."

CONCLUSION

The Office has had a very busy year with the introduction of the servicing of insurance complaints. However, the transition was relatively smooth because of the experience gained from the operations of the Banking Service Ombudsman Scheme over the previous two years.

Even though the experience with the insurance industry was not as good as with the banking industry, it is the hope that over time, the insurance companies will put in appropriate systems and upgrade their complaints policies and procedures so that complaints from the insuring public are resolved more promptly.

Almost ninety (90%) of the complaints handled by the Office relate to claims arising from motor vehicular accidents and are from third parties. In the main, they are for less than $25,000.00, the limit set under the Agreement. In the circumstances therefore, the decision to include third party motor vehicle property damage claims, unlike other jurisdictions, is a good one. Otherwise, the Scheme will not have benefited that stratum of our society that needs the services most, and for whom the Office was primarily set up.

However, it would be ideal if the self-same public who has access to the services provided by the Office, free of charge, could share the responsibility for the system as a whole by exercising more discipline and caution on the roads. If we all exercise discipline on the roads, have respect for each other, exercise a measure of courtesy for one another and drive within the speed limits, we will all benefit. There will be less damage caused to people and properties and the country will be a better place for everyone. True, our Office can expect to receive fewer complaints but that is the position that we all want to achieve in the long run. ■

BANKING CASE STUDY 4

FOREIGN EXCHANGE TRANSACTION

THE CUSTOMER CONDUCTED SOME FOREIGN EXCHANGE BUSINESS AT HIS BANK, AND REQUESTED A US DOLLAR WIRE TRANSFER. THIS WAS DONE AS USUAL, AT THE BANK'S US$ SELLING RATE.

The following day, the customer telephoned the branch to cancel the transaction and was advised by the bank representative that the transaction would be cancelled because the funds had not yet left the bank, but he would still have to incur the expense of the commission fee, to which he agreed. However, when the customer checked his bank statement, he realized that the balance in his account was less than what it should have been. He was informed that the US dollars were reconverted at the bank's US$ buying rate, so that he had incurred a loss of over $1,000.00.

The customer disagreed with the bank on their decision to reconvert using the US$ buying rate, because the transaction was cancelled before the foreign funds actually left the bank, so in fact it was an incomplete transaction. He requested the assistance of the OFSO and the bank agreed to refund to the customer the total loss that he had incurred.

Lesson of the case: It is customary for a bank to charge its customers the selling (or higher) rate when the customer is purchasing foreign exchange and the buying (or lower) rate when selling foreign exchange to the bank. One should be quite sure of the amount of foreign exchange required before transacting business with a bank; otherwise one could suffer a loss when reconverting back to the local currency. ■

BANKING CASE STUDY 5

REFUND OF COMMITMENT FEE

THE CUSTOMER HAD RECEIVED APPROVAL FROM THE BANK FOR A MORTGAGE LOAN. A LETTER OF OFFER WAS ISSUED BY THE BANK AND, IN ACCORDANCE WITH NORMAL PROCEDURES, A NON-REFUNDABLE COMMITMENT FEE WAS REQUIRED TO BE PAID BY THE CUSTOMER WHICH WAS DONE.

Sometime later, the customer advised the bank that due to no fault of his, he was unable to obtain the completion certificate and was forced to abort the transaction. Based on this, he requested a full refund of the commitment fee. In keeping with good customer relations, the bank agreed to refund 50% of the fee, but the customer requested the assistance of the OFSO in an attempt to obtain a100% refund.

The OFSO informed the customer that the ex-gratia payment of 50% refund of the commitment fee was considered to be reasonable. In the opinion of the OFSO, the bank had acted outside of its contractual agreement in its attempt to resolve the matter.

Lesson of the case: It is customary for a bank to charge a commitment fee when applying for a mortgage, which fee is usually non-refundable. It may be advisable and prudent to negotiate for a refund of the fee, at the time of the application for the mortgage, in the event that the purchase does not materialize. ■

The Office of the Banking Services Ombudsman changed its name to the Office of the Financial Services Ombudsman (OFSO) on May 2, 2005 (two years after its existence), at which time it took on the added responsibility of handling complaints from the insuring public. The Office was established as a result of an agreement between the Central Bank of Trinidad and Tobago and the insurance companies, similar to that signed with the commercial banks. As of the date of the report, all insurance companies have signed the agreement to become participators. Their names are printed on pages 6 and 7 of the report.

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

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

The Office provides a legitimate and independent channel through which complainants can seek redress, if necessary, in their dealings with the financial institutions. Under the system, 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 FINCANCIAL COMPLEX WITH UTC BUILDING, TSTT BUILDING, AND NICHOLAS TOWER. THE PARKING LOT ON RICHMOND STREET IN THE FOREGROUND HAS NOW BECOME THE CAMPUS BUILDINGS.

HOW THE PROCESS WORKS

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 small business is defined as any business with assets (excluding lands and buildings) not exceeding TT$1.5 million.

THE COMPLAINTS PROCESS AT THE FINANCIAL INSTITUTION

The process of registering a complaint starts at the local branch or agency office of the financial services provider where the transaction occurred. The complaint should be submitted in writing and accompanied by all appropriate documentation, including brochures, statements and copies of contracts or agreements.
If a complaint is not settled at the level of the branch or agency office, the complainant may then seek further redress at the dispute resolution centre of the financial institution. Under the terms of agreement, all financial institutions are obliged to set up a dispute resolution centre to handle complaints. The dispute resolution centre at each institution should be staffed with a senior officer to liaise with complainants as well as the OFSO.

"MANY THANKS FOR YOUR ASSISTANCE IN GETTING MY INSURANCE CLAIM FROM XYZ INSURANCE COMPANY LIMITED." (NOT REAL NAME OF COMPANY)

If complaints are not satisfactorily resolved using the internal process provided by the financial institution, the institution should advise the complainant that he/she is entitled to take the case to the OFSO. All complaints must be lodged with the OFSO within six months of having exhausted all appeals at the institution.

There is no charge for the services provided by the OFSO. The terms of reference enable the Office to investigate a wide range of issues relating to the products and financial services and instruments offered by the institutions.

THE COMPLAINTS PROCESS AT THE OFSO

Complaints should be submitted to the OFSO in writing. The document should summarise the nature of the complaint. If it is determined that the case falls within the terms of reference, the complainant is requested to complete and sign a prescribed complaint form. 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 authorizes 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-ay-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 other 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.

Most qualifying cases are formally investigated and documented by the OFSO. Conclusions 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.

If an Award is made by the Ombudsman and accepted by the complainant, it is binding on the financial institution. However, if a financial institution does not comply with an Award made by the Ombudsman, the Ombudsman is obliged to report the noncompliance to the Governor of the Central Bank. To date, no such Award has been made.

INSURANCE CASE STUDY 3

DENIAL OF DISABILITY BENEFIT DUE TO MISREPRESENTATION

THE COMPLAINANT COMPLETED AN APPLICATION FOR ENHANCED BENEFITS UNDER AN ACCIDENT AND SICKNESS DISABILITY POLICY IN AUGUST 2003 WHICH HIS INSURANCE COMPANY ACCEPTED WITH EFFECT FROM SEPTEMBER 1, 2003. IN JANUARY 2004 HE SUBMITTED A CLAIM FOR PAYMENT OF DISABILITY INCOME BENEFIT AND AN ACCOMPANYING CLAIM FOR WAIVER OF PREMIUM BECAUSE OF HIS INABILITY TO WORK.

The insurance company denied his claim for payment of Disability Income on the grounds that the insured did not honestly disclose pertinent information at the time of his application, which would have impacted significantly on the Underwriter's decision.

The Application Form completed by the insured, included a question which asked "Do any of the Proposed Persons intend to seek medical advice, treatment, or have medical tests done? The applicant responded "No" despite the fact that his doctor had told him ten days prior, that he would be required to have some tests done which subsequently proved to be positive.

The Financial Services Ombudsman concurred with the insurance company and advised the complainant accordingly.

The second request by the insured for waiver of premiums due to his disability was granted.

Lesson of the case: A prospective insured has a duty to disclose honestly all material facts bearing on the risk to be borne by the insurer. Information withheld or not honestly disclosed can lead to a cancellation of the policy. ■

INSURANCE CASE STUDY 4

UNINTENTIONAL IRREVOCABLE TRUST CREATED SO POLICY CANCELLED

THE INSURED PURCHASED A SINGLE PREMIUM RETIREMENT ANNUITY POLICY AND NOMINATED HER DAUGHTER AS THE BENEFICIARY. HER DAUGHTER, AT THE TIME OF PURCHASE, WAS NINE YEARS OLD

Two years after the issue of the policy, she tried to access funds from the policy only to discover that, having nominated her daughter as a beneficiary, she had created an irrevocable trust in her daughter's favour. As a result, she was not able to make any withdrawals from the policy, neither could she assign nor surrender the policy.

The insured claimed that it was her intention to use the funds for her daughter's University education. In addition, she had been given the assurance by the agent that she would be able to access up to 75% of the funds at any time during the life of the policy.

Investigations revealed that the insured was not properly advised by the agent about the creation and implication of an irrevocable trust. In addition, the agent had not sold the insured the correct policy for placing her funds to match the intended use.

The insurance company agreed to grant the insured's request to have the policy cancelled. The insured was refunded all monies paid towards the policy, along with interest, from the dates of payment to the date of refund.

Lesson of the case for prospective policy holders: Prospective insurance policy holders need to explain to their agents, as clearly as possible, their intentions with regard to the use for which the policy is being purchased, so that they can be appropriately guided.

Lesson for insurance companies: Agents should be properly trained to ensure that they understand fully the implications of key insurance terms and they can match the needs of their clients to the policy being sold. ■

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, 2004, except where the complainant only became aware, and cannot be expected to become aware, of the matter after January 1, 2004.

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. ■

THE FINANCIAL COMPLEX AS SEEN FROM THE NATIONAL LIBRARY, WITH THE INDUSTRIAL COURT IN THE FOREGROUND.

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. ■

INSURANCE CASE STUDY 5

AUTOMATIC PREMIUM LOANS WHEN IN ARREARS

THE INSURED PURCHASED A LIFE INSURANCE POLICY IN 1976 FROM AN INSURANCE COMPANY. HE MADE ARRANGEMENTS WITH HIS BANK TO PAY HIS PREMIUMS BY MEANS OF A STANDING ORDER. THE INSURED WENT AWAY FROM TRINIDAD AND TOBAGO FOR AN EXTENDED PERIOD.

In 2000, the insured became aware of an outstanding loan of approximately $20,000.00 against his policy. He claimed to have made attempts between 2001 and 2005 to get information from the insurance company about the loan but was unsuccessful.

In 2006, he was advised that an Automatic Premium Loan (APL) had been applied against his policy for the months in which the company had not received payments of premium , in accordance with the terms of the policy contract.

The insurance company also indicated that he was advised of the APL from as early as 1998, via correspondence mailed to the same address which had not changed from inception, starting with a loan balance of approximately $6,300.00. The complainant claimed that he did not receive any such letter and asked only to pay the loan balance as at 1998.

This request was denied by the insurance company on the basis that the insured had not reported any change of address at any time during his relationship with the insurance company. In fact, his address remained the same to date. Having sent the correspondence to his usual mailing address, they felt that they had satisfied their obligation. Additionally, they had no record of any attempt being made to query the outstanding accumulated loan amount, which increased as further premium loans and compound interest were added over time.

Lesson of the case: Consumers need to monitor the payments made against their policies very closely as Automatic Premium loans are a feature of most life insurance policies. In instances where a premium is not received by the insurance company, the outstanding premium will be treated automatically as a loan as long as there is sufficient cash value attached to the policy. This is to avoid the policy going into a lapsed state. Interest will be added to the loan on a compound basis and, over time, the loan balance could erode altogether the cash surrender value of the policy. ■

NOTES

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