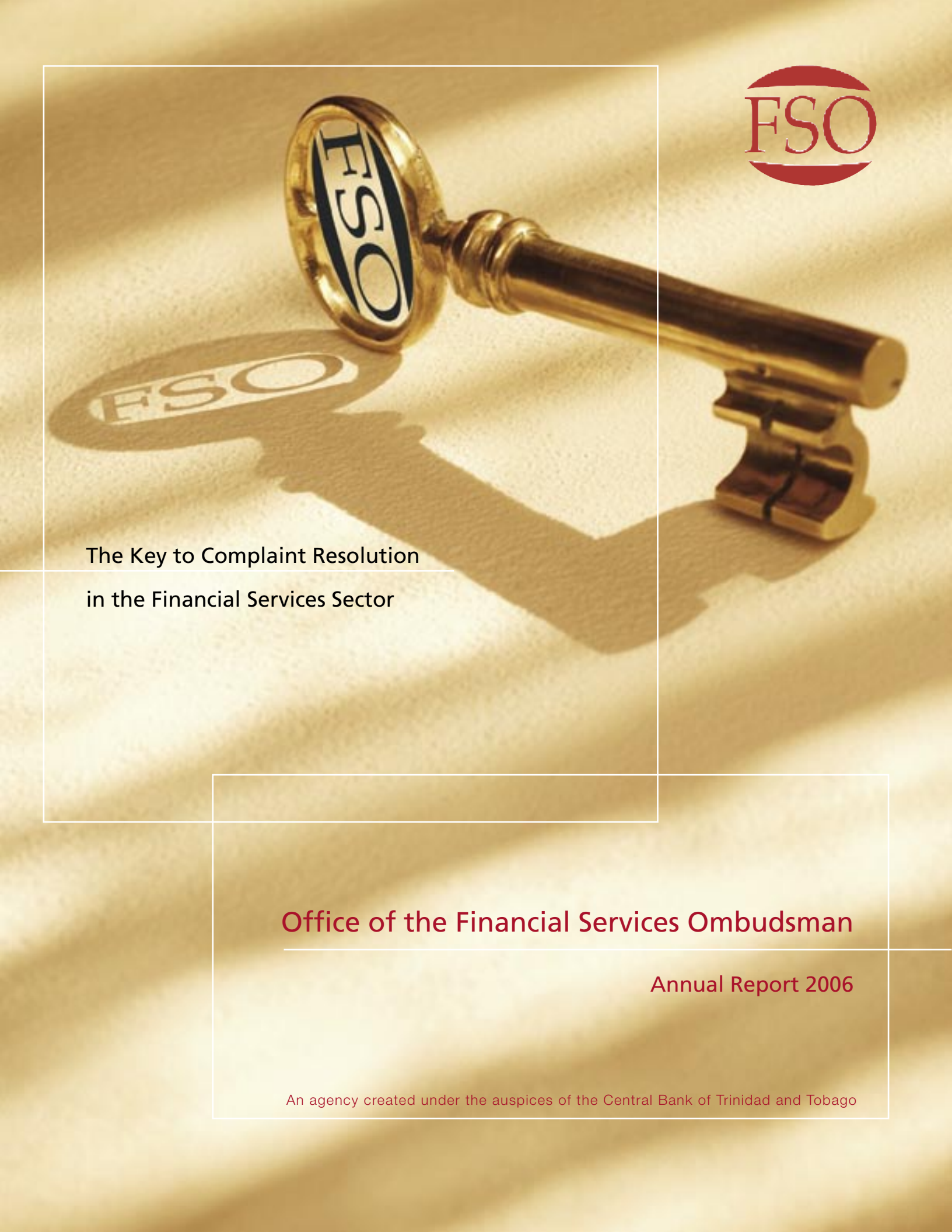

The Key to Complaint Resolution

in the Financial Services Sector

Office of the Financial Services Ombudsman

Annual Report 2006

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

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FOREWORD

BY THE GOVERNOR OF THE CENTRAL BANK

Ewart S. Williams

The Office of the Financial Services Ombudsman began operation in May 2003, initially addressing complaints only against the commercial banks. During its first year of operation, the work of the Office spurred the commercial banks into improving their customer service and strengthening their complaints handling machinery. As a result, the number of reported complaints against the banks declined from a high of 154 in 2003 (8 months only) to 73 in 2005 and 40 in 2006.

In May 2005, the Ombudsman's Office was expanded to cover the insurance companies. Since then, about seventy five percent of the Office's time has been devoted to addressing insurance complaints.

The work of the Ombudsman's Office supports efforts by the Central Bank's Financial Institutions Supervision Department (FISD) in the area of market conduct. FISD has also intensified its supervisory activity with a view to strengthening the financial and operational standards in the industry. To this end intervention action has been taken against two insurance companies that accounted for twenty five percent of total insurance complaints in 2006.

An examination of the range of complaints illustrates some systemic weaknesses that plague the insurance industry. These include a culture of considerable tardiness in the settlement of claims, non-transparent claims administration whereby all policyholders are not given equal treatment and a pre-disposition to minimum rather than fair payments.

I am very pleased at the efforts being made by the Ombudsman's Office as well as by the Association of Trinidad and Tobago Insurance Companies (ATTIC) to encourage and promote best practices in the industry. However, there are still a few insurance companies whose modus operandi, fall short of minimum operating status. These four or five companies continue to be responsible for the credibility problems that confront the insurance industry.

I congratulate the Financial Services Ombudsman for her leadership and success in raising the visibility of the Office and winning over the confidence of all the stakeholders. I also thank the staff for the tremendous contribution it has made for making the Ombudsman's Office an important and essential part of our financial sector infrastructure.

Ewart S Williams
Governor
Central Bank of Trinidad and Tobago

PREFACE

BY THE FINANCIAL SERVICES OMBUDSMAN

Judy Y. Chang

The year 2006 was a very busy one for the Office. It was the first full year of handling insurance complaints and they posed several challenges. The four (4) insurance companies that did not join the scheme at the inception in May 2005, did so during the latter part of 2005 and early 2006.

All six (6) commercial banks and thirty two (32) insurance companies are therefore now participators of the Scheme.

Regrettably, I have to report that the Central Bank of Trinidad and Tobago intervened in the case of Citizen Insurance Company Limited and Goodwill General Insurance Company Limited in March 2006, debarring the contracting of new business in the former company and of new and renewal business in the latter. A judicial manager was appointed for the former company in February 2007 and, in the case of the latter, the judicial manager appointed in October 2006 was replaced by a liquidator in January 2007.

On May 1, 2006, the first anniversary of the Scheme for insurance companies, a presentation was made to the insurance companies at which the statistics for the first year were presented and some of the challenges enunciated. Generally, the Scheme was found to be working well. The budget for the seventeen month period from May 1, 2006 to September 30, 2007 was approved at that meeting and so too the allocation of the contributions among the companies to take into consideration the greater number of motor complaints that were being processed.

DOLLARS AND $ENSE

In my previous report I had mentioned the series of advertisements on banking tips entitled “Dollars and $ense” which were placed in the daily newspapers. I am happy to report that they will be used as material for the National Financial Literacy Programme launched by the Central Bank of Trinidad and Tobago and which will be rolled out to the nation during this coming year. The insurance tips that were amassed will also form part of the programme.

NATIONAL FINANCIAL LITERACY PRORAMME

I am delighted to be included as a member of the management team of such a programme as I am convinced that financial literacy is key to the success of any developed country and important to the achievement of the mandate of the Office of the Financial Services Ombudsman. A financially literate populace is equipped to make choices, demand their rights and entitlements and become aware of potential financial blunders. Financially aware consumers also understand their responsibilities. Far too often, our Office gets complaints from individuals who are not aware of basic financial fundamentals.

BANKING

The banking complaints have been declining since the inception of the Scheme for banks in May 2003. This is very encouraging and no doubt is as a result of the seriousness and attention paid by the commercial banks towards better customer service and the will to maintain good customer relations. The greater part of the resources of the Unit is utilised towards the handling of insurance complaints.

INSURANCE

The handling of insurance complaints over the last two years indicates that considerable work needs to be done by some insurance companies to lift the image of the insurance industry. There is need to have written procedures and a structure in place for dealing with complaints and the will to cater for timely intervention.

More often than not, the insurance companies would be dealing with third parties and not with their own insured. While this may be the reason for less than perfect intervention, such insurance companies fail to realise that the claimants may end up being their customers if they are treated with dignity and in a timely manner.

In addition, we have found that the practices among insurance companies are not standardised and, as a result, this often leaves the public in a quandary. For example, why should I as an insured with comprehensive cover have to go to the third party insurer to plead for my claim when I am not liable? I have paid for comprehensive cover and I expect to get service from my insurer when there is a claim, whether I am liable or not. This practice varies from one insurance company to another.

Some companies would send their customers, with comprehensive cover, to the third party insurance company if they are not liable or if the amount claimed is less than or close to the excess. Happily, other companies will assist their customers in handling their claims and this practice should be adopted by all.

Insurance companies that are not now members of the Association of Trinidad and Tobago Insurance Companies (ATTIC) would do well to join the Association, so that as an industry, the public can expect a certain standard of service and practice. As one body covering the whole industry, the companies will be able to set rules to regulate themselves, rather than have rules and regulations imposed upon them.

The code of ethics to which members of ATTIC subscribe, should be reviewed further to strengthen the practices presently in place. The mediation service provided by the Office of the Financial Services Ombudsman should be included in the Code so that customers are made aware that there is an appeal process if they are not satisfied with the outcome of their claims. This will help to enhance the image of the industry.

Another area where the practice varies among insurance companies is in the case of a third party claim being made against an insurance company and where the company maintains that its insured was in breach of certain conditions under his or her policy. For example, even if the insured party is at fault but the driver is not the authorised driver under the policy, the claim is denied. Although the complainant is not the liable party, he becomes a victim. He is told by the other party's insurer to seek redress by claiming on the individual personally or take the individual to court. The insured against whose insurance company the claim is made is also asked by his company to settle the matter directly with the other party.

Happily too, this stance, though contrary to the spirit and intent of the amendments to the Motor Insurance (Third Party Risks) Act, is not universally applied throughout the industry. However, legal opinion suggests that even though it is the intent, the law is not clear. Such opinion indicates that it is only a court that can determine liability in the circumstances. This frustrates the system, puts pressure on our Office and leaves those affected without any redress since the court is not a viable option for the victims.

This apparent loophole in the insurance practice needs to be reviewed and the Act amended so that the law is not ambiguous and does not lead to differing results, leaving innocent third parties without any cover.

There are other cases where the motoring public has no recourse to insurance relief through no fault of their own and they have no avenue of redress. This can be the case in a hit and run accident or where someone cannot get insurance or is driving without any insurance cover in breach of the law.

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

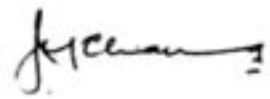
In the case of Goodwill, some members of the public had become victims of those who were insured by Goodwill but who, innocently or otherwise, had not taken out fresh insurance cover after the company had been placed into liquidation or who had unsuspectingly be allowed to renew their policies after the date of intervention by the Central Bank when all renewals and new insurance were prohibited.

CONCLUSION

Despite the challenges experienced, I have enjoyed being of service to the many complainants who sought assistance from our Office. 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 am thankful for 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 wish to acknowledge the team work of the members of my staff who worked diligently and assiduously to ensure that the complaints are handled fairly and in a timely manner.



Judy Y Chang
Financial Services Ombudsman

BANKING CASE 1

UNAUTHORISED ATM WITHDRAWALS NOT REFUNDED

The complainant visited her home branch ATM machine, on a Friday afternoon, and withdrew funds using her ATM card. The complainant claimed that she returned to the same ATM machine later that evening, at 8.00pm, and attempted to withdraw funds from her account, when her ATM card became stuck in the machine. After unsuccessfully trying to retrieve her card, she left the ATM and telephoned the bank the following Monday to report the incident.

The bank informed the customer that her ATM card was not in their possession but that they would investigate the matter. She visited the bank on the following day only to discover that there were unauthorised withdrawals from her account and practically all her funds were withdrawn.

A thorough investigation was conducted by the bank and the Fraud Squad during which the ATM camera footage for the times and date given by the customer, was viewed. The customer was seen on the camera footage at the ATM in the afternoon, conducting a normal transaction, which did not suggest any Fraud Typology. However, the camera

footage did not show her present in the evening at the time she claimed (8.00pm). The bank viewed the footage for the few hours before and after 8.00pm but she was not seen.

Based on the interviews and the investigations that were carried out in collaboration with the Police, the Bank was unable to find any evidence to support the customer's version of the events. The case was brought to the OFSO. After extensive investigations and interviews with both the complaint and the bank's officials, the OFSO could not find credible evidence to conclude that the complainant was a victim of ATM card fraud and declined the case.

LESSON OF THE CASE:

A complainant must be able to provide credible and positive evidence to support the case.

REPORT FOR THE YEAR ENDED DECEMBER 31, 2006

INTRODUCTION

Even though the banking complaints continued its downward slide, the decline was more than outweighed by the increase in the number of insurance complaints. The Office was kept busy with the increased influx of insurance complaints.

In February 2006, the Central Bank intervened in the operations of Goodwill General Insurance Company Limited and Citizens Insurance Limited. In the case of the former, the Company was prohibited from taking any new business or renewing existing business and in the case of the latter, they were allowed to take renewal business only.

In August 2006, the Central Bank obtained approval from the Court to appoint a Judicial Manager to Goodwill General Insurance Company Limited who, after assessing the financial position of the Company, recommended to the Court that the Company be placed into compulsory liquidation. That was done in January 2007.

The insurance complaints represented more than ninety percent (90%) of the complaints received; further, more than eighty percent (80%) of the complaints related to third party motor claims where both parties have third party insurance cover only. While the Ombudsman's schemes in other jurisdictions deal only with first party complaints, the decision to include third party claims in the Trinidad and Tobago scheme was a wise one. Had they not been included, we would not have been able to reach as many persons needing our assistance and we might not even be able to justify our very existence.

The decision taken by the Committee establishing the scheme to set the limit of third party property damage claims at $25,000 is also a good one. The number of complaints that our Office has forwarded the FISD because they exceeded the limit is relatively small.

GENERAL COMMENTS

The Office views very seriously any claims that are not genuine or carry any element of a fraudulent nature. In such instances and in cases where the complaints do not have any merit or creditable evidence to support the case before the financial institution, complainants are advised that our Office is not able to assist them.

Unfortunately, many complainants do not understand the products that they have purchased and rely too heavily on their agents who themselves are not sufficiently aware of the terms and conditions attached to the products.

The operations for the banking and insurance functions are shown separately in the report below. While it is the fourth year of operations for the banking industry it is the second period, and the first full year, for the insurance industry.

BANKING OPERATIONS

FOR THE YEAR ENDED DECEMBER 31, 2006

During the year ended December 31, 2006, the number of banking complaints continued its downward slide. Only 40 complaints were received during the year as against 73 complaints for the year 2005, representing only 56% of the number of complaints received last year.

Of those received in 2006, 17 met all the conditions under the terms of reference while 23 fell outside of the terms of reference of the agreement under which the operations of the Office are governed. This compares to 36 and 37 respectively for 2005, the third year of operations for this Office.

The reduction in complaints may be attributed to the maturity of the process and the structures put in place by the banks to monitor the complaints as they all seek to achieve greater and greater customer satisfaction. This is demonstrated by the number of letters written to the management of banks, copies of which are sent to our Office but which do not manifest themselves later as official complaints.

However, our Office cannot assume that all is well in the banking industry. There will always be complaints. In order to ensure that the general public is aware of the existence of the services provided by the Office and there is an avenue to whom to turn, the Ombudsman plans to carry out a public awareness campaign.

ANALYSIS OF STATISTICS

In the same manner as the number of complaints was almost half of those for the previous year, the decreases in both the qualifying and non-qualifying as well as the type of complaints were almost half of those for the previous year. Complaints about accounts and transactions top the list of type of complaints, amounting to 40% as compared to 44% last year. They were also at the same level between the qualifying and non-qualifying categories.

Somewhat surprisingly, even though card services accounted for 25% of the overall complaints in 2005, and 44% of the qualifying complaints in 2005, this percentage was reduced to an overall 15% in 2006. This may be attributed to the banks handling such complaints to the satisfaction of their customers before they reach our Office.

Sixteen (16) of the banking complaints were brought forward from 2005; forty (40) received and fifty (50) resolved, leaving six (6) to be carried forward. These figures compare to an overall number of four hundred and twenty four (424) complaints received for the period from inception in May 2003 to December 31, 2006 of which four hundred and eighteen (418) were resolved and six (6) carried forward.

As to be expected, the number of complaints received from each bank was in proportion to the relative size of each bank to each other.

BANKING COMPLAINTS

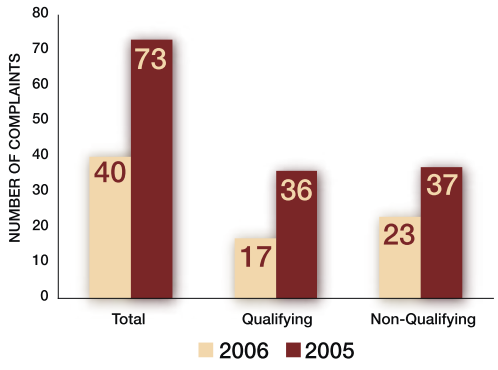
	Jan to Dec 06	May 03 to Dec 06
Brought forward	16	0
Received	40	424
	56	424
Resolved	(50)	418
Carried forward	6	6

STATISTICAL OVERVIEW OF BANKING COMPLAINTS

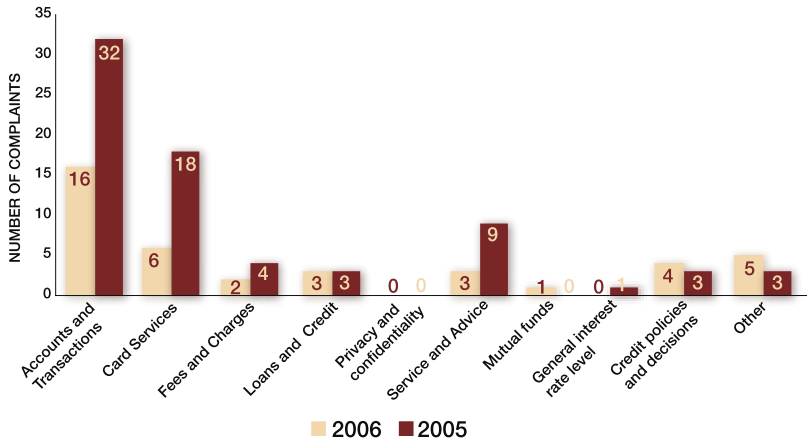
ANALYSED BY TYPE OF COMPLAINTS — FOR THE YEAR 2006 AS COMPARED TO 2005

	TOTAL		Qualifying		Non-Qualifying	
	2006	2005	2006	2005	2006	2005
Accounts and Transactions	16	32	6	13	10	19
Card Services	6	18	5	16	1	2
Fees and Charges	2	4	1	1	1	3
Loans and Credit	3	3	2	1	1	2
Privacy and confidentiality	0	0	0	0	0	0
Service and Advice	3	9	1	5	2	4
Mutual funds	1	0	0	0	1	0
General interest rate level	0	1	0	0	0	1
Credit policies and decisions	4	3	0	0	4	3
Other	5	3	2	0	3	3
Total	40	73	17	36	23	37
			Percent			
Accounts and Transactions	40	44	35	36	44	51
Card Services	15	25	29	44	4	5
Fees and Charges	5	6	6	3	4	9
Loans and Credit	8	4	12	3	4	5
Privacy and confidentiality	0	0	0	0	0	0
Service and Advice	8	12	6	14	9	11
Mutual funds	2	0	0	0	4	0
General interest rate level	0	1	0	0	0	3
Credit policies and decisions	10	4	0	0	18	8
Other	12	4	12	0	13	8
Total	100	100	100	100	100	100

TOTAL COMPLAINTS
FOR THE YEAR 2006 AS COMPARED TO 2005



TYPE OF COMPLAINT
FOR THE YEAR 2006 AS COMPARED TO 2005



BANKING CASE 2

UNAUTHORISED ATM WITHDRAWALS REFUNDED IN FULL

The customer attempted to withdraw funds from his account, via the LINX system, using a 'stand-alone' ATM machine, on a Friday evening. His card was captured by the machine and his attempts to retrieve his ATM card were futile. While he was still in the vestibule, a lady entered and offered assistance, but was still unsuccessful. On leaving the ATM machine, the customer telephoned the emergency number for that bank, but was given the emergency contact number for his bank. The customer called that contact number several times over the weekend, but was unsuccessful in making contact with any bank representative. The following Monday, he went into his branch and discovered that most of his money was withdrawn from his account without his authorisation.

The Bank decided to offer an ex gratia payment of 50% of the customer's losses because they could not conclusively determine that the customer did not disclose his PIN to the third party. The customer refused this offer.

After investigating the matter, the OFSO found that the customer was the victim of the typology of fraud commonly referred to as the Lebanese Loop, and the customer did attempt to contact the bank's emergency number within the 48 hour period, to de-activate his card, but was unsuccessful. The OFSO recommended that the Bank reimburse the full amount of the loss suffered as a result of the unauthorised withdrawals from his account.

LESSON OF THE CASE:

Once the PIN is not disclosed and a report is made to your bank within 48 hours, followed in writing within 14 days, of the loss of your debit or credit card, any loss incurred should be refunded in full under the provisions of the Electronic Transfer of Funds Crime Act 2000.

BANKING CASE 3

ACCOUNTING FOR CASH

The complainant went into the bank to cash a cheque over the counter. The cash was counted with the aid of a cash counting machine and placed in bundles of $10,000 in front of the customer. The complainant admitted that he did not double-check the cash in front of the teller before he left the bank. He claimed that when he reached his destination, he realised that he was short paid. The customer further claimed that he did return to the bank that same day, but the bank was closed, so he returned to the bank on the following day to report the matter. The bank investigated the matter and examined the CCTV surveillance tapes in the presence of the customer and there was nothing suspicious to be seen.

The OFSO agreed with the decision made by the bank not to reimburse the customer, because customers are expected to ensure that all cash transactions are properly and accurately accounted for in the presence of the teller, before leaving the bank. The bank cannot take responsibility for any monies that are missing after the customer leaves the bank.

LESSON OF THE CASE:

It is important that cash should be counted in the presence of the teller and agreed before leaving the bank.

BANKING CASE 4

INSURANCE COVER ON CREDIT CARD

The complainant's husband died while he was in possession of a valid bank credit card, with a balance owing of $12,770.60. The complainant was not accustomed dealing with the bank or paying any bills for that matter, but she informed the bank of her husband's death and paid off the balance owing on his credit card, which was returned to the bank. Sometime later, when she was going through her deceased husband's old statements, she realised that her husband had been paying a Balance Cover fee towards Balance Cover Credit Card Insurance on his credit card. The complainant tried unsuccessfully to recover any refund from the bank and requested the assistance of the OFSO. The complainant was later refunded the amount of $12,770.60 since her husband had been paying insurance premium for such cover.

LESSON OF THE CASE:

It is important to be vigilant and follow up on any entitlements, including any insurance cover that may be applicable. Of equal importance is the need to inform relatives of any insurance cover that may materialise upon death and for individuals to be aware of their financial position.

BANKING CASE 5

COSTS ASSOCIATED WITH FORECLOSURE OF PROPERTY

The complainant had a facility with a bank secured by a mortgage on a property. Her account went into arrears and legal action for possession of the property ensued. The complainant, in an effort to rectify the situation, made a payment towards the outstanding loan, but because the account was already in arrears and the bank discovered two registered judgments against her, the bank maintained their decision to foreclose on the property.

The bank provided settlement figures to the complainant and she was advised later that these figures did not include final legal fees. She then obtained a loan from another bank to pay off the first facility and this was done after some time had elapsed.

The customer was subsequently advised of additional charges that had been incurred as a result of the delays in settling the loan. She argued that it was as a result of the delays by the bank and that she should not have to bear the costs.

The OFSO intervened and, after hearing both sides of the case, agreed that the bank is entitled to recover all charges associated with the recovery of its debts. It is expected that customers in arrears have to pay for the provision of security guards, change of locks, etc. in the case of a foreclosure should that become necessary, in addition to any interest charges that may be accrued up to the time of the repayment of the debt in full.

LESSON OF THE CASE:

Interest applies to all sums owing to the bank and is payable up to the time of the repayment of the debt in full. In the case of a foreclosure, all charges related to the sale of the property are also for the account of the customer who is in default.

INSURANCE OPERATIONS

FOR THE YEAR ENDED DECEMBER 31, 2006

This is our second period of reporting on the insurance activities of our Office and the first full year. In 2005 the insurance Scheme was only in operation for eight (8) months. Throughout the year, our Office continued in its collaborative efforts with all the insurers in an attempt to achieve our ultimate objective, that is, to assist in a significant way in fostering an increase in the confidence and goodwill of the public towards the insurance industry. Admittedly, there were some setbacks in this area, particularly with the intervention of the Central Bank of Trinidad and Tobago in the affairs of two insurers. One of these companies, Goodwill General Insurance Company Limited, was eventually placed under judicial management by the order of the court and subsequently under compulsory liquidation.

In accordance with the mandate given to us under the Terms of Reference of the Financial Services Ombudsman Scheme, we endeavoured to facilitate the independent, prompt and amicable resolution of all complaints that were lodged at our Office by members of the public against the insurers. Moreover, we tried to ensure that our complaints handling procedures were conducted in a fair and reasonable manner. However, while it can be said that we have succeeded in achieving our goal in this regard, perhaps the efforts of our Office could have borne more fruit if a greater degree of co-operation was exercised on the part of some insurance companies in speedier processing and more structured claims handling procedures.

COMPLAINTS RECEIVED

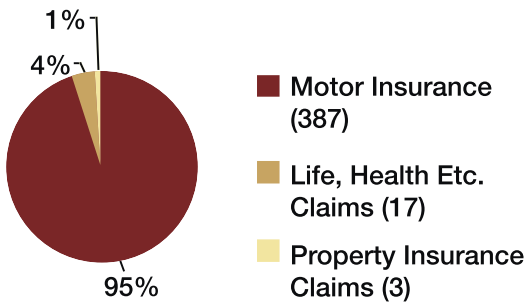
At the beginning of 2006, there were eighty seven (87) complaints that were outstanding and being processed. During the year, our Office received a total of four hundred and eighty (480) complaints from the public against insurance companies. Three (3) of these were complaints from small businesses. Seventy three (73) of the complaints received in 2006 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 our Office to treat with these complaints.

TABLE 1: NUMBER OF COMPLAINTS PROCESSED

	# of Complaints
Brought forward	87
Received during the year	480
Subtotal	567
Transferred to FISD	(73)
Transferred to Goodwill	(96)
Subtotal	398
Resolved/closed	(301)
Carried forward	97

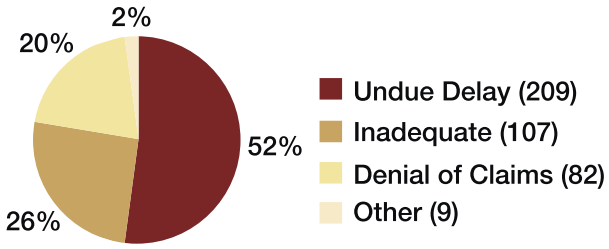
Three hundred and eighty seven (387), or approximately 95 %, of the complaints that were received and handled by the OFSO were about insurances services in relation to the settlement of claims that arose as a result of motor vehicle accidents. Seventeen (17) complaints related to issues concerning policies for life insurance and health benefits, annuities and similar products. Three (3) complaints were lodged by persons who were dissatisfied with amounts being offered for compensation for damages to their properties and the losses sustained as a result of fire and earthquake. (See Figure 1)

FIGURE 1: TYPES OF COMPLAINTS RECEIVED



Most of the complaints handled by the Office of the Financial Services Ombudsman were in relation to 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 quite a few instances, the subject matter of the complaints was the denial of liability by the insurers and their refusal to pay compensation. (See Figure 2)

FIGURE 2: CATEGORIES OF COMPLAINTS



DISTRIBUTION OF COMPLAINTS BY COMPANIES

The distribution of all complaints received for the reporting period is illustrated in Figure 3 and Table 2 below. A significant majority, 76%, of the complaints received were lodged against six (6) insurers. No complaints were received against nine (9) companies.

FIGURE 3: DISTRIBUTION OF COMPLAINTS BY COMPANIES

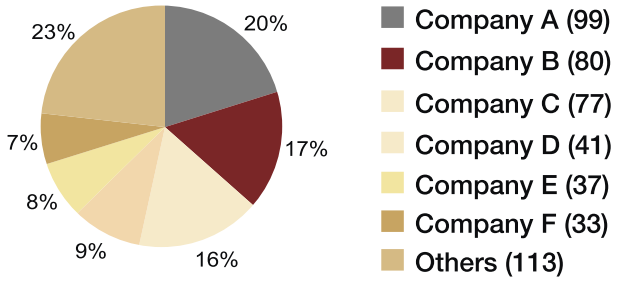


TABLE 2: DISTRIBUTION OF COMPLAINTS BY COMPANIES

	COMPLAINTS RECEIVED FOR THE YEAR JANUARY- DECEMBER 2006						% OF TOTAL COMPLAINTS RECEIVED
COMPANY	**JAN-MAR**	**APR -JUN**	**JUL-SEP**	**OCT- DEC**	**FISD**	**TOTAL**	
Company A	11	23	30	17	18	99	20.63
Company B	9	20	23	18	10	80	16.67
Company C	14	14	27	15	7	77	16.04
Company D	8	11	9	5	8	41	8.54
Company E	10	6	8	8	5	37	7.71
Company F	6	7	7	7	6	33	6.88
SUB TOTAL	**58**	**81**	**104**	**70**	**54**	**367**	**76.47**
ALL OTHER COMPANIES	24	27	29	14	19	113	23.53
TOTAL	82	108	133	84	73	480	100.00

RESOLUTION OF COMPLAINTS

During the period January to December 2006, the files on three hundred and ninety seven (397) complaints were closed. One hundred and eighty one (181) of these complaints were resolved by agreement between the complainants and the respective insurers. Unfortunately, there were instances where complainants expressed their dissatisfaction in the proposals being made by the insurers for the resolution of their complaints. Both parties refused to move from their stated positions and the OFSO had no option but to withdraw these complaints.

In some cases, the insurers declined to honour the claims that were presented to them for compensation since their investigations revealed that there was no liability on their part for the payment of any claim. In these instances, the OFSO had requested that the complainants submit further evidence to support their complaints. No such evidence was tendered and the files were closed.

The Terms of Reference of the Scheme requires that the OFSO examine each complaint that is received to establish whether there is any substance in the nature of the complaint. Where it is determined that a complaint is without merit the file is closed and the complainant is notified accordingly. Six (6) complaints were withdrawn for this reason. There were two (2) cases where the complainants had indicated to the OFSO that they preferred to have their disputes with the insurers determined by the court and these were also withdrawn. With the Central Bank's intervention into the affairs of Goodwill General Insurance Company Limited and the subsequent placement of the company under judicial management by the court, the OFSO was constrained to transfer the handling of the cases of all outstanding complaints against this company to its Judicial Manager. Ninety six (96) such cases were withdrawn and transferred. The respective complainants were also informed by letter of this development and were further advised to direct all enquiries with respect to their complaints to the Judicial Manager.

The period of time taken for the resolution of complaints continues to be a source of concern to the OFSO. (See Table 3.) Almost 35% of the files that were closed were closed after more than 90 days of receipt of the complaints. This is not satisfactory. The main contributing factor to this state of affairs continues to be the delay by the some insurance companies in treating with the claims relating to the complaints. Perhaps the process can be expedited if the companies would contact the complainants directly for further discussions as is being suggested by the OFSO. In other instances, the complainants either neglected to provide additional information to support their complaints, as was requested by the OFSO, or submitted such information well beyond the stated deadlines.

TABLE 3: RESOLUTION OF COMPLAINTS – JANUARY TO DECEMBER 2006

Resolution within	**Complaints "resolved" by**			**Total complaints closed**
	Settlement of claims agreement	**Claims rejected/ denial of liability**	**Withdrawal of by complaint**	
30 days of receipt	89	0	6	95
60 days of receipt	21	17	0	38
90 days of receipt	41	23	0	64
120 days of receipt	22	47	0	69
More than 120 days of receipt	8	25	2	35
	181	112	8	301
Transferred to Judicial Manager of Goodwill				96
TOTAL				397

There were also a number of instances where members of the public contacted the Office by telephone and sought the assistance of the resolution officers. Most of these complaints were dealt with informally, and to the satisfaction of the complainants, since in our view the filing of a formal complaint was not necessary.

CONCLUSION

The OFSO received a proportionally higher number of complaints in 2006 than in the previous reporting period, that is, the first eight months of its operations in 2005. This perhaps may be viewed as an indication that there is growing dissatisfaction by the public with the services being offered by the insurance companies. On the other hand, with the significant increase in the motor vehicle population, the attendant increase in motor insurance coverage and the frustration being experienced by the motoring public as they cope daily with the increasing traffic snarls on the roads throughout the nation, it was expected that the volume of claims arising from vehicular accidents would also have increased.

Regrettably, a few insurers are not living up to the spirit and letter of the Agreement of the Financial Services Ombudsman Scheme and continue to be uncooperative with our Office. This of course makes the job of our Office a lot more difficult. Nevertheless, the OFSO will continue in its efforts to work along with all insurers to facilitate the resolution of all complaints in a fair, reasonable and timely manner. It is also our intent to reach out with programmes and information to further educate the public about the role and function of the OFSO and the type of assistance they can receive from us.

INSURANCE CASE 1

POLICY EXCESS NOT RECOVERABLE

The complainant was insured with Company A when her vehicle was involved in an accident in April 2006. She was forced to take evasive action to avoid colliding with another car and in so doing, her car sustained considerable damage when it ran off the road. No other vehicle was damaged in the accident.

She subsequently submitted a claim to her insurers, under her comprehensive policy, seeking recovery of the damages to her car. However, the complainant was unable to get any word from her insurers as to the status of her complaint and after repeated delays she lodged a complaint at the Office of the Financial Services Ombudsman (OFSO).

The OFSO presented the complainant's case to the Company. They appointed an investigator to review the circumstances surrounding the accident and at the same time, assess the damages sustained by the vehicle. When the report was submitted, an offer of settlement was made to the complainant based on the investigator's report less the applicable excess under her policy. The complainant accepted the offer. However, she was unable to recover the excess.

LESSON OF THE CASE:
Notwithstanding the fact that she was not the negligent party in the accident, the complainant was unable to recover her excess as there was no accident to report by the other party. Her insurers were therefore unable to recover any monies paid out to her under her comprehensive cover. Both the complainant and her insurance company were out of pocket by the excess amount and the settlement amount respectively. And, unfortunately, she would have to suffer the reversal of any no claim bonus she would have earned.

INSURANCE CASE 2

RECOVERY OF UNINSURED LOSSES

The complainant was insured with comprehensive cover with Company A. His vehicle was involved in an accident in September 2005 with another vehicle insured with Company B. Company B's insured was subsequently deemed to be liable for the damages sustained by the complainant's vehicle.

Given that he was covered under a comprehensive policy at Company A, claim was submitted to that company and the complainant was able to reach a settlement with his company for repair of his vehicle, subject to payment of the applicable policy excess.

The complainant was then given a letter to take to company B for recovery of his uninsured losses, namely, the policy excess and an additional amount for the loss of use of his vehicle.

The complainant tried unsuccessfully to recover his losses from Company B. His claim was initially denied on the basis that it was invalid due to exceptions in the policy contract, however, this was found to be inaccurate. Subsequent attempts also did not yield any positive response from the company. After eight months of not getting anywhere, the complainant sought the assistance

of the Office of the Financial Services Ombudsman.

After presenting the complainant's case to Company B, the OFSO was able to recover for the complainant his policy excess and a portion of the amount requested as Loss of Use. Resolution of this complaint was achieved within three months of receipt of the Complaint Form.

LESSON OF THE CASE:

Persons covered under comprehensive insurance policies are required to pay a Policy Excess for every claim submitted under the policy. An Excess is the portion of a claim that an insured pays on his own behalf and may be considered as partial self-insurance. If the other party in the accident is found to be liable, the insured can approach the other party's insurer for recovery of the excess. It may also be viewed also as a deterrent to the insured in helping him to exercise due care on the roads and thereby, avoid accidents and having to pay the excess.

Company B offered settlement of a portion of the complainant's Loss of Use claim using their internal standard for private vehicles. It is the norm in the industry that Loss of Use be paid for the number of days it would take to repair the vehicle times the company's daily rate for either private or commercial vehicles. It is not to cover for the length of time that the insured has lost the use of his vehicle.

INSURANCE CASE 3

ANNUITIES & SURRENDER CHARGES

The complainant was in possession of a flexible premium annuity, Annuity A, from an insurance company. She received a call from her financial advisor indicating that the current rate of interest on that product was declining. After some discussion, they decided that the proceeds from Annuity A would be reinvested 'in another fund' in order to maximise the returns. The relevant application forms were then completed and submitted to the company for approval.

Some time after, the complainant received a phone call from the Board of Inland Revenue querying the registration of a new annuity, Annuity B. The complainant was naturally surprised since she was already in possession of an annuity and did not want another. She then visited the insurance company and discovered that Annuity A had been surrendered and the proceeds less surrender charges were transferred to Annuity B. at that point. The complainant then requested that the insurance company waive the surrender charges on Annuity A and refund her the monies accumulated. She stated further that her servicing agent obtained the second annuity from her 'under false pretenses' and, given her financial situation at that time, he should be aware that she should not have taken out a second annuity.

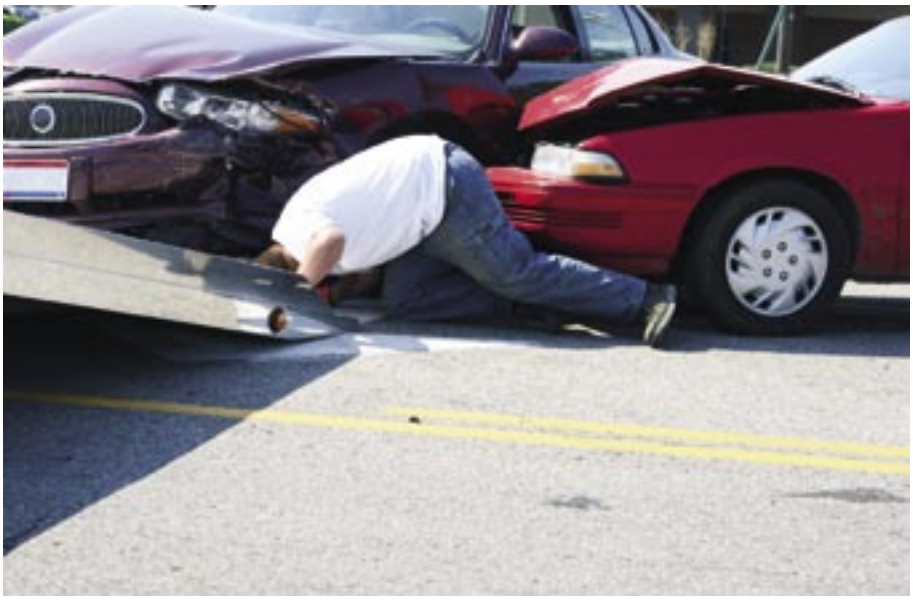
After some investigation, the insurance company declined to waive the surrender charges on the annuity on the grounds that the complainant submitted an application form for the product and she was bound to the terms and conditions therein. Further, the agent stated that he notified the complainant of the type of plan being purchased and that it was designed to provide income upon retirement. The registration of the policy therefore followed and as this was a legal requirement the company would be unable to accede to the complainant's request to have the plan deregistered.

LESSON OF THE CASE:

This case illustrates the need for consumers to take an active role in their financial affairs. While the call from the agent about the declining interest rates may have been the trigger alerting the consumer about the status of her investment, the onus is on the consumer to seek out all relevant information before purchasing financial products. Many insurance companies have service centres and customer call centres set up that are designed to answer queries from existing and potential clients. Having signed the application form (whether she read it or not), the complainant indicated her agreement with all attached terms and conditions.

INSURANCE CASE 4

COMPREHENSIVE INSURANCE DOES NOT COVER ALL LOSSES



The complainant was insured with Company A, under a comprehensive policy. Her vehicle was involved in an accident in December 2005. At the time of the accident, the vehicle was at a standstill. As two persons were about to enter the car, another vehicle collided with the complainant's car on the right broadside. As a result of the impact, the complainant's car was pushed to the side and hit a utility pole.

A claim was submitted to the complainant's insurers within one week of the accident but the claim was initially denied on the grounds that the vehicle was used for hire which was in breach of the conditions under the policy, a position which was later denied and accepted. The complainant was given a letter to take to the other driver's insurer to have her damages settled. The second insurer also denied responsibility for her damages, sending her back to her insurer to lodge a claim. This was done by the complainant but she never received any feedback on her claim from her insurers. She then lodged a complaint with the Financial Services Ombudsman.

The Ombudsman's office presented the complainant's case in which she was seeking complete compensation of the money spent to repair her vehicle and loss of use. An initial offer was made to the complainant who refused same on the grounds that it did not completely cover the cost to repair her car. She was also seeking reimbursement for wrecking fees and repairs to her air-condition system which was damaged in the accident.

After negotiations with the insurer, the OFSO was able to obtain an enhanced settlement for the complainant, including the full amount spent for the wrecking fees. No additional payment was made for the repair of the air-condition system as this was considered as part of the damages to her car. The payment of the policy excess was also waived since her insurers will recover on her behalf, through the subrogation process with the other driver's insurer.

LESSON OF THE CASE:

This complainant was able to secure settlement under her comprehensive policy. Although the excess is a feature on most, if not all, comprehensive policies, due to the delay in having this claim settled, the excess was waived as a gesture of good customer relations. The complainant was under the impression that her insurers were simply going to reimburse her for the total bill for repairs to her vehicle. However, estimates are normally subject to adjustment by loss adjusters who are qualified to assess the damages and the cost of replacement to the position before the loss. This process helps insurers to monitor their claim payments by making offers that are more reflective of the actual costs to repair the vehicle.

INSURANCE CASE 5

EARTHQUAKE DAMAGE NOT COVERED

The complainant's home was covered under a homeowner's protection policy when her house was damaged by an earthquake. She stated that she noticed cracks and breakage in the walls close to the roof of her patio and immediately made a report to her insurers. She was directed by them, to someone else, later identified as a loss adjuster who worked for the company, to have the damages reviewed.

Some time after the adjuster visited the premises, the damaged portion of the roof collapsed, causing the complainant to again contact the adjuster who then advised her to proceed with the necessary demolition work. He further advised her to submit an estimate for her costs to demolish and rebuild her patio. The complainant proceeded to repair her home, at her own expenses and await reimbursement from her insurers. To her surprise, her claim was denied on the grounds of 'construction inadequacies tantamount to poor workmanship'.

The insurance company, supported by the report produced by their loss adjuster denied the complainant's claim on the basis that the damage was due to poor workmanship and this was strictly excluded under the policy. In his report, the adjuster also stated that the porch was added subsequent to the initial construction of the building and perhaps improper fastening of the porch roof, coupled with inadequate support columns were jointly responsible for the collapse.

However, after the intervention of the Ombudsman's office and considering the long relationship with the customer, the company offered an ex-gratia payment. This recommendation was then reviewed by an independent investigator appointed by the Ombudsman office who concurred that the calculation of the settlement was reasonable and that the complainant should be advised to accept same. The complainant however, declined to accept same and the OFSO closed our files on the matter.

LESSON OF THE CASE:

The investigator appointed by the Ombudsman's office found that the ex-gratia payment offered by the company was fair and worthy of consideration by the complainant. In his evaluation of the claim, the OFSO's investigator considered both earthquakes mentioned by the complainant as separate events and his estimated settlement was not far from that offered by the company. The investigator also indicated that any additions to the main building should have been brought to the attention of the insurer to have same covered by way of an endorsement on the policy. The complainant did not accept the calculation provided by our investigator, insisting that the damage resulted from one earthquake.

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 (excluding lands and buildings) not exceeding TT$1.5 million.

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-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 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 2006

Card: "Thanks" is such a little word
For all that you have done
So when this card says "thanks" to you
It's only just begun
To say how very nice you are, how kind and thoughtful, too
And show the special gratitude
It's meant to bring to you.

Customer: If at times your work seems harder and you think that no one cares, if you feel unappreciated and that you are taken for granted, do not be bitter, do not despair, whatever little you do dries many tears so be of good cheer.

Card: Only someone as wonderful as you could do something so special!

Customer: Thanks a million for taking time to sort out my little problem and for responding so promptly to my letter. If only more people can be just like you.

Card: You've been so kind and thoughtful
It's difficult to say how much appreciation this "Thank You" brings your way.
With Special Thoughts

Card: Just a note to say thank you so much

Card: Some people make you happier than any words can say ...
That's why this "Thank You" comes to you with so much love today.

Customer: May the Lord continue to bless you all always

Excerpt from letter: "I wish to thank you very much for your assistance. It has been very professional, efficient and effective. You have kept me informed of what was being done all the way, service par excellence. For this I am very grateful, you have restored my hope and expectations of this country. Many people are quick to complain but few give praise when it is due".

Excerpt from letter: I would like to express my deepest gratitude to everyone who worked on the resolution of my matter with special thanks to (name of officer) who always addressed my concerns, returned all my phone calls and answered every question I asked with professional courtesy. Thank you.

Letter to the Editor of one of the newspapers:

Kudos for Financial Ombudsman

I wish to take this opportunity to thank the Office of the Financial Services Ombudsman for assisting me in recovering my insurance claim from an insurance company. I first approached the insurance company on October 31, 2005. Initially, the claims manager said that my claim was not valid due to certain clauses in the policy contract. Upon checking with professionals in the insurance industry, I realise that his explanation was nonsense.

Eventually, he agreed to settle. However, over the months that followed, this claims manager gave me countless runarounds. In frustration, I went to the Financial Services Ombudsman in June 2006.

To my amazement, the Ombudsman Office was able to obtain settlement for me within ten weeks. Once again, thanks, especially (names of officers) in having my matter resolved.

I would like to advise readers who have problems with insurance companies to utilise the resources available at the Office of the Financial Services Ombudsman, 625-4835 Ext 2685 at the Central Bank Building. They do get results!

STAFF OF THE OFFICE OF THE FINANCIAL SERVICES OMBUDSMAN

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

MEETING WITH THE INSURANCE COMPANIES

Presentation by Judy Chang, Financial Services Ombudsman

Judy Chang, Financial Services Ombudsman, with the Governor, Ewart Williams, prior to the meeting.

LIST OF PARTICIPATORS

COMMERCIAL BANKS

- Citibank (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.
- Citizen Insurance Company Ltd. (in Compulsory Liquidation)
- Colonial Fire and General Insurance Company Ltd.
- Colonial Life Insurance Company (Trinidad) Ltd.
- Cuna Caribbean Insurance Society Ltd.
- Furness Anchorage General Insurance Ltd.
- Goodwill General Insurance Company Ltd. (in Compulsory Liquidation)
- 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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