ombudsman news

issue 32 October 2003

essential reading for financial firms and consumer advisers

in this issue



# about this issue

The jurisdiction of the Financial Ombudsman Service (the matters we can and cannot look into) is defined in the rules under which we operate. Our jurisdiction is a broad one – but not quite as broad as some consumers believe – and we do sometimes have to explain that we are unable to deal with a particular complaint. Often this is because the firm concerned is not regulated.

Firms, too, can sometimes be mistaken about the extent of our jurisdiction. Unlike consumers, however, they generally tend to think it narrower than it actually is. In this edition of *ombudsman news* we take a look at two specific areas of our jurisdiction that can give rise to misunderstandings in relation to insurance complaints:

- cases that involve group policies; *and*
- commercial cases (where the event being complained about happened before we gained our statutory powers on 1 December 2001).

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We also feature a wide range of recent banking and investment-related cases, including complaints from:

- a woman who said the firm misled her about the free travel insurance it offered with its credit card;
- a man who applied for a waiver of premiums for his life assurance policy after he had suffered a serious heart attack, but was told he had left it too late to apply; *and*
- a couple who cashed in their endowment policy a year before it was due to mature and thought the firm was guilty of discrimination because it did not pay them a terminal bonus.

As always, we welcome your questions for our *ask ombudsman news* feature on the back page of every edition. This month we include a query about a mortgage endowment complaint that appears to have reached a dead-end, since neither of the firms involved will accept responsibility for the investment advice given to the consumer.

# 1 banking case round-up

## a selection of some of the banking-related complaints we have dealt with recently

■ **32/1**
**business loan – whether firm entitled to make early repayment charge**

Mrs L borrowed £50,000 from the firm to buy a café. The loan was repayable over 10 years, at a fixed rate of interest. Unfortunately, the business never did very well and three years after it opened, Mrs L decided to close it down and pay off the balance of the loan.

When she asked the firm for confirmation of how much she owed, she was shocked to learn she would have to pay an early repayment charge of £5,000. She had not allowed for this in her calculations.

She complained to the firm, saying it was not within its rights to make the charge. The firm told her the loan agreement she had signed made it clear that a charge was payable if the loan was paid off early.

**complaint rejected**
A fixed rate protects the borrower against rising interest rates. In order to lend at a fixed rate, firms usually borrow on the money market, also at a fixed rate. If a borrower pays off a loan early, and interest rates have fallen since the loan was taken out, the firm will have to pay to break the money-market deal. So it levies an early repayment charge on the customer to recoup its losses.

We looked at the loan agreement that Mrs L had signed. This:

- explained the circumstances in which the firm could make an early repayment charge;
- said the charge could be substantial; *and*
- told borrowers they might wish to seek independent legal advice before taking out the loan.

The agreement did not say how much the charge would actually be. But it could not do this, because the amount would depend on the interest rate at the time the loan was repaid. We decided the firm had been entitled to charge the fee and we rejected Mrs L's complaint.

■ **32/2**
**firm as executor – duty to advise on inheritance tax had not arisen**

When Mr C remarried, five years after his first wife died, he and his second wife both made wills, appointing the firm as executor.

**... the avoidance of inheritance tax can be an important consideration.**

Two years later, Mr C died. Under his will, his second wife was given a life interest in his collection of antique furniture. After her death the furniture would pass to Mr C's three daughters from his first marriage.

Long before Mr C had remarried, his daughters had decided which items of furniture each of them wanted – they had even labelled the individual pieces accordingly. So they were very dismayed to learn, shortly after the death of their stepmother, that they would have to pay inheritance tax on the value of the furniture. This was because their stepmother only had a life interest in it.

They complained to the firm that it had been in breach of its duties and that it should have arranged matters so that inheritance tax could be avoided.

**complaint rejected**

Mr C's will had been prepared by his solicitor, not by the firm, and we agreed with the firm that it was reasonable to assume the will reflected Mr C's wishes. The avoidance of inheritance tax can be an important consideration but it is not the only factor that people have in mind when making a will. There was no evidence that, after Mr C's death, Mrs C would have wanted to vary the terms of the will for the benefit of his daughters. The firm was not at fault and we rejected the complaint.

■ **32/3**
**mortgage – wrong repayment figure quoted**

Mr Q applied to the firm for a £100,000 repayment mortgage. When he filled in the application form he made a mistake and got the address of the new property wrong.

The firm subsequently sent him a mortgage offer but it got the monthly payment wrong – quoting £480, instead of the correct amount – £640. Mr Q later told us that it was at this point that he contacted the firm and gave it the correct address for the new property.

A couple of weeks later, the firm wrote to Mr Q to tell him the monthly payment was £640, and not as stated in the mortgage offer. Mr Q never received the letter. It later transpired that the firm had sent it to the address that Mr Q had given incorrectly on the application form.

The house purchase went ahead but Mr Q contacted the firm to complain when he noticed that it started taking direct debit payments of £640 a month.

**... at first the firm agreed that it was taking the wrong payment. Later it said it was taking the right payment.**

A period of considerable confusion ensued. There were long delays before the firm responded to any of Mr Q's letters and telephone calls. And it then contradicted itself. At first it agreed that it was taking the wrong payment. Later it said it was taking the right payment. Mr Q insisted that the firm was committed to accepting the figure of £480. The firm told Mr Q that he was wrong, so he came to us.

**complaint rejected**
Before Mr Q completed the mortgage application form, the firm had given him an illustration, showing how much the monthly payment was likely to be. So we did not accept his view that the firm had misled him, and that he would not have proceeded if it had quoted the correct figure in the offer. However, we said the firm should compensate Mr Q for the inconvenience it had caused him.

## 32/4
**deposit account – disputed payment in**

Miss B complained to the firm that it had never credited her deposit account with the payment of £5,000 she had made some months earlier. She sent the firm a photocopy of what appeared to be a stamped receipt for the money.

The firm refused to credit her account as it said it had no record of the payment. Miss B then complained to us.

**... at the time she paid for her holiday, she had already used the credit card up to its limit.**

**complaint rejected**
We were satisfied that the payment did not appear in the branch records. We asked Miss B to let us see the original receipt, but she refused to do so. And when we asked her where the £5,000 came from, she said she had forgotten. We thought it reasonable to expect her to remember how she received such a large sum. We did not uphold her complaint.

## 32/5
**debit card – free travel insurance offer did not apply**

Mrs T took up the firm's offer of a special deal, which included a current account (with a debit card) and a separate credit-card account. As part of the package, customers got free travel insurance for trips they paid for with the credit card.

Some months later, Mrs T used the debit card to pay for a foreign holiday. While she was abroad, her handbag was stolen. She assumed the firm's free travel insurance would cover her loss, but when she put in a claim the firm told her she was not covered. This was because she had used the debit – not the credit – card to pay for the holiday.

Mrs T complained to the firm, saying it had told her *both* cards carried free travel insurance. However, the firm said that the literature it had given her about the offer made the situation clear. It rejected her claim, so she came to us.

**complaint rejected**
Mrs T was adamant that the firm had misled her. She said that if she had realised the travel insurance did not apply to both cards then she would have paid with the credit card.

However, we noted that – at the time she paid for her holiday – Mrs T had already used the credit card up to its limit. The literature the firm had given Mrs T was perfectly clear. And there was no evidence to suggest that the firm had told her the debit card carried free travel insurance. We did not uphold her complaint.

## 32/6
## mortgage – lender's mistake about insurance premiums

In 1996, Mr and Mrs E, who were first-time property buyers, tookout a mortgage with the firm. Their monthly payments included premiums for buildings insurance and payment-protection insurance.

The following year, the couple asked the firm if they could change the day of the month on which they made their payments. The firm made the change, but unfortunately it failed to include the insurance premiums.

**... we told the firm it should pay for the inconvenience its mistake had caused.**

It was five years after this that Mr and Mrs E complained to the firm. They said they had onlyjust discovered that it had not been deducting payments for the insurance premiums. The firm refused to accept responsibility. It said the couple should have noticed that the amount they paid each month had dropped significantly. And it told them they would have to pay the arrears, together with interest.

**complaint upheld**
Mr and Mrs E admitted that they *had* noticed their monthly payments were smaller. However, they said they had assumed that this was because of a reduction in the interest rate, which had taken place around the time they had changed their repayment date.

The firm had sent Mr and Mrs E yearly statements showing their mortgage payments. However, there was nothing on the statements to indicate that the insurance premiums had not been paid. And there was no evidence that the firm had noticed that these payments had stopped.

Mr and Mrs E had continued to have the benefit of the insurance during the period when no premiums had been paid. We therefore decided it was fair to expect them to pay the arrears. However, we told the firm it should write off the interest and pay the couple £750 for the inconvenience its mistake had caused.

# 2 some jurisdiction issues in insurance cases

The jurisdiction of the Financial Ombudsman Service (the matters we can and cannot look into) is defined in the rules under which we operate. These rules are made (or approved by) the Financial Services Authority (FSA) and published in its *Handbook of rules and guidance* in the section, *Dispute resolution: Complaints* (DISP).

Our jurisdiction is a broad one – but not quite as broad as some consumers believe. We do sometimes have to explain that we are unable to deal with a particular complaint – often because the firm concerned is not regulated. When we are unable to deal with an insurance case, it can sometimes be because the consumer bringing the complaint to us is not the beneficiary of the insurance contract that is the subject of the dispute.

Firms are also sometimes mistaken about the extent of our jurisdiction. But unlike consumers, they generally tend to think it narrower than it actually is. They will sometimes try to argue that a case is outside our jurisdiction when, in fact, it is not.

**... our jurisdiction is a broad one – but not quite as broad as some consumers believe.**

Insurance firms occasionally try to insist that we cannot look at complaints about underwriting matters, or where legal proceedings have been issued. These misconceptions are a legacy from the past. The Terms of Reference of one of our predecessors, the Insurance Ombudsman Bureau, precluded such cases. However, the FSA rules give us wider powers and such cases are *not* outside our jurisdiction. They are, however, among the types of cases that we can, under the rules, decline to deal with.

Two areas in particular that can give rise to more problematic jurisdiction issues are:

- cases that involve group policies; *and*
- commercial cases (where the event being complained about happened before the Financial Ombudsman Service gained its statutory powers on 1 December 2001).

## group policies

We see plenty of cases relating to group Permanent Health Insurance (PHI) and similar policies, where the employer has taken out the policy for the benefit of its employees and one of those employees refers a complaint to us. Some insurance firms have tried to argue that we cannot investigate cases that involve group policies (even where the policy was taken out for the benefit of an employee) if the policyholder is a large company with an annual turnover of £1million or more.

## ... firms are sometimes mistaken about the extent of our jurisdiction.

Under our rules (DISP 2.4), an *eligible complainant* (someone who is able to bring their complaint to the ombudsman service) includes '*a person for whose benefit a contract of insurance was taken out or was intended to be taken out*'.

To decide whether a case is one we can look into, we need to assess whether the policy was taken out for the benefit of the individual who has complained to us. We do this by looking at the policy wording and the employment contract. If it is clear that any payments made by the insurer go directly to the employee, then we will probably conclude that the complaint is within our jurisdiction.

But where we find the employer is effectively reinsuring its own clear contractual liability to pay sickness benefits, or is merely protecting the business – for example, with a 'key man'-type policy – then we might conclude that the complaint was *not* taken out for the employee's benefit and is *not* one we are able to deal with.

The fact that individuals other than the person who complains to us might also benefit under the policy does not automatically exclude the complaint. We look carefully to see if there is a direct or indirect link between the payments made by the insurer and the payments the employer makes to the employee. If we are satisfied that the employer is contractually obliged to make payments to the employee only if the insurer accepts the claim – then we are likely to conclude that the complaint is within our jurisdiction. In such circumstances the policy was clearly taken out for the benefit of the employee.

Of course, if the employer has a turnover of less than £1million and is well-disposed towards its employee, it may bring the complaint to us in its own right as the firm's customer.

### commercial complaints

Firms are sometimes confused about whether we can investigate *relevant new complaints* about commercial policies. A *relevant new complaint* is one where:

- the matter complained about occurred before the Financial Ombudsman Service effectively existed (that is, before 1 December 2001); *but*
- the complaint was not made to us until *after* 1 December 2001.

Because the *relevant predecessor scheme* – the Insurance Ombudsman Bureau – was not empowered to consider commercial disputes, there is a statutory instrument that prohibits us from considering *relevant new complaints* unless the complainant is an individual and the complaint does not concern aspects of a policy that relate to a business or trade carried out by the complainant. This is in the rules at DISP 2.4.15G.

Some firms have interpreted this to mean that we cannot look at commercial complaints where the *insured event* (that is, the fire, the flood, the theft, *etc*) occurred before 1 December 2001. This is incorrect. The customer is not complaining about the insured event but about the firm's decision on, or handling of, the claim. And if this occurred months after the insured event took place (*as it may well have done*) and, moreover, it was after 1 December 2001, then the complaint is properly within our jurisdiction. Provided the commercial complainant's turnover is less than £1million, there should be no reason why we cannot investigate.

**... we need to assess whether the policy was taken out for the benefit of the individual who has complained to us.**

## case studies – some jurisdiction issues in insurance cases

### 32/7
**jurisdiction decision – group PHI policy – whether complainant eligible**

XYZ Ltd held a group personal health insurance policy with the firm and offered health insurance to its staff. In July 2001, one of its employees (Mr W) made a claim under this policy, but the firm turned it down. When Mr W said he would take his complaint to the ombudsman, the firm told him the complaint was outside our jurisdiction. The reason it gave was that XYZ Ltd, not Mr W, was the policyholder, and XYZ Ltd had not given consent for us to consider the complaint.

Despite this, Mr W decided to refer his complaint to us.

**complaint outside our jurisdiction**
While firms do sometimes express a view to customers about whether or not they think a complaint is within our jurisdiction, this is ultimately a matter for us to determine. In this particular case, we decided that the complaint was indeed outside our jurisdiction.

This was a *relevant new complaint* – one where:

- the matter complained about occurred before the Financial Ombudsman Service effectively existed (that is, before 1 December 2001); *but*
- the complaint was not made to us until *after* 1 December 2001.

Under our rules, we therefore had to look at how the relevant predecessor scheme – in this case, the Insurance Ombudsman Bureau (IOB) – would have treated the complaint.

Mr W was complaining about the fact that the firm had turned down his claim. It did this in July 2001, which was before the Financial Ombudsman Service effectively existed. The IOB's terms of reference said it could not consider a complaint unless the complainant was the policyholder, or the policyholder had given express permission.

The policyholder in this case, XYZ Ltd, had not given us permission, so we were unable to look at the complaint.

**... we had to look at how the relevant predecessor scheme would have treated the complaint.**

■ **32/8**
**jurisdiction decision – whether employee was eligible complainant – was key man policy taken out for his benefit?**

DP Ltd was a company with an annual turnover of over £1million. When Mr A (one of its employees) was off sick for some time, DP Ltd made a claim to the insurance firm on his behalf. The firm turned down the claim. It told DP Ltd that the complaint could not be referred to us. It said the matter would be outside our jurisdiction because the size of DP Ltd's turnover made it ineligible to complain to us. Mr A subsequently brought the complaint to us himself.

**complaint outside our jurisdiction**
The firm had been correct in telling DP Ltd that it was not eligible to complain to us. But we needed to establish whether Mr A was an *eligible complainant*.

When we asked for further information about the policy, we discovered it was not a personal health policy as we had been led to believe. It was a 'key man' policy (insurance taken out on the life of an individual – in this case, Mr A – whose serious illness or death would create a loss of earnings for the company).

The policy was not taken out for Mr A's benefit, but for the benefit of DP Ltd. It was not designed to pay salary or sick pay to Mr A and there appeared to be no direct or indirect link between any payments the firm was liable to make and any payments that Mr A might receive.

We therefore concluded that the complaint was outside our jurisdiction.

■ **32/9**

**jurisdiction decision – commercial policy – whether event pre-dated 1 December 2001 – what is the relevant 'event'?**

Mr D was the owner of a hotel that was badly damaged during an arson attack in August 2000. A couple of months later, he put in a claim under his commercial policy. The firm paid it. However, it turned down a further claim that Mr D made in September 2001 for business losses and sundry expenses in connection with the fire.

When the firm rejected Mr D's complaint about this, he came to us.

**complaint outside our jurisdiction**

The firm argued that Mr D's complaint was outside our jurisdiction because the fire had occurred in August 2000, before the Financial Ombudsman Service effectively existed.

We came to the conclusion that the complaint *was* outside our jurisdiction, but not for the reasons given by the firm.

This was a *relevant new complaint* about a commercial policy. It therefore needed to be looked at in accordance with the *Ombudsman Transitional Order*. The relevant date was *not* the one on which the fire had taken place – August 2000 – but the date when the firm turned down Mr D's claim – over a year later. However, in this particular case, this was still before 1 December 2001, so the complaint was outside our jurisdiction.

■ **32/10**

**group PHI policy – whether case within jurisdiction – employer was policyholder – whether employee an 'eligible complainant'**

Mr H worked at GJ Ltd, a large supermarket that offered private health insurance to its staff. After a period of ill health, Mr H put in a claim to the insurance firm. When the firm refused to pay, Mr H referred his complaint to us.

**complaint within our jurisdiction**

The firm argued that the complaint was not one we could deal with because neither GJ Ltd nor Mr H were *eligible complainants;* GJ Ltd because it was a commercial customer with an annual turnover of over £1million, and Mr H because the policyholder was GJ Ltd, not him.

**... the complaint *was* outside our jurisdiction, but not for the reasons given by the firm.**

We found that the complaint *was* within our jurisdiction. It was true that, because of its size, GJ Ltd was not an *eligible complainant*. However, Mr H was. Under the rules (DISP 2.4.12R), we were able to look at this complaint because '*... the complainant [was] a person for whose benefit a contract of insurance was taken out or was intended to be taken out*'.

It was clear that the policy was taken out for the benefit of GJ Ltd's employees, including Mr H. For the complaint to be within our jurisdiction, it was not necessary for Mr H to be the only person to benefit from the policy. The fact that the employer also benefited was immaterial.

**some of the jurisdiction issues that arise include territorial scope, as the following case illustrates**

■ **32/11**
**jurisdiction decision – complainant resident in Jersey – firm based in Jersey – territorial scope of our jurisdiction**

Mrs S, who lived in Jersey, rang us to ask if we could look into her complaint against a financial services firm based in the Channel Islands.

**complaint outside our jurisdiction**
Under the rules (DISP 2.7.1), the territorial scope of the Financial Ombudsman Service '*covers complaints about the activities of a firm... carried on from an establishment in the United Kingdom*'. The Channel Islands are not part of the UK and therefore not subject to the regulatory requirements of UKfinancial services law.

If the firm complained about had a registered office in England, Wales, Scotland or Northern Ireland, and the transaction complained about had been carried out there, then we might have been able to help. As it was, however, the complaint was outside our jurisdiction. We suggested that Mrs S should contact the Jersey FinancialServices Commission to see if it could help with her complaint.

**... the Channel Islands are not subject to the regulatory requirements of UK financial services law.**

# 3 investment case round-up

## illustrating some of the investment complaints we have dealt with recently

■ **32/12**
**life assurance policy – request for waiver of premiums made 'too late' – whether firm should reconsider granting the request**

After suffering a heart attack, Mr F needed heart bypass surgery and he was seriously ill for some months. Nine months after his heart attack, Mr F contacted the firm to ask for a 'waiver of premiums' for his life assurance policy (in other words to suspend his payments for a period). He was still not well enough to return to work, even part-time, and his earnings had been substantially reduced.

When the firm told him that it was unable to consider his request, Mr F came to us.

**complaint settled**
Under its policy conditions, there were certain circumstances in which the firm could allow policyholders to suspend payments temporarily. These circumstances included ill health, but the policyholder had to apply within six months of becoming ill. So the firm said Mr F had left it too late to apply.

Mr F and his wife told us that the months following his heart attack had been very traumatic and there had been some doubt as to whether he would survive. Mrs F said that her only concern during this period had been her husband's health. It was only when his condition improved that they were able to start thinking about other matters, including their finances.

We accepted that the firm was not under any contractual obligation to agree to the couple's request. However, we suggested that in view of the couple's circumstances and the seriousness of Mr F's illness, it should review its decision. The firm agreed to waive the premiums for a certain period.

■ **32/13**
**medium-risk ISA sold to cautious investors – whether adviser explained risk of investment**

Mr and Mrs D lived on a very modest income and had no investment experience. They were very pleasantly surprised when they inherited £14,000 from a distant relative. After seeking advice from an independent financial adviser, they invested all of the money in a medium-risk Individual Savings Account (ISA) fund.

Two years later, very disappointed with the ISA's performance, they complained to the firm, saying they would have been better off leaving the money in a simple deposit account. The firm told the couple that some degree of risk was inevitable with the type of investment they had chosen, so they came to us.

**complaint upheld**
The adviser agreed that the couple had been inexperienced and cautious investors. However, he said that once he had explained to them how ISAs worked, the couple '*became more at ease with the idea of*

*adopting a medium-risk investment approach*'. Mr and Mrs D denied that their attitude to risk had changed, as the adviser suggested. They said he had not discussed risk at all.

The adviser told us he had advised Mr and Mrs D to invest only £10,000 of their inheritance. And he said he had suggested they put half of this in the ISA and the remainder in a low-risk bond. He said the couple had ignored this advice and wanted to invest *all* of the money they had inherited and to put it all in the ISA. So he said that he had carried out the couple's instructions against his better judgement.

We pointed out to him that the letter he had sent the couple shortly after their meeting had recommended investing the full £14,000 in the ISA. And his notes of the meeting with Mr and Mrs D recorded that they were cautious investors. If the couple had indeed acted against his advice, then we would have expected him to have made a formal note of this.

We concluded that the advice had been inappropriate and we told the firm to pay the couple the difference between the current value of their ISA investment and the amount they would have got if they had put the money in a straightforward deposit account over the same period.

## 32/14
## endowment policy cashed in early – whether policyholders entitled to at least a proportion of the terminal bonus

Mr and Mrs B decided to cash in their endowment policy a year before it was due to mature. They were very disappointed when the firm said they were not entitled to receive a terminal bonus. It said this was only payable to policyholders who held on to their policies until the maturity date. But the couple said that since the policy only had a year to go before it matured, the firm could at least give them a proportion of the terminal bonus.

Dissatisfied with the firm's response, Mr and Mrs B came to us. They said that they had been discriminated against because the firm had treated them less fairly than other policyholders. They claimed there was nothing in the policy's terms and conditions that excused such discrimination.

**complaint rejected**

We examined the terms and conditions of the policy, together with other documents the firm had sent the couple. We wanted to check there was nothing that might have led them to believe they would get some form of terminal bonus if they cashed in their policy early. However, we found nothing to support the couple's view.

We pointed out to Mr and Mrs B that it was entirely a matter for the firm's commercial judgement whether policyholders should get any proportion of the terminal bonus if they cashed in their policies early. The rules under which we operate say that '*The Ombudsman may dismiss a complaint without considering the merits if he... is satisfied that it is a complaint about the legitimate exercise of a firm's commercial judgement*.' (Rule 3.3.1(11)).

We therefore dismissed the complaint.

# *working* **together**


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# ask ombudsman news
## your questions answered

### *dead-end for mortgage endowment complaint?*

**Q** A client of the advice bureau where I work has reached a dead-end with his mortgage endowment complaint.

In 1987 he took out a mortgage through his building society. It directed him to a life assurance firm to get an endowment policy to cover the mortgage. He's now discovered that the policy probably won't produce enough to repay his mortgage. But when he complained to the building society, it just didn't want to know. It said it wasn't responsible for the advice he received and that he should complain to the life assurance firm. When he did this, the insurer didn't want to know either. It said the building society was responsible.

He is a customer of both firms, yet neither will help him. What should he do?

**A** In the past, relationships between financial firms were sometimes more complicated than they are now. This can lead to difficulties in finding out who is responsible for the advice that was given. The Financial Services Authority lays down rules for firms about how they should deal with their customers' complaints.

When a dispute arises and it is unclear who was responsible for giving the advice in question, we expect the firms involved to get together and agree a way forward – so that the customer's complaint is handled appropriately and in accordance with the rules.

Unfortunately, in your client's case the firms appear simply to have laid the responsibility at each other's doors. It's not our role to resolve disagreements between firms. However, if your client contacts our consumer helpline – 0845 080 1800 – we can consider the issue as a whole and see if we can establish which firm has responsibility for the original advice and, therefore, for considering the complaint.

### *telling customers about the ombudsman service*

**Q** I work for a small firm of financial advisers and we've just had our first-ever complaint. I know we're supposed to tell the customer about the ombudsman service. Is it OK just to give him a page or two printed-off from your website?

**A** No. You must give your customer a copy of the leaflet – *your complaint and the ombudsman* – as required under the FSA rules. The leaflet is available in packs of 25 at £5 per pack – including postage. You will need to send us a cheque with your order – made payable to Financial Ombudsman Service Limited.

For more information and an order form – look on the publications pages of the frequently asked questions section of our website (www.financial-ombudsman.org.uk) or call us on 020 7964 0370.