ombudsman news

essential reading for people interested in financial complaints – and how to prevent or settle them

Financial Ombudsman Service

welcome to ombudsman news

Walter Merricks
chief ombudsman

Welcome to the second insurance issue of ombudsman news. We were delighted to receive such a positive reaction to our January issue. Do please continue to send us your comments and suggestions.

Ombudsman news covers a wide range of topics this month, starting with loan protection insurance. Complaints reaching us show that sufficient care is not always taken to ensure the suitability of policies for prospective policyholders. Restrictions which significantly limit the cover available are not always made clear before purchase, and the exclusion of claims for mental illness is something that causes us particular concern in this regard.

We also look at some of the problems caused by lack of clarity in insurers' documents. In recent years there have been considerable improvements to policies and other literature. However, even when insurers use simple, everyday terms, they can still sometimes fail to communicate as clearly as they should do.

Other issues we discuss this month include:

- legal expenses insurance
- the "sum insured" and problems arising when claims exceed this amount
- minimum security requirements in household and caravan policies
- keys left on or in cars, a topic revisited in the light of a recent Court of Appeal decision; and
- a summary of our complaints-handling procedures.

in this issue

loan payment protection

ensuring suitability

Most borrowers are urged to protect their loans by taking out insurance to meet the repayments if they become unable to work. But the people who sell this type of insurance are often not specialists in this field and some have little or no knowledge of the policy terms. Their "advice" will therefore not be of great assistance to borrowers, who may be uncertain what they are paying for and unable to judge whether it is suitable for them.

The Code of the Association of British Insurers (ABI) - shortly to be replaced by the Code of the General Insurance Standards Council (GISC) - requires the seller to "ensure as far as possible that the policy proposed is suitable to the needs and resources of the prospective policyholder". But many of the complaints we receive indicate this has not happened.

When determining whether a policy is suitable, a seller - whether a lender or an agent for the insurer - must obviously take into consideration any information the prospective policyholder volunteers. However, we do not consider the seller's duty is limited simply to recording what the borrower discloses. It is only by asking questions that the seller can properly determine suitability. These questions cannot cover every aspect of a borrower's personal position and should not be expected to do so. To paraphrase the ABI Statement, only those matters deemed to be relevant by the insurer should be the subject of questions.

ensuring suitability

If sufficient care were being taken to ensure suitability, we would not be continuing to see complaints from borrowers who have been sold insurance for which they were clearly not eligible. For example, most policies exclude from cover anyone who is not "actively working" on the date of the sale. Take the case of a borrower who is incorrectly sold a policy while on sick leave and later submits a claim, which the insurer refuses to meet. The insurer can leave the borrower in a serious financial predicament if, acknowledging the unsuitable sale, it refunds the premiums. The borrower's predicament will, of course, be even more serious if his house is at risk. We generally take the view that insurers should meet claims in circumstances.

It is also common for policies to include additional eligibility requirements concerning the insured person's age and number of hours worked each week. Some policies exclude from cover anyone who is self-employed or employed on a short-term contract. Other insurers deem such borrowers eligible for cover, but restrict the benefits available to them under the policy. The ABI Statement on Payment Protection Insurance requires that

"details of the main features of the cover as well as **important and relevant restrictions will be** made available and **highlighted at the time the insurance is taken out** with full details being sent afterwards" (our emphasis).

If the insurer fails to ensure sellers meet these requirements, we regard this as indicating that it waives any right it might have to avoid giving effect to the insurance.

extending the debt

When existing borrowers extend their debt, it is common for the lender to issue a new loan incorporating all the borrower's liabilities. This will result in the sale of a new insurance policy, but it can leave the borrower unprotected, at least for part of the loan.

For example, if a borrower has consulted a doctor before the new policy comes into force, any illness that is later diagnosed as being related to the symptoms for which the borrower saw the doctor is unlikely to be covered.

And if the borrower then becomes unemployed, he or she will not be able to claim during the initial period excluded by the policy - often the first 90 days.

Insurers have generally accepted liability for such claims under the borrower's previous policy (if there was one). However, where the new loan is significantly larger than the old one, the borrower could be left without protection for the balance of the repayments.

In such cases, we need to satisfy ourselves that the borrower was told of the effect of the new policy provisions or, at the very least, that the borrower would have acted in the same way if he or she had been told of them, and that the borrower has not therefore been prejudiced by the seller's failure to highlight these restrictions.

claims for mental illness

Another type of claim has caused us real concern. Almost all policies exclude claims which arise from stress or other forms of mental illness. We have seen a number of complaints recently where this restriction has meant an unemployed claimant has been left with no recourse.

It seems to us that the clear distinction that was once made between physical and mental illnesses has largely disappeared. Illness (or for that matter disability) is generally understood to cover a range of medical conditions with both physical and mental symptoms and causes. Media reports suggest that some 50% of all illness may be due to mental causes. Excluding claims for all mental illnesses is therefore a significant limitation of cover, and should be made clear to purchasers before the policy sale is completed. An example of such an exclusion states:

"No claim shall be payable hereunder if ... caused or aggravated by any psychiatric illness or any mental or nervous disorder."

Clearly, mental or nervous disorders, such as stress or depression, can be difficult to verify and diagnose with confidence - and insurers are concerned about the potential for numerous claims where it would be difficult to assess claimants' fitness to work. Some insurers have addressed this by excluding mental illness only where the claimant has not received treatment or been referred to a consultant. These insurers will accept claims where the insured person is receiving treatment or seeing a consultant for their condition.

For insured persons who are made redundant and then suffer from depression, the situation is more complicated; they will generally be unable to claim for either unemployment or disability. Unemployment claims are subject to proof that the claimant is seeking work, but a sick claimant will not be in a position to sign on.

Thus, the mental illness exclusion will defeat a disability claim and the effect of the redundancy exclusions means that the unemployment claim will also fail. Neither of these exclusions is generally unreasonable, but we are concerned about their combined impact. Redundancy is likely to be a difficult time and symptoms related to stress and/or depression must be common in such cases. When someone's sole reason for not looking for work is that they are sick, we consider it unreasonable for an insurer to reject an otherwise justified claim by relying on the largely procedural requirement that a claimant be registered as unemployed and actively seeking work.

It is relevant to contrast this situation with that of someone who is made redundant and then suffers an illness which, if it had arisen before the redundancy, would have given rise to a successful claim under the policy's disability section. At face value, both claimants would be in a similar position. The wording of the redundancy provision which requires a person to look for work would apply and, generally, policies of this type require the claimant to be in employment on the day the disability started. Despite the wording of these policies, in a number of cases we have concluded the insurer should pay benefits in such circumstances. In essence this is because either the redundancy claim would be valid were it not for the disability or the disability claim would be valid were it not for the previous redundancy.

Of course, where an insurer offers on-going payments in the case of redundancy, it is not unreasonable that it wishes to confirm that a claimant is seeking new employment. But it is also not unreasonable for it to accept that people made redundant may sometimes suffer periods of ill-health which prevent them seeking work for a time but have little, if any, impact on their prospects for re-employment.

When looking at individual cases, we therefore need to consider whether the illness was so severe that it would have prevented the person from working. We also need to consider the extent of any prejudice to the insurer's position (that is, how likely it is that the insured person would have found work were it not for the illness).

loan payment protection insurance case studies

04/1 loan protection - joint insureds - calculation of benefit - whether each insured entitled to full monthly benefit.

Mr and Mrs H took out insurance to protect their joint mortgage repayments, choosing a monthly benefit of £500. In October 1998, Mrs H became unemployed and submitted a claim. The insurer made monthly payments of £250. Mrs H and her husband argued that she was entitled to £500 per month. In their opinion, the policy covered each of them for that amount. They said this was what they were told when they bought the policy and it had been confirmed in the insurer's letter accepting the claim.

The insurer did not accept this argument, stating that the policy explained clearly how benefit would be calculated. However, it offered £50 compensation "for the errors and incorrect advice".

how we helped

Neither the application form nor the insurance certificate explained the amount of monthly benefit that would be paid in the case of joint applicants. Both documents showed the amount of the monthly benefit required as £500 and contained no more than a general reference to the booklet which detailed the conditions. There was no specific reference to the limitation of cover in the case of joint borrowers.

The layout of the conditions booklet was confusing and unlikely to help anyone wishing to ascertain the position for joint borrowers. On Page 4, "monthly benefit" was defined as "the amount you have agreed with us as specified in your certificate of insurance" but there was no reference to the limitation that applied to joint borrowers. The sections of the booklet, "What we will pay", "What we will not pay" and "How to claim" also failed to reveal the relevant limitation.

The limitation was, in fact, set out under the heading "Eligibility" -"If the mortgage has been taken out by joint borrowers who are all eligible for cover ... each borrower's cover is limited to an equal share of the monthly benefit, eg if the monthly benefit is £600 and there are three borrowers eligible for cover, each would be covered for £200".

The insurer appeared to have accepted at an early stage that there was some substance in the complaint. It accepted our recommendation that it should make an additional payment to Mrs H on the basis that her true entitlement was to benefit payments of £500, plus interest. It also increased its compensation offer to £200.

04/02

loan protection - accidental death - meaning of "accidental".

A young couple, Mr and Mrs R, had mortgage payment protection insurance which included accidental death cover. When Mrs R died suddenly, her husband claimed the policy benefit.

The insurer made enquiries and was advised that the cause of death was pneumococcal meningitis and pneumonia. It rejected the claim on the ground that an accident.

Mr R argued that the policy defined "accident" as "a sudden unforeseen unintentional violent external event" and that his claim was therefore valid, particularly as the policy did not exclude death by sickness or disease.

how we helped

An exclusion for death by sickness or disease would only be necessary if the definition of "accident" were wide enough to include such deaths.

It was not. Mrs R's death resulted not from an accident but from a viral infection. We accepted that the death was accidental in the sense that it was not anticipated. However, it could not be regarded as due to a "violent external event" in any ordinary use of that term.

We did not agree there was any ambiguity in the policy terms and we considered the insurer was entitled to reject the claim.

04/03

loan protection - eligibility - self-employed insured on "maternity leave" - whether "actively working at her business".

Mrs M was a self-employed dietician for a dieting organisation. After the birth of her child in February 1998, she did not return to work for some months. In June 1998, while she was still unemployed, a lender telephoned to offer a loan to her and her husband, who was in full-time employment. She was also offered insurance to cover the repayments and she agreed to take out both the loan and the insurance. The paperwork named only Mrs M as the borrower but she did not consider this important.

Mrs M returned to work in September 1998, but was offered less work than previously and her earnings were only £12 per week. Her husband fell ill in November and was diagnosed as having a brain tumour.

When the couple put in a claim for disability benefits, they were told the policy did not cover him. Mrs M contended that when the policy was sold she had provided full details of her husband's earnings and her own status, and had discussed the recent birth of their child.

how we helped

It was up to the insurer to prove that the policy had been properly sold and that the sale complied with the provisions of the ABI Code. The insurer was clearly aware that Mrs M was both self-employed and on "maternity leave". Since she was not "actively working at her business" she was not eligible for the policy.

However, we did not consider that the insurer's refunding the premium constituted an appropriate resolution of the dispute.

We accepted the insurer's contention that the policy could have been transferred into the husband's name at Mrs M's request. However, we did not agree that her failure to make such a request meant she had deliberately chosen not to take out cover for her husband. We were satisfied that the policy had not been properly explained at the time of the sale.

The appropriate outcome was for the insurer to amend its records to include the name of the husband on the policy and to meet his disability claim.

04/04 loan protection - unemployment - fixed-term contract - whether claim for unemployment at end of fixed-term contract valid.

A university lecturer, Dr J, took out a loan with loan protection insurance in May 1999. On 1 October that year, he became unemployed and claimed benefit under the insurance. The insurer rejected his claim, stating that the policy did not cover unemployment occurring at the end of a fixed-term contract.

Dr J maintained that his claim was covered, as the policy stated that the exclusion did not apply because he had been "in continuous work for the same employer for at least 24 months, and [his] contract has been renewed at least twice and [he had] no reason to believe that it would not be renewed again".

However, Dr J's employer stated that his contract had been from 20 January 1997 until 1 October 1999 and that he had been told on 27 October 1998 that it would not be renewed.

how we helped

It was clear that Dr J had been aware before taking out the loan that he would become unemployed on 1 October 1999. There were no grounds for requiring the insurer to make any payment to him. Moreover, on the facts, Dr J did not meet the other conditions of the exception as there was no evidence that his contract had been renewed twice.

04/05 loan protection - disability - exclusion for any mental or nervous disorder - insured made redundant and affected by stress - whether insurer liable for disability or unemployment benefit.

Miss K was made redundant in January 1999. She subsequently became unwell and her GP signed her off with depression. When she submitted a claim for disability benefits under her loan payment protection insurance, the insurer rejected it on the ground that the policy specifically excluded claims "caused or aggravated by any psychiatric illness or any mental or nervous disorder".

She was unable to claim unemployment benefit because her illness prevented her from signing on. She was not therefore "actively seeking new employment". Miss K maintained it was unfair to deny her benefit on either ground because of her circumstances.

how we helped

We were concerned about the impact of the two exclusions on the claimant. Redundancy is likely to be a difficult time for anyone and stress and/or depression can be common. The policy clearly excluded any claim for mental illness, so Miss K was not entitled to disability benefit.

However, since she would have been entitled to redundancy benefits if she had not been signed off with depression, we did not consider it would be fair for her to forgo all benefits. In the circumstances, we concluded that payment of 50% of the maximum benefit was appropriate.

04/06 loan protection - insured unable to sign on as disabled - whether unemployment claim valid - whether payment of disability claim reduced entitlement to unemployment benefits.

Mr E was employed as a courier/driver from November 1998 until spring 1999. He submitted disability claims for benefits under a number of loan payment policies, stating that he had been signed off work by his GP from 13 April 1999 for whiplash injuries and anxiety.

When the insurer asked for confirmation of Mr E's employment, his employer stated that his last day at work was 11 April 1999, although on Mr E's P45 the employer had given the date as 31 March. The employer refused to answer all further enquiries from the insurer.

The insurer rejected the claim on the ground that Mr E had ceased working before becoming unwell. However, after Mr E won a claim for unfair dismissal at an industrial tribunal it agreed to review the claim. The insurer paid Mr E disability benefits under the three policies from 13 April until 12 December 1999, the date when his GP said he was fit for work.

Thereafter, Mr E submitted an unemployment claim and was paid benefit under one of his policies for the balance of the policy maximum of 360 days. The insurer rejected Mr E's claims on the other policies because he had cancelled the policies.

Mr E said he had only done this because the insurer had refused his disability claims.

how we helped

complaint upheld

Mr E had taken out protection against both disability and unemployment and both these misfortunes had befallen him at the same time. His first sick note was dated 12 April, immediately after his employment was terminated.

We therefore considered that a separate maximum benefit period applied for the unemployment claim and that the insurer should not have combined this with the disability claim. Both policies clearly provided for a maximum unemployment benefit of 360 days. So Mr E's claims should not have been limited by the payment of the earlier disability benefits and his unemployment benefit should have run from the date he was first able to sign on.

With respect to the two cancelled policies, we put it to the insurer that Mr E had cancelled them simply because of justifiable frustration at the handling of his claims, not because he no longer wished the insurer to consider claims under those policies. The insurer agreed to treat the claims as if the policies had continued in force.

how no one else knew her PIN. We found her account of what had happened, including what she'd said to the police, to be consistent and plausible. And taking everything into account, we didn't think the bank had shown she'd been grossly negligent with either of these things.

We recognised that there was a limited number of people that could have made the transactions. But on balance, we didn't think it was more likely than not that Jas had made or authorised the transactions – or that she'd been grossly negligent. So we told the bank to refund the two disputed transactions.

04/07 loan protection - unemployment - exclusion for employees working outside UK - insured employed abroad but registered as unemployed in UK - whether claim valid

Mr D worked as an oil industry welder in the UK. In March 1999 he bought a car on hire purchase and took out insurance to cover the loan repayments. In June 1999 his employment was terminated. He obtained work as a welder through an agency in Manchester and was employed in Belgium from August 1999 until January 2000, when that job was terminated. He then returned to the UK and signed on as unemployed.

The insurer rejected his claim for unemployment benefit on the ground that the policy contained an exclusion for anyone working outside the UK.

how we helped

Mr D was a UK citizen who had returned to the UK and was registered for employment here. This was not a case where there was a need for the insurer to make enquiries of the relevant authorities abroad to see whether he met foreign criteria for state benefits. We considered that Mr D had complied with the spirit of the policy terms, if not with the strict wording. The insurer agreed to our recommendation that it should meet the claim and reimburse any penalties charged by the lender.

legal expenses insurance

One of the most common complaints about legal expenses insurance concerns who chooses the policyholder's legal representatives. Both parties feel strongly about this. Insurers consider that their panel of solicitors has the relevant expertise to deal with any type of legal proceedings, and that these solicitors' costs are properly controlled.

Policyholders take the view that only someone they have chosen will represent their interests vigorously and impartially. In many cases, they are unsure whether a solicitor chosen by the insurer will represent their interests, or the insurer's. And they frequently complain that the firm of solicitors chosen by the insurer is in a less convenient location than their preferred firm. The fact that both parties may be giving instructions to the same solicitors only complicates matters.

The Insurance Companies (Legal Expenses Insurance) Regulations 1990 gives policyholders the right to choose a lawyer. However, they can only exercise this right after administrative or legal proceedings have started. The effect of this qualification is to dilute the policyholders' right. Policyholders may - with some justification - feel reluctant to exercise their right when it means they will be appointing solicitors to take over mid-stream. Indeed, they may not always be able to afford to choose new solicitors. This is because some insurers require policyholders to meet the new solicitors' costs for updating themselves with the work done by the previous firm.

The converse also gives rise to disputes. Where policyholders have paid for legal advice before notifying the insurer of a claim, they will not unnaturally wish that same firm to continue with their case. However, their insurer may prefer to insist that a solicitor from its own panel takes over the action. We do not always support insurers in this position, despite the fact that, legally, they are entitled to make a new appointment. This is for two reasons. First, the current firm will already be familiar with progress to date and appointing a new firm will require duplication of effort and expense. Second, the replacement of the original firm may only be temporary, since it is highly likely the policyholder will insist on returning the case to them as soon as possible.

We consider that insurers should take a pragmatic approach. Where one firm is already familiar with all the background and is dealing satisfactorily with the case, it will generally not be sensible for the insurer to involve another firm unless, for example, the new firm has superior expertise. Otherwise, insurers risk alienating their policyholders to little or no advantage.

legal expenses insurance case studies

Many of the legal expenses complaints we consider involve employment or property disputes. The following is typical of the complaints we receive concerning property disputes.

04/08

legal expenses - policy covering "acts any affecting policyholder's legal rights" - policyholder claiming cover to determine his legal rights - whether claim valid.

When Mr and Mrs G bought their house in July 1997, they found their drive obstructed by a fence panel which their neighbours had erected. They could not reach agreement with their neighbours as to the correct boundary and, in February 2000, the neighbours issued proceedings.

Mr and Mrs G notified their legal expenses insurer that they were claiming indemnity for their legal costs. The insurer rejected their claim, stating that the policy only covered "any act which affects [their] legal rights arising out of or to do with [their] living in or owning [their] home". The insurer contended that until Mr and Mrs G had proved that their rights had been affected by the neighbours' action, it had no liability to provide any indemnity.

how we helped

If the court decided that Mr and Mrs G were wrong, then it could not be said that the neighbours' act had affected their legal rights. Nevertheless, it could not be correct that cover only operated after the issue in dispute had been determined.

The insurer was, of course, entitled to receive sufficient evidence to show that a "prima facie" case existed, but in our view the policyholder could establish his "rights" by producing evidence, such as documents, before the case had come to court.

In this instance, in April 2000 the policyholders' solicitor had sent the insurer documents which established that Mr and Mrs G had a prima facie case, and the insurer had not explained why the claim was not covered. We upheld Mr and Mrs G's complaint and the insurer agreed to provide indemnity for all "reasonable and necessary costs" they had incurred since 28 February 2000, the date when it had rejected the claim.

calling a spade a shovel - lack of clarity in policy documents

It is hardly surprising that misunderstandings occur when some insurers appear to share the view of Lewis Carroll's Humpty Dumpty that "a word means what I want it to mean." Insurance jargon is not for the uninitiated. Most insurers recognise this and devote much time and thought to the wording of their policies. But however straightforward the words in the policy may appear, lack of clarity can persist.

Insurers tend to forget that many of their most frequently used terms have a meaning in common usage that is different from the very specific meaning they intend in their policy. In such cases, unless they make their intended meaning very clear, their use of language may be misleading.

In the January 2001 issue of ombudsman news, we discussed how the term "chronic" is often misinterpreted. Our casework reveals many other examples. For example, most policyholders will be familiar with the word "valuables" from everyday usage. However, insurers often use the word to include items that most of us would not normally consider as valuables.

One travel policy defines "valuables" as including "photographic, audio, video and electrical equipment of any kind (including CDs, video and audio tapes), telescopes and binoculars, antiques, jewellery, watches, furs, perfumes, leather goods, animal skins, silks, precious stones and articles made of or containing gold, silver or precious metals."

Since an overall limit of £250 applies to "valuables" under this policy, the loss of - say - a few audio tapes, a leather jacket and a pair of binoculars could easily go well beyond the policy limit.

Motor insurers, too, sometimes fail to make it clear what is covered. We receive far too many complaints from people - usually young people - who have been caught driving without insurance. Almost invariably these are not reckless people who have chosen not to take out insurance. Typically, they are responsible individuals who mistakenly believed their policy covered them for driving other cars because of the policy wording "you are covered if your policy schedule includes this risk". The policy schedule will be silent unless the risk is included, but many people fail to understand the significance of the omission. They ask why the exclusion was not made clearer. The insurers' response is "We do not have to state that the risk is excluded - it just was not included".

As we have noted, most of these complainants are young. Insurers know very well that young people drive one another's cars. That is why cover for driving other cars is included for most drivers - other than young ones. Insurers are, of course, legally correct in saying they are not obliged to state everything a policy does not cover. However, it seems to us that where a particular situation regularly causes problems, it would be in the best interests of motorists, insurers and the general public if insurers made the correct position abundantly clear.

As a general rule, motor insurers are highly sceptical when drivers wish to include their children on their policies as named drivers. Sometimes the aim may be to obtain insurance for young drivers at a lower premium than the young drivers could obtain themselves. However, many parents simply wish to allow the newly qualified driver to use the family car occasionally.

We have upheld a number of complaints despite insurers' allegations that the proposers deliberately misrepresented their position. Instead of asking a prospective policyholder who the main car user will be, some insurers simply ask "Do you have access to another car-" This question is less clear than it might appear. What does "access" mean- If someone drives his mother's car once a year, does he have access to that car- Does it make any difference if she lives nearby-

If insurers require information about the number of cars in the family, they should ask that very simple question. The ABI Statement requires insurers to ask "clear questions" about "matters generally found to be material" and this seems the simplest solution to an increasingly common problem. Setting traps for unwary proposers does not help anyone.

The layout of policies, too, can be a source of confusion. In many policies the exclusions are printed on different pages from the paragraphs they modify. This can mean policyholders are unaware of relevant exclusions until their claims are rejected. In our experience, many complaints would be avoided if, for example, exclusions from theft cover were printed next to the paragraph setting out what the insurer will pay for.

When we consider cases we will look first to the common usage meaning of words. Unless insurers bring exceptions clearly to policyholders' attention, they will find it difficult to argue cases which rely on a specific definition which would not be generally recognised by policyholders. Insurers should call a spade a spade.

case studies - lack of clarity in policy documents

04/09

household contents - policy limits - limit for high risk items - whether insurer making limits clear to policyholder.

The insurance Mrs M arranged for her household contents had a standard limit of £7,500 for high risk items. She was sent confirmation of her policy details which stated:

"Your policy will be issued with a limit of £11,500 for High Risk Items and a High Risk Item single article limit of £1,000. If you require the total High Risk Items limit to be increased, please state the amount required. If there are any High Risk Items which exceed £1,000, please provide the descriptions and values in the box below."

Mrs M provided the insurer with details of a number of items she wished to specify separately. When she was burgled, the loss adjusters recommended settlement of her claim at £11,504.09 for the high risk items and £7,179 for the specified articles. The insurer refused to make these payments, stating that Mrs M was under-insured. It said the values she stated for the high risk Items should have been sufficient to include all the specified items as well as those not specified.

How we helped

The insurer had failed to make the policy limits clear to Mrs M. The wording of the confirmation details was not plain and Mrs M and the insurer had different recollections of their conversation before the policy was issued. We were not satisfied that the insurer had asked clear questions, as it was required to do under the ABI Statement.

We concluded it was not appropriate for the insurer to reduce the claim because the high risk items limit was insufficient to include the items specified separately. We considered it should meet the claim in full, subject to deduction of the additional premium it would have charged.

04/10 household contents - policy limits - valuables - conflicting limits - whether both limits had to be drawn to policyholder's attention.

Mrs L had a collection of ornaments and claimed £1,200 under her household insurance when her granddaughter accidentally damaged some of them. Initially, the insurer rejected her claim, stating that she had not chosen the optional accidental damage policy extension to her contents cover. She disputed this and the insurer accepted that the ornaments came within the definition of "valuables" for which she was covered. However, it sent her a cheque for only £500, the maximum payable. This was because the policy stated that the single article limit applied to "any item, collection or set".

how we helped

There was no doubt that the damaged items were part of a collection or set. However, we agreed with the policyholder that there was a discrepancy in the policy wording. The schedule simply referred to the single article limit and did not mention collections or sets. That limit appeared only on page 21 of the policy.

Moreover, this was a significant restriction which should have been clearly drawn to Mrs L's attention. It would not be difficult for the £500 limit to be exceeded by almost any collection of jewellery, pictures or works of art. The insurer accepted our view that the claim should be met in full.

04/11 personal possessions - mobile phone – cover for lost property - exclusion for unattended property - whether exclusion a significant restriction on cover.

Mr B bought a mobile phone and insured it. The policy provided an indemnity if the phone was lost or stolen. However, it specifically excluded "theft or damage arising where equipment is left unattended by the insured ... in any property, place or premises or in or on any form of public conveyance".

After a shopping trip, Mr B reported that his phone had been lost or stolen, probably after he had left it on a shop counter. The insurer repudiated liability, in accordance with the exclusion. It also contended that Mr B was in breach of a policy condition to take all reasonable precautions to prevent loss or damage.

how we helped

Within 20 minutes of realising that he did not have his phone, Mr B returned to the shop where he thought he had left it. The phone had clearly been "unattended" during his absence. However, by applying the exclusion to losses as well as to theft claims, the insurer had severely restricted the cover it purported to provide. This exclusion should therefore have been drawn to Mr B's attention before he bought the policy. Since the insurer could provide no proof that this had happened, we did not consider it could rely on the exclusion.

As to lack of reasonable care, the insurer had to prove that Mr B had been reckless and there was no evidence of this. Mr B had acted inadvertently and had not shown any lack of care. We therefore required the insurer to reimburse the cost of the phone and to add interest to its payment.

04/12 household buildings - landslip - exclusion for "faulty design" - boundary fence failing to prevent landslip - whether design of fence "faulty".

The house Mr A bought in 1992 was part of a new development whose back gardens overlooked a railway embankment. His garden was separated from the top of the embankment by a large fence, set into the embankment with tall posts similar to telegraph poles.

By the following year, the fence was leaning outwards over the embankment and a fissure appeared in the lawn. Mr A replaced the fence and built a patio over the lawn. But by 1995, both were showing signs of downward creep. A new fence was put up in 1997, but did not remedy the problem, so Mr A claimed for the cost of stabilising his property.

The insurer refused indemnity. It concluded that the original fence was built to retain the embankment and its replacement had failed to prevent movement of the site. As the policy excluded damage due to "faulty design", it said it had no liability for the cost of repairs.

how we helped

We appointed a surveyor to advise whether the original fence had been constructed in order to retain the embankment. He concluded that the builder had not taken the possibility of landslip into account and that the design of the fence could not be regarded as faulty. In any event, we were not persuaded that a fence could "retain" an embankment which lay below it.

We required the insurer to deal with the damage to Mr A's property. However, it did not have any liability for stabilising the embankment. The embankment was not part of Mr B's property and such works would constitute significant betterment.

04/13 travel - cover terminating on return home - policyholder returning home before end of trip - whether cover in force.

Mr and Mrs N took out holiday insurance to cover them from 6-30 October 1998. They spent the first part of their holiday in Italy, where they met an old friend, Mr G. They decided to return home earlier than they originally intended - on 26 October. They planned to collect fresh clothes and provisions before setting off for Wales with Mr G. However, after Mrs N had dropped off her husband at home, together with Mr G, while she went to fill up the car with petrol, she was killed in an accident.

Mr N made a claim under the policy for death benefit of £60,000. However, the insurer said the policy stated that cover "finishes immediately [they returned] to [their] home ... for any reason". Mr N argued, first, that his wife had not returned home since she had merely dropped him off there with Mr G before going to the filling station. Second he contended that the insurance had not expired because the policy was due to continue until 30 October.

how we helped

The personal accident section of the policy stated that benefit was payable while the policyholders were on their "trip". This was defined as "any journey or holiday ... which starts and finishes in the United Kingdom ... for which [the policyholder has] paid the premium".

We considered the word "trip" was wide enough to cover a two stage holiday, even though that holiday was broken by a stopover at the travellers' home, provided that it was over by 30 October. The insurer accepted that Mr N had a valid claim for benefit and interest.

04/14 travel - policy limits - loss or theft of cash - whether limits clear.

Mr T took out "gold plus" travel insurance to cover his holiday in Corfu. The policy included cover for loss of money. A table on the front of the policy stated that the limit of cover was £500, although it also said "This is a guide only. Please read the terms and conditions of this insurance". The policy terms provided:

"We will pay up to £500.00 for the loss or theft of cash or travel cheques, if you can give us evidence that you owned them and evidence of their value. We will pay up to £300.00 for cash for travel outside Area 1 and up to £150.00 for places within Area 1 for gold plus cover, winter sports cover and multi-trip cover only." Area 1 was defined as Europe.

Mr T's money was stolen while he was on the way to Corfu. The insurer settled his claim subject to the £150 gold plus cover limit. Mr T argued that the proper limit was £500, which the insurer had several times confirmed as applicable.

how we helped

The policy document was confusing. The first line stated that the insurer would pay up to £500 if a claimant could provide evidence of ownership and value. Mr T had done this. However, the insurer argued that the rest of the section contained a limitation. This was not clear to the reader. Indeed, it was not clear whether the insurer would ever pay up to £500 if the upper limit outside Area 1 was set at £300.

We were satisfied not only that the limit had not been pointed out to Mr T, but that he had been assured there was cover for up to £500. We recommended that the insurer should pay Mr T the outstanding balance between its settlement and his loss, up to £500, and it agreed to do this.

04/15 medical expenses - exclusion for treatment related to engagement in professional sport - meaning of "professional sport".

The policyholder had insurance to cover his family's medical expenses and submitted claims for the cost of treatment for his daughter, a member of the Great Britain Ladies Hockey Team. The insurer made enquiries and established that she had been given an award from the Sport England Lottery Fund (World Class). It considered that treatment of her sports injuries was excluded under the policy. This was because it decided the treatment consisted of "care and/or treatment arising from or related to engaging in professional sport".

The policy defined "professional sport" as "a sport where a fee or benefit in kind is received either directly or indirectly for playing or training". The policyholder stated that the Inland Revenue did not treat the lottery grant as "income". He said the insurer had not notified him when it added this restriction to the policy and he denied his daughter was a "professional" player.

The insurer did meet the claims, but it did not admit liability. The policyholder was dissatisfied with the way the insurer had handled matters and claimed compensation for the distress and inconvenience caused by the insurer's disputing liability.

how we helped

The insurer seemed to have interpreted its definition of "professional" sports people as including those who were seriously committed players. This extended the definition beyond its generally accepted meaning. The lottery grant was not directly related to past or future appearances, performance or training requirements; it could more properly be described as a charitable donation. We did not agree that it was a "fee or benefit in kind" or that receiving this payment had altered the status of the policyholder's daughter from amateur to professional. We agreed with the policyholder that the insurer was liable for the cost of his daughter's treatment.

However, the insurer's handling of the claims was not unacceptable. We had not agreed with the insurer's interpretation of the exclusion, but the judgment was a fine one and the insurer's position was not without merit. Any annoyance the policyholder had experienced did not amount to material maladministration. We therefore concluded it would not be right to award any compensation.

exceeding the sum insured

The sum insured is an important component of most household policies and policyholders need to take reasonable steps to assess this amount as accurately as possible. We will support those insurers which reduce payments to policyholders where the total sum insured is clearly quite inadequate to cover the property at risk.

However, assessing the correct amount is not an exact science and it is evident from our caseload that many policyholders find it a genuinely difficult assessment to make. Even where they have made a full and honest attempt to value all their household contents, they may be under-insured. We therefore take a sympathetic line where more detailed scrutiny by a loss adjuster suggests the sum insured may be somewhat short of the true replacement cost.

Policyholders can find valuation a significant problem in the case of contents policies, but it may be even more acute a problem in the case of buildings policies. Rebuilding costs are something that most householders can only guess at.

Householders purchasing a property with a mortgage will usually obtain this valuation from the lender's surveyor. Many other policyholders will rely on the purchase price (a notoriously poor indicator of rebuilding costs).

Even where the purchaser has obtained a good rebuilding cost estimate, it may not represent the maximum potential cost of rebuilding. Albeit rarely, actual rebuilding costs can necessarily exceed the sum insured; an example is given in case study 04/16 on page 20. We do not believe it reasonable in such cases for the insurer to rely on the maximum sum insured to limit their liability. It is precisely this sort of unusual eventuality that policyholders expect their insurance to cover.

case studies - exceeding the sum insured

04/16

household - sum insured - inflation-linking causing policyholder to be over-insured - whether policyholder entitled to premium refund.

Mrs G and her aunt had, for many years, held household buildings and contents insurance for their two-bedroom terraced house in Wales. The policy was inflation-linked and premiums increased by 15% annually. Mrs G did not query the sums insured until 1999, when her daughter began managing her affairs. The annual premium had increased by then to £1,674.91. The contents were insured for £141,488 and the buildings sum insured was £212,042.

The correct amounts should have been £40,000 and £55,000 respectively. The insurer accepted that the values for both buildings and contents were far too high and it offered a rebate of £1,000 and a further year's cover without charge.

How we helped

Although it was the policyholder's responsibility to assess the replacement cost, the consequence in this case of the firm's applying an automatic annual increase was an insured value which was totally unjustified. If the policyholder submitted a total loss claim, the sums insured would have had no bearing on the insurer's liability.

We considered a fair result would be achieved if the insurer refunded 50% of the premiums paid over the previous five years, with interest, and it agreed to do this.

04/17

household contents - minimum security requirements - policyholder noting requirements before start of insurance - whether policyholder entitled to compensation for distress and

Mr C telephoned the insurer on 12 June to ask about household insurance. He wanted the cover to start on 1 July. When he received the policy documents, he was dismayed to learn that cover depended on his complying with a minimum security condition. He protested, saying no one had mentioned this when he enquired about the policy, and he cancelled the policy on 21 June.

The insurer returned his premium in full but rejected his demand for a payment of £3,000 as compensation for the inconvenience he said the insurer had caused him.

How we helped

The insurer recorded most calls made to its call centres and we were able to listen to tape recordings of Mr C's conversations with the insurer's staff. On several occasions, matters of security had been discussed at considerable length.

We were therefore surprised that Mr C alleged he had not been told of the insurer's requirements. He had not been put to any unnecessary inconvenience and we agreed that the insurer was fully justified in refusing to pay compensation.

04/18 household buildings - sum insured - reinstatement - whether insurer entitled to limit cost of reinstatement to sum insured.

Following a serious fire at Mrs Y's house in March 1999, the insurer appointed loss adjusters to assess the damage. They considered that repairs would not exceed the sum insured of £110,000. They also calculated that the sum insured was too low and that the cost of rebuilding would be £135,000. Mrs Y increased the sum insured to the amount they recommended.

The insurer paid over £7,000 for emergency works to make the property safe, but there was bad weather in April and further damage occurred. When tenders for the repairs came in, however, the lowest was for £139,250. The insurer agreed to reinstate the property, but it limited repair works to a total of £103,000 - the sum insured less the cost of emergency work. This was sufficient to rebuild the property, but left the first floor a shell.

Mrs Y said she had been promised that if she increased the sum insured to the amount the loss adjusters recommended, the insurer would meet the claim in full and would make no deduction for under-insurance.

how we helped

The policy gave the insurer the option of making a cash settlement, repairing, replacing or reinstating. The insurer had clearly opted to reinstate and was therefore bound to replace as new, with no deduction for wear and tear or depreciation. The cost was accordingly not limited to the sum insured.

If the insurer wished to impose a ceiling of £110,000 on its liability, it had to communicate that to the policyholder. It had not done this until after the house had been demolished and it could not impose the limit in the middle of agreed works. We required the insurer to meet the full cost of reinstatement.

04/19 maladministration - confidentiality - insurer disclosing information in breach of policyholder's instructions - whether compensation payable.

Mr D insured his house and garage with one insurer, while the business property, which he stored in the garage, was insured by a different insurer. When he made a claim under the business property policy, the loss adjusters appointed by that insurer wrote to Mr D's household insurer, seeking information. The household insurer responded, confirming that it insured the house and garage, giving the policy number, and stating that no claim had been received.

Mr D was extremely aggrieved to learn that his household insurer had provided information to the loss adjusters, asserting that this was in breach both of his specific instructions and the Data Protection Act. He demanded £60,000 compensation for damage to his stock. The household insurer accepted that it should not have released information to the loss adjusters. It offered Mr D £100 in recognition of the distress and inconvenience it had caused.

how we helped

There was no link between the household insurer's unauthorised disclosure of information to the loss adjusters and any loss by Mr D. No evidence had appeared which indicated that the disclosure had influenced the loss adjusters' handling of the business insurance claim. In the circumstances, we were satisfied that the insurer's offer was appropriate and we stated that we would not require it to increase its offer or to contribute to Mr D's alleged losses.

04/20 household - sum insured

Mr J insured his house for an index-linked sum - £285,000 - when he renewed the insurance in 1993. In February 1995, he discovered landslip damage to his tennis court. He appointed an engineer and notified the insurer. It became apparent almost immediately that the damage was progressing rapidly and, in March 1995, the insurer agreed to pay for emergency work to stabilise the site.

This work did not halt the slippage and a meeting was held in June 1995 to discuss possible remedies. Mr J asked the insurer to settle his claim by declaring the property a total loss and paying the full sum insured. However, the insurer's loss adjusters were of the opinion that the insurer's liability was limited to underwriting the cost of remedial work up to the sum insured.

Work continued, becoming more complicated as time went on, until eventually the site was stabilised. The insurer informed Mr J that the sum insured had been exhausted.

He complained, asserting that the insurer had elected in June 1995 to reinstate the property instead of making a cash settlement, and that it was therefore bound to meet the balance of the full cost of repairing his house. This was estimated at £145,000.

how we helped

Cases of catastrophe such as this are fortunately very rare. The sum insured had been correctly calculated and was sufficient to cover the rebuilding and associated fees, as stipulated in the policy. However, it was not sufficient to cover the additional cost of stabilising the site. Although insurers are generally aware there is a theoretical possibility of rebuilding costs exceeding an adequate sum insured, the insurer in this case had not advised Mr J of this possibility.

The insurer had never agreed to reinstate the property regardless of cost. However, we did not accept it was appropriate for it to limit its settlement of this claim to the sum insured.

The insurer had been closely involved in approving repairs and, once they had begun, both the insurer and the policyholder had effectively been committed to their completion. It was reasonable for Mr J to believe his property would be fully reinstated and he could not be said to have been indemnified if he was left with a badly cracked house on a stable site.

More generally, Mr J was not in a position to assess the likelihood of such rare combinations of events when he decided on the sum insured. The sum insured was generally accepted to be appropriate and we concluded that, in such cases, the sum insured should not act as an absolute cap on the insurer's liability. We therefore required the insurer to pay £100,000 towards Mr J's repair costs. We also recommended the insurer to meet the balance of his costs, although we had no jurisdiction to make a binding award for any amount in excess of £100,000.

minimum security requirements

These are of particular relevance in two types of insurance - household and caravan policies. Our view is well established: insurers must alert their policyholders to any significant requirements before the insurance comes into force. It is not sufficient simply to send out the documentation and rely on policyholders reading it to notice the standards they are required to meet.

Nor is it sufficient to rely on a question on the proposal regarding security arrangements. If the insurance depends on policyholders having certain security devices in place, then that must be drawn to consumers' attention before they commit themselves to the insurance.

If, when applying for the insurance, a consumer claims, incorrectly, to have certain locks, and the insurer subsequently rejects a theft claim because of this mis-statement, we will expect the insurer to demonstrate that it had only agreed to issue cover on the basis that the policyholder had the specific locks which he or she claimed, incorrectly, to have.

In our view, a policyholder who has failed to comply with the security requirements in force will not lose protection under the policy unless failure to comply is relevant to the loss. If, for example, the policyholder agreed to have his or her window locks secured whenever the house was empty, but then forgot and was burgled, it would not be reasonable for the insurer to reject the claim unless the burglars were able to get into or out of the house by means of an unlocked window.

Many caravan insurances stipulate that theft cover will not operate unless the policyholder has taken various security measures. One insurer requires the following:

"The caravan must have an effective hitch lock which protects the coupling security bolts, in addition to a proprietary heavy duty wheel-clamp with a high security integral lock".

If the caravan is unattended for more than 24 hours, it must be kept **"in a properly fenced and securely locked storage compound with the following minimum requirements: security lighting, mobile security patrols and/or resident caretaker or owner or operator of the storage location whose private dwelling shall be situated immediately adjacent to the sole access point of the compound".**

In addition, if the caravan has a value in excess of £5,000, it is required to have its own security lighting and alarm systems.

These requirements are not typical, nor would they be matters of obvious common sense for most consumers. They must therefore be highlighted before consumers commit themselves to taking out the policy. As a general rule, the more unusual and burdensome the terms of the policy, the greater the insurer's duty to ensure consumers are aware of these terms before they pay for the policy.

case studies - minimum security requirements

Many of the legal expenses complaints we consider involve employment or property disputes. The following is typical of the complaints we receive concerning property disputes.

04/21

household buildings - cover dependent on satisfactory survey - delay by insurer in arranging survey - whether policyholder prejudiced by cancellation of cover.

Miss F had a mortgage valuation survey carried out in November 1998 before she purchased her rented property. The surveyor noted the presence of minor hairline differential cracking and a slight bulge in one wall. He concluded there was no indication of recent or continuing movement and suggested the most likely cause was historic bomb damage. Miss F telephoned the insurer asking for insurance cover. Policy documents were issued on 15 December, with the proviso "Cover is provided subject to a satisfactory building survey."
The insurer did not have the survey carried out for two months, but progressive movement was then identified and the insurer cancelled the policy. Miss F was dissatisfied and asserted that the insurer's delay in carrying out the full survey had prejudiced her.

The insurer maintained that she was advised during her initial telephone conversation that cover was conditional on a satisfactory survey and it stated that the risk did not meet its underwriting criteria. However, it agreed to extend cover until May 2000. Miss F remained dissatisfied and sought compensation.

How we helped

It was not possible to determine whether Miss F was advised of the need for a full survey during the telephone conversation. Even if she was, she might not have acted any differently. She was clearly aware of the cracking and did not consider it significant. Moreover, she had the opportunity of cancelling the policy when she received confirmation of the proposal, highlighting the insurer's requirement.

However, the delay in carrying out the survey was regrettable and the insurer's decision to cancel the policy meant Miss F would almost certainly be unable to find alternative cover.

The insurer accepted that its delay had prejudiced Miss F. It would now be extremely difficult for her to go back to her last insurer or to find another. We considered the insurer should reinstate the policy without conditions, which it agreed to do. However, we did not think there was any justification for awarding compensation in addition to reinstating the policy.

04/22 caravan - minimum security requirements - theft - whether theft linked to breach of requirements - whether insurer entitled to reject theft claim.

Mr J submitted a claim for the theft of his caravan and its contents. The insurer rejected the claim on the ground that he had not complied with the policy's security requirements. The caravan's storage facility did not have security lighting and the gate to the caravan park had been unlocked.

Mr J pointed out that he had fitted the caravan with a hitch lock and wheel clamp and that the park had some 25 other caravans. Although he accepted that there was no security lighting, he stated this was usual and that, in any event, lighting would not have deterred the thieves.

how we helped

There was no evidence as to whether the theft had taken place at night or in the daytime or whether the gate was open or merely unpadlocked.

In the circumstances, we were not persuaded that Mr J's failure to comply with all the security requirements was linked to the theft. The ABI Statement says that insurers will not reject claims on the ground of a breach of condition unless the loss is connected with the breach. We therefore recommended that the insurer should meet the claim in full and it agreed to do so.

04/23 caravan - minimum security requirements - theft - whether policyholder's failure to secure caravan justified rejection of theft claim.

Mr S purchased a caravan on 20 June 2000. He took it on a trip on 10 July and brought it back on 13 July, when he left it at a friend's house for four days. He was aware that he needed to buy a wheel clamp and other accessories, but on 16 July, before he had done so, the caravan was stolen.

The insurer rejected Mr S's theft claim on the grounds that he had failed both to exercise reasonable care and to safeguard the vehicle, because it had no wheel clamp and was neither attached to a hitch post nor stored in a secure compound. Mr S explained that he had been about to comply with the insurer's requirements but the caravan was stolen before he could do so.

how we helped

Although the caravan had been left unsecured for only a short period, the policy endorsement applied regardless of the length of time. We were satisfied that Mr S knew which precautions he was required to take and had simply failed to secure the vehicle when he left. In the circumstances, we were satisfied that the insurer's rejection of his claim was justified.

keys left in or on cars

In the January issue of ombudsman news, we set out our general position regarding claims where cars have been stolen when the keys were left in or on them. We noted that at least one case (Hayward v Norwich Union) was being considered by the courts and might provide us with further guidance on our stance.

Following the Court of Appeal decision in Hayward v Norwich Union (February 2001, unreported, The Times Law Reports, 8 March 2001), we have reviewed the position. We concluded that we do not need to adjust our approach materially as a result of this judgment. Lord Justice Peter Gibson decided that the policy exclusion where the "keys of your car have been left in or on the car" meant that the person leaving the keys had caused them to remain in the car, or allowed them to remain there, and had moved away from the keys.

A review of the cases we summarised in our January issue shows that applying this test would produce the same results for those cases. In case 1/06, we would not regard someone who leaves the engine running while he opens his garage door as having moved away from the car. The conclusion in case 1/07, by contrast, was reached because the policyholder had not been made aware of the exclusion. She had clearly moved away from the car when she went into the filling station kiosk to pay.

The test of "going away" from a car cannot be precisely formulated. It must be judged in a common sense way on the basis of the individual circumstances of each case. The fact that a theft occurred is not sufficient to demonstrate that the policyholder was not close enough to make a theft unlikely. The relevant consideration here is whether the degree of proximity made the prevention of the theft likely, not whether it made the theft impossible (or indeed whether theft was, of itself, likely).

In practice we can do no better than consider whether the policyholder:

- was in reasonable proximity to the vehicle
- was able to keep it under observation; and
- would have had a reasonable prospect of intervening.

An important factor in assessing the degree of proximity required will be the nature of the location. The responsible person needs to be nearer to a car left in a busy street (or petrol forecourt) than to a car left in the middle of an empty field.

This exclusion is now reasonably commonplace, but nonetheless comes as an unpleasant surprise to most policyholders. They will often have expected the insurer to meet claims for theft arising from some carelessness on their part, in just the same way as they expect it to meet a claim for a road traffic accident. We expect insurers to word exclusion clauses clearly in their policies and to highlight them for the policyholder. Where they fail to do this, we are unlikely to agree that they are entitled to reject the claim.

how we handle complaints

The ombudsmen for the different financial sectors have now been together under one roof for a year.

All now work for the Financial Ombudsman Service - but continue to operate under the rules of the original schemes until the Financial Ombudsman Service's own rules come into force on the date we call "N2". The government has said this will be no later than the end of November 2001.

In preparation for the new regime we are introducing common complaint-handling procedures throughout the Financial Ombudsman Service. Our new procedures are designed to be flexible and we will want to maintain an active dialogue with both the firm and the customer in our handling of cases.

customer contact division

Our customer contact division (formerly enquiries) is the common point of entry for all customers, whether their complaint concerns an insurance, banking or investment matter.

This division does not investigate complaints, but will check if there seems to be a good chance of settling the matter right away, without the need to convert the complaint into a case requiring investigation. This will be a progressive change and, of course, it remains a matter for the individual firm to respond initially to its customers' concerns in accordance with good complaint-handling procedures.

If, when the customer first contacts us, we conclude the firm has not had an adequate opportunity to respond to the complaint, we will contact the firm, setting out the concerns the customer has raised with us. We will ask the firm to resolve the matter and will tell the customer what we have done.

time limits for dealing with a complaint

We will ask firms to try to resolve complaints, or issue a "decision letter", within 8 weeks of the date the customer first complained to the firm. If those 8 weeks have already expired by the time the customer contacts us, we will:

- notify the firm that we have received the case
- take on the complaint
- request the firm's case papers; and
- make the case chargeable (one for which we charge the firm a fee) without further delay.

Of course, there will be situations where the firm may, unavoidably and for good reason, need extra time. For example, it may be awaiting an independent report from a surveyor or medical practitioner or the customer may have significantly delayed the process.

In such cases and at the firm's request, we may recommend that the customer allows the firm extra time before we start our formal investigation. However, such requests should only be made in exceptional circumstances.

casework division

Our casework division will adopt a similar approach to case resolution to that followed in the customer contact division. If, once a complaint moves through to the casework division, the division thinks a case can be brought to an early conclusion, we will attempt to give an initial view of the case's merits by telephoning or writing to one or both parties, as appropriate. Again the aim will be to achieve a prompt conclusion.

Our assessment team (formerly the new cases unit) in the casework division, has, since last September, focused on the early resolution of cases through mediation. Insurers and customers have generally responded favourably. By placing greater emphasis on this initial stage of the process, we aim to resolve all straightforward cases at the assessment team stage. If appropriate, an ombudsman will make a decision where the proposed mediated settlement is not accepted.

Where we consider our assessment team cannot resolve a case by mediation, we will pass on the case to one of our adjudicators for a formal investigation. As now, the adjudicator will seek opportunities wherever possible to reach an agreed settlement by setting out an "initial view". An initial view is not binding and either party can ask for a full investigation. However, we may decline to carry out a full investigation if we feel the facts of the case are clear. In such instances, we may proceed instead to a formal decision by an ombudsman.

If, while we are looking into a complaint, either party raises any significant points, we may disclose them to the other party if we believe this will help the fair resolution of the dispute.

We expect to resolve most complaints through conciliation. However, for more complex or intractable cases, we will complete a full investigation During that investigation, the adjudicator will put points to the firm or the customer for comment, if this seems appropriate. When the investigation is complete, the adjudicator will issue a "conclusions letter" to both parties simultaneously. This will enclose a report setting out the main facts of the case and the adjudicator's conclusions, based on the merits of the case.

ombudsman's decisions

If the adjudicator's conclusions are not acceptable to both parties, the case will be referred to an ombudsman for decision.

An ombudsman may sometimes consider it necessary for a fair resolution to first call a hearing, to consider material disputes about the facts of the case.

When the ombudsman's "final decision letter" is issued, it will be sent to both parties, simultaneously, and, as now, there will be no appeal.

customer information

We have produced a new leaflet for customers:

"taking your insurance complaint to the Financial Ombudsman Service: how we can help you".

Or click here for details of how to obtain copies of this leaflet and our other publications.

getting ready

With the new rules in mind, firms should now be reviewing their own arrangements for handling complaints. For example, it will be important to ensure that formal decision letters mention the Financial Ombudsman Service as a potential avenue for the complainant wherever the matter seems to be one that might be within our jurisdiction. If you need to know more about the new rules, and how they may affect your complaints-handling arrangements, we'll be happy to help. See the back page for more details.