

July 2001

Financial Ombudsman Service

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Aimed at financial firms and professional advisers – and at consumer advice agencies – we focus each month on news from one of our three case-handling divisions: investment, banking & loans – and this month – insurance

## about this issue of ombudsman news

by **Tony Boorman**  
principal ombudsman  
insurance division

It's holiday time again for the insurance ombudsmen! Airport delays and flight cancellations, lost baggage, accidents, illness, and even – in a few tragic cases – deaths. The holidays we look at are usually the ones where the holidaymaker is pleased to return to work! In this edition of *ombudsman news* we feature a selection of recent cases illustrating different aspects of travel insurance. We also highlight some of our concerns.

When assessing claims relating to medical conditions, insurers frequently require medical reports. It is becoming increasingly common for doctors to charge a fee for such reports, but practice appears to vary among insurers as to whether the policyholder or the firm should pay. Our views are frequently sought about this and on page 22 we highlight some of the issues and invite your comments.

Motor insurance provides the case studies for our discussion about our approach to 'innocent non-disclosure', where policyholders have unintentionally failed to disclose a material fact to their insurers.

In this edition we also explain the approach we take when assessing whether a complaint involving a group insurance policy falls within our jurisdiction. And we announce details of the new rate of interest we will use in all awards we make from 1 September 2001 onwards.

As always, we welcome your comments about *ombudsman news*. Please let us know if there are any particular topics you would like us to include in future editions.

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# 1 travel insurance

**...for many customers, travel insurance is perhaps the most complex financial product they purchase during the year.**

Complaints about travel insurance account for about one in eight of our cases. Unlike car or household policies, travel insurance is normally sold as an add-on to another product – typically to the holiday itself but also, increasingly, as part of a wider set of benefits provided by a financial services firm. Where it is sold as a stand-alone product, customers seem more often influenced by price rather than by details of the cover provided, and rarely, if ever, by the quality of claims administration. However with ten or more different types of cover being provided, travel policies are far from straightforward. Indeed for many customers, travel insurance is perhaps the most complex financial product they purchase during the year.

The General Insurance Standards Council (GISC) Code for private customers commits members to ***'make sure, as far as possible, that the products and services we offer will match your requirements'*** and to ***'explain all the main features of the products and services that we offer including: ... all the important details of cover and benefits; any significant or unusual restrictions or exclusions; [and] any significant conditions or obligations which [the policyholder] must meet'***. The GISC code builds upon the ABI (Association of British Insurers) Code, where compliance is widely recognised as haphazard at best for most sales of travel policies.

Our experience is that not enough is done by the industry to explain these policies and to correct many of the common misconceptions about their scope. There is a general expectation that travel policies provide a financial remedy for almost every loss which can occur on a holiday, although almost all travel insurance policies contain strict limitations as to the sort of loss covered and the amounts the insurer may have to pay.

The circumstances of most travel policy sales mean that if customers consider the product in any detail at all, they place considerable emphasis on the brochure or other introductory documentation they receive. Insurers often give potential policyholders a 'cooling-off period', during which they may cancel the policy and receive a full premium refund. Some firms argue that this is sufficient to ensure the product's suitability, since it allows customers time to read the policy and return it if it does not meet their requirements. However, we do not agree that it is reasonable to expect customers to familiarise themselves with an insurance contract without any guidance at the point of sale. For travel insurance, with its unusually complicated provisions, we would expect purchasers to rely heavily on the guidance they receive from the person selling the policy and from any brochure or summary they have received.

The main risks covered by travel policies are cancellation, curtailment, medical expenses and loss or theft of baggage. Each of these, not to mention other reasons for claiming, such as personal accidents or delayed transport, give rise to disputes – illustrated in the cases summarised below.

### **cancellation**

There are many reasons for cancelling a holiday. All policies cover cancellation due to the accidental injury, illness or death of the policyholder or other closely connected person, but there are many exclusions. One of the main causes of dispute is the exclusion for any existing medical condition or for a condition about which the consumer has seen a doctor before buying the insurance. We frequently receive complaints from policyholders who have interpreted this as meaning that only illnesses that have been diagnosed are excluded. However, the standard exclusion applies to *all* medical conditions, regardless of whether the policyholder's doctor has identified the cause of the problem. The only exception would be illnesses where an incorrect diagnosis has been made and the true cause is only determined after the claimant has bought both holiday and insurance.

Where the person who is ill is not the policyholder but a family member, or someone with whom the policyholder was planning to travel, the exclusion for pre-existing medical conditions may be more onerous. Most of us do not have full details of other people's medical history. When investigating complaints of this type, a detailed enquiry may be required to establish both the precise state of health of the person concerned and also what the policyholder should reasonably be taken to have known.

Policies normally also include cover for cancellation due to missed departures, although the cover provided is strictly limited. Cancellation due to a disinclination to travel because of a change in personal circumstances – such as the end of a romance – will not normally give rise to a valid claim. Only a truly unforeseen cause will fall within the policy cover.

### **curtailment**

Two disputes are common: whether the insurer is entitled to rely on the exclusion for pre-existing medical conditions and whether it was 'medically necessary' for the policyholder to cut short his holiday. Some travellers who feel unwell decide to return home without consulting the insurer's emergency helpline, arguing that their ill-health was not sufficiently serious to warrant such a call. We do not generally accept that there was any need for them to terminate the holiday. On the other hand, we frequently uphold complaints from policyholders who are seriously unwell and confined to their hotel rooms, even though

**... there is a general expectation that travel policies provide a financial remedy for almost every loss which can occur on a holiday.**

## ...a more unusual problem arises where the policyholder's only loss is the air ticket.

they have not been hospitalised or repatriated. However, we will only uphold their partners' claims if we are satisfied there was a medical need for a partner to stay with the patient.

A more unusual problem arises where the policyholder's only loss is the air ticket. Here, an insurer might argue that there has been no 'loss', as the policyholder has used both parts of the ticket. However, this would only be the case if the airline has allowed the policyholder to change the scheduled return date in order to go home early. Where the airline does not allow the policyholder to alter the ticket, the insurer will, in appropriate circumstances, pay for the flight home. It seems doubly unfair that the policyholder will not be compensated merely because their arrangements could be altered. Few people would, for example, choose to pay for a return flight to Australia if they knew they would have to come home only a few days later. In situations such as these, we have considerable sympathy for the argument that the cost of the flight should be reimbursed proportionately, bearing in mind the number of days actually spent on holiday compared to the length of holiday originally scheduled. Such a settlement may be the fair and reasonable result, even if the insurer was not strictly liable to make a payment.

### **Medical expenses**

Here again the policy will not cover any illness which started before the policyholder bought the insurance. However, many policies

recommend potential policyholders to telephone a medical helpline for advice:

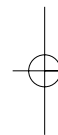
- n if they have recently seen a doctor
- n if they are taking medication or having any treatment *or*
- n if they are on a waiting list for tests or results.

Once the extent of the existing problem has been clarified, the insurer may then decide to offer cover for claims arising from that condition and whether to charge an additional premium. At the very least, the customer will know definitely what the position is.

Where we are satisfied that the insurer failed to make it clear that there was no cover for any claim arising from a pre-existing medical condition, and did not stress the importance of contacting the helpline, we take the view that the insurer cannot rely on the exclusion to reject a claim.

Medical expenses cover is of real importance in some countries, such as the USA, but in others, such as Europe or Australia, its value is less because of the local healthcare provision. Nevertheless, the possibility that the policyholder might need an air ambulance, or to be repatriated by stretcher, makes this form of cover an important and expensive aspect of any travel policy.

We seldom support the consumer in complaints about the standard or availability of care in a holiday destination. Insurers agree to pay for the cost of appropriate treatment, not to ensure that it is available, much less to



## ...few claimants appreciate that there are limits affecting different parts of their loss...

ensure it will meet UK standards. Decisions about repatriation will depend on the advice of the local practitioner. The fact that, with hindsight, the course of action recommended was inappropriate, is not a cause for complaint. Only when we are satisfied that an insurer has refused to sanction proper treatment will we overrule decisions taken by the medical advisers.

Most policies restrict the activities which those covered by the insurance may undertake while still retaining their cover for medical expenses and personal accident benefits. People requiring cover for 'adventure' holidays should make sure the insurer has full information about all the activities contemplated. If they do not, the insurer is likely to refuse any indemnity if there is an accident. This applies to claims from both the policyholder and anyone else, in respect of injuries or property damage.

Confusion sometimes arises if the policy does not make it clear what activities the insurer regards as 'hazardous'. This is not always obvious and, in accordance with the legal maxim that the party responsible for drafting the policy wording bears responsibility for any ambiguity, the terms will be construed in favour of the other party. Since insurance contracts are almost always drafted by the insurer, the benefit of any doubt is normally given to the consumer. For example, if the policy contains a list of hazardous activities, it would not be right to give force to further exclusions which are contained only in a different segment of the policy.

### **baggage**

The bulk of the travel insurance complaints we consider concern baggage. The main area of dispute is the application of various exclusions and limits. Most policies contain exclusions for 'unattended' baggage or baggage left in vehicles (although different provisions are common amongst insurers). Typically, insurers will reject losses in their entirety where the claimant cannot produce receipts or a written police report. Few claimants appreciate that there are limits affecting different parts of their loss, such as 'valuables', 'money' and single article limits.

Examples of the limits which might apply are:

<b>Baggage and personal effects</b>	up to £1,500
Maximum for any one article, pair or set	£250
Limit for all valuables (see definition)	£300
Activity equipment	£500
<i>Excess</i>	£50
<b>Money and documents up to</b>	up to £500
Maximum for all banknotes, currency notes and coins in custody of one person (regardless of ownership)	£200
<i>Excess</i>	£50

The fact that travel insurers normally settle claims on an indemnity basis, paying a depreciated value rather than the cost of replacement as new, also comes as a shock to many. Indeed, the need to provide receipts for every item poses difficulties for many claimants. And most policyholders appear not to understand that they will forgo a part of their claim when the insurer, seemingly adding insult to injury, deducts an excess (or more than one) from any settlement.

Travel policies do not offer redress against all the things that may go wrong during a holiday. If the industry made this clear when marketing these policies, and improved both the clarity and simplicity of policies and the information available at the point of sale about what is and is not covered, then the disappointment so often expressed by consumers might well be avoided.

In the absence of compliance with industry codes and in the face of complex policies, it will be for the ombudsmen to consider where the reasonable expectations of policyholders should be met.

**...travel policies do not offer redress against all the things that may go wrong during a holiday.**

## case studies – travel insurance

07/1

### n **travel – accidental death benefit – exclusion for ‘hazardous activities’ – whether exclusion brought to insured’s attention.**

Mr H took out an annual travel policy for his two adult sons before they went to America in May 1999. The insurer took approximately three weeks to issue the policy and then sent it to Mr H. As he was away at the time, the sons were unable to check – before they set out on their trip – whether the policy was suitable for their needs. In fact, it was not. It restricted cover for individual trips to 30 days, whereas they planned to be away for 74 days, and it did not cover claims arising from hazardous activities, including riding motorcycles over 125cc.

The following April, one of Mr H’s sons went out to Australia. Whilst there, he had a fatal accident riding a 600cc motorcycle. Mr and Mrs H put in a claim for repatriation and funeral expenses and for the accidental death benefit of £30,000.

The insurer explained that, because of the motorcycle exclusion, the policy did not provide any cover. However, it accepted that it had not sold, issued or explained the policy correctly. It therefore met the repatriation and funeral expenses as a gesture of goodwill. Mr and Mrs H did not accept that the motorcycle exclusion was valid, since it had not been drawn to their attention, and they felt they were entitled to the full death benefit.

**complaint rejected**

Mr H bought the policy specifically for the trip to America and had decided to buy an annual policy because of the length of the trip. The insurer had accepted that the policy had not been properly sold and it confirmed that it would not have relied on the exclusions or restrictions to repudiate any claims arising during the trip to America.

However, by the time of the second trip, the family was aware that the policy did not cover all hazardous activities and the policyholders had had ample opportunity to check whether the policy was appropriate for their needs and to request an amendment if necessary. The policy was, in any event, due to lapse shortly after the son’s departure to Australia yet they had not checked that it would cover the trip or the activities he planned. In these circumstances, we took the view that the insurer’s offer to pay the repatriation and funeral costs was reasonable and that it had no liability for the death claim.

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07/2

n **travel – baggage – temporary loss – meaning of ‘temporary’.**

Mr and Mrs N flew to Barcelona to join a cruise and the airline lost Mr N’s baggage. He notified the cruise operator and was advised that the insurer would reimburse emergency purchases. He bought some shirts and, some days later, other clothing. His bag was found fairly quickly and was sent to the ship when it docked at Athens.

Mr N claimed £345 from the insurer. It sent him a cheque for £150, explaining that this was the maximum payable for temporary loss of baggage. The insurer submitted a claim to the airline and in due course received £150, which it regarded as reimbursement of its payment to Mr N.

Mr N argued that his claim should not be limited because the loss was not ‘temporary’. He had restricted his purchases until the ship had left port and had no means of knowing when or if his bag would be found.

**Complaint upheld in part**

We accepted that a claimant could not know for some time whether the loss of baggage was temporary and that Mr N had taken all reasonable steps to minimise his expenditure. However, he had received his bag within a week and the policy terms made the limited nature of this cover clear. The insurer was justified in limiting its payment to £150.

However, Mr N was entitled to payment from the airline in priority to the insurer’s right to recover its payment to him. We decided the insurer should not have kept the airline’s payment and should send it to Mr N, giving him a total recovery of £300.

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07/3

n **travel – baggage – theft – exclusion for theft at night from unattended vehicle – whether exclusion onerous.**

Miss H went on holiday with her partner to Crete. They left a beach bag containing a camera, two mobile phones, a tape player

and some cash, in the locked boot of their hire car. The car was broken into and Miss H claimed for theft of the bag. The insurer rejected the claim on the ground that all the items were within the policy definition of 'valuables' and therefore excluded from cover in unattended motor vehicles.

The policy defined 'valuables' as *'photographic and video equipment, camcorders, radios and personal stereo equipment, computers, computer games and associated equipment, hearing aids, mobile telephones, telescopes and binoculars, antiques, jewellery, watches, furs, precious stones and articles made of or containing gold, silver or other precious metals or animal skins or hides'*.

Miss H argued that the policy was self-contradictory, in that another exclusion stated that the insurer would not be liable for *'any theft from motor vehicles left unattended at any time between 10 pm and 8 am'*.

### **Complaint upheld in part**

We did not agree that there was a contradiction between the two exclusions; the more onerous exclusion applied only to valuables and meant that they were not covered at any time in an unattended car.

However, that exclusion was unusually onerous and required Miss H to take specific action in order to maintain cover under the policy. The insurer should therefore have drawn it to her attention at the time she bought the insurance. There was no evidence that the insurer had done so.

The fact that she had been given time to read the policy and the option to cancel it was not sufficient for the insurer to comply with its duty to draw such exclusions to the attention of anyone purchasing the policy.

We required the insurer to deal with the claim. However, the policy contained a limit of £200 for all valuables and an excess of £45 for cash. These meant that Miss H and her partner would not be reimbursed for the majority of their losses.

07/4

### **travel – cancellation – disability – cause known to policyholder when buying insurance – whether claim valid.**

On 28 January 2000, Mr A booked air tickets for his family to travel from Manchester to Saudi Arabia on holiday from 8 to 30 March. On 26 February, he bought insurance to cover their travel. He cancelled the flights on 2 March, stating that Mrs A was suffering from complications of her pregnancy and that travel was inadvisable for her.

The insurer's investigation established that Mr A had tried unsuccessfully to amend the air tickets on 7 February and that his wife's GP had made a formal diagnosis a week later. The insurer rejected the claim, explaining that the policy did not include cover for any medical condition which existed when the policy was issued on 26 February. Mr A argued that they had no reason to believe that the trip might have to be cancelled when they bought the tickets and he said the sales operator had



told him he would be reimbursed if Mrs A became ill. However, the insurer would only refund the premium, not meet the claim.

**complaint rejected**

We accepted that Mr and Mrs A did not know that the pregnancy was subject to complications when the flights were booked. However, they had been aware of the problem for two weeks before they bought the insurance. The insurer was therefore fully justified in refusing to meet the claim.

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07/5

n **travel – cancellation – disability arising after start of insurance – whether insurer liable for cancellation cost.**

In January 2000, Mr W and Mrs G arranged to go on a holiday in July. Mrs G’s son was admitted to hospital in April and underwent a series of tests. Mr W and Mrs G paid the balance of the holiday costs on 5 May. The son was discharged in the middle of that month but was referred back to a consultant on 24 May, readmitted to hospital a few days later, and died on 13 June, one day after his illness had been diagnosed.

Mr W and Mrs G claimed reimbursement of the cost of cancelling their holiday, but the insurer refused to make any payment beyond the £200 deposit. It relied on a condition in the policy which required policyholders to notify the insurer’s helpline if an immediate relative was ‘receiving, recovering from, or on a waiting list for, in-patient treatment in a hospital’ or ‘waiting for the results of tests or investigations or referral for an existing medical condition’.

**complaint upheld**

We interpreted the requirement as applying only at the time the policy was issued in January 2000, as is usual with this type of wording. If the insurer had intended this requirement to cover the whole period until the date of departure, that would be an onerous obligation and the insurer would have had to have made it much clearer in its documentation, as well as drawing it to the attention of potential policyholders.

Moreover, even if we considered it reasonable to treat the condition as if it applied when the balance of the money was paid, the claim would still be valid. Although Mr G was in hospital when the payment was made on 5 May, the insurer accepted that it would have provided full cover after his discharge from hospital in mid-May. He would therefore not have come within the terms of the condition when he saw the consultant on 24 May or was readmitted to hospital on 28 May.

The insurer agreed to pay the balance of the holiday cost, which the couple had forfeited when they cancelled.

07/6

n **travel – cancellation – disability arising after start of insurance – whether insurer liable for full cancellation charge.**

In February 2000, Mr and Mrs T booked a holiday in Florida for May and paid a deposit. On 17 March, Mrs T fell off a ladder, breaking bones in her foot.

The foot did not heal well and, when the balance of the holiday cost was due to be paid, Mr T telephoned the insurer for advice.

The insurer would not take responsibility for deciding whether the couple should go ahead with the holiday. It told Mr T that if they went ahead and then found Mrs T was not well enough to travel in May, it would only reimburse the deposit, not the balance of the holiday cost. Mrs T's foot was not sufficiently recovered before departure and they cancelled the holiday. Mr and Mrs T claimed the full cost of the holiday, but the insurer refused to pay more than the deposit.

#### **complaint rejected**

It was Mr T's decision to pay the remaining balance, trusting that his wife's foot would have recovered before the holiday started. We were satisfied that the additional expenditure he incurred when paying the balance of the cost of the holiday was a risk he had personally agreed to take. In these unusual circumstances, the insurer was justified in refusing to indemnify him.

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07/7

#### **n travel – cancellation – event leading to cancellation pre-dating insurance – policyholder choosing date of departure as start date of policy – whether insurer liable for cancellation due to event occurring after insurance bought but before start date.**

On 9 February 2000, Miss S bought insurance to cover her holiday, which was to begin on 20 February. On 17 February, she injured her back and had to postpone the holiday. A month later, she gave up hope of being fit to travel and cancelled the holiday. She submitted a claim for the cancellation cost, but the insurer refused to make any payment. It explained that she had asked for the policy to come into force on 20 February, which was after her injury had occurred. Even though the cancellation date was after the policy's start date, the insurer considered that the event leading to cancellation had pre-dated the insurance.

#### **complaint upheld**

It is normal practice for policyholders to ask for their insurance to start on the date they book a holiday so that cancellation cover operates immediately. Miss S had bought the policy from her travel agent, but he had apparently not given her any advice as to how she should complete the application form. She had not intentionally inserted an incorrect date for the policy to start, but it was not the insurer's fault that she had asked for cover to begin only on the date of departure.

On a strict interpretation, Miss S was not entitled to reimbursement of the cancellation charges. However, owing to the unusual circumstances, we asked the insurer to meet the claim without admitting liability and it agreed to do so. We could not agree that Miss S was also entitled to interest, or to reimbursement of the fee her GP charged for completing her claim form.

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07/8

**n travel – cancellation – exclusion for pre-existing medical conditions – need for exclusion to be drawn to policyholder’s attention.**

Mr R booked a week’s holiday in January 2000, with a departure date of 12 May. He knew he was due to undergo surgery for his hernia and the operation was scheduled for June. When Mr R was told the operation would be performed in April, his daughter asked the travel agent what alternatives were available. The travel agent said that the insurer would meet the cost of cancelling the holiday.

However, when Mr R cancelled, the insurer said it was not liable to make any payment, since Mr R had known about his operation since October 1999. The policy excluded any claim arising out of a medical condition which the policyholder was aware of before buying the insurance. Mr R contended that he had not had any reason to expect the surgery would interfere with his holiday. He also said that, had the travel agent not misled his daughter, he would have rearranged the holiday or transferred it to someone else.

**complaint upheld**

Mr R could not have been expected to disclose his operation to the insurer unless the travel agent had made him aware of the need to do so, and had explained that the insurer would not otherwise cover any claim resulting from his medical condition. The insurer did not comply sufficiently with the industry selling code by simply requiring the person applying for the insurance to sign a declaration that they had read and understood the policy terms.

Unless there was evidence that the exclusion for pre-existing medical conditions had been drawn to Mr R’s attention before he bought the insurance, we considered that the insurer had to meet the cancellation claim. It accepted our view.

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07/09

**n travel – cancellation – exclusion for pre-existing medical conditions – whether complications of surgery a pre-existing medical condition.**

Mr D booked a holiday for himself, his wife and daughter to start in August 1999. In June, his daughter underwent a kidney transplant and suffered complications, Mr D cancelled the holiday and claimed reimbursement of the cost.

The insurer rejected the claim because Mr D’s daughter had suffered from kidney problems and been on dialysis for some years.

Mr D argued that they had not cancelled because of his daughter's kidney problems but because of complications that had arisen after her operation. The operation had not been planned when they booked the holiday, but was a one-off life-saving opportunity that they could not pass up.

#### **complaint rejected**

The policy excluded any condition *'which [they] knew about at the time [they] bought the insurance ... unless [the insurer] agreed to cover it in writing'*.

This clearly excluded liability for the claim, even though we acknowledged that the reason for cancelling the holiday was because of deterioration in Miss D's condition.

Although Mr D denied that this exclusion had been discussed with him, he had signed a declaration that he was aware of it. There was clear advice to call the insurer's helpline to arrange cover for any pre-existing condition. However, Mr D had not done so. We considered that the insurer's rejection of the claim was fully justified.

07/10

#### **n travel – cancellation – illness of relative – definition of 'relative' – whether illness of next of kin covered.**

Mrs and Miss M were due to fly to Rome on 6 August 2000. In July, their parish priest was admitted to hospital as an emergency case and put in intensive care. Mrs M cancelled her holiday to stay by his bedside. The insurer rejected her claim for

the cost of cancelling the holiday since the policy stated that benefit would be paid for cancellation *'because of the death, injury or illness of a relative, travelling companion or a business colleague'*, and the priest did not come into any of these categories. The policy definition of 'relative' listed various blood relations.

Although the priest was not a blood relation, Mrs M produced proof that she was specifically named as his next of kin.

#### **complaint upheld**

Although the policy definition of 'relative' was clear and the priest did not come within it, the situation was highly unusual and not one which a policy could be expected to mention.

In the circumstances, we considered that anyone who is named as 'next of kin' for someone hospitalised on an emergency basis should be treated as a 'relative' of that person. We required the insurer to meet the claim in full.

07/11

#### **n travel – cancellation – missed departure – failure or disruption of pre-booked public transport – 'additional expenses' – whether cancellation claim valid – whether cost of taxi to and from airport 'additional expenses'.**

Mr D booked a flight to Malta for a week's holiday and arranged for a car to take him to the airport. A motorway accident, causing serious congestion and tailbacks, meant that he missed the plane. The next flight was not for more than 25 hours and

would have cost a further £115, so Mr D decided to give up his holiday and return home.

The insurer refused to reimburse the cost of the flight (£173) because the policy only covered cancellation in the event of *'failure or disruption of the pre-booked public transport service in which the insured is due to depart from the UK'*. As the flight had not failed or been disrupted, Mr D's claim was not covered.

Mr D then contended that the insurer should reimburse the cost of the car taking him to the airport as 'additional expenses' for missed departure due to failure of his 'pre-booked connecting public transport'. He produced a taxi receipt for £90 for the return trip.

**complaint rejected**

The insurer correctly rejected the cancellation claim. However, Mr D's claim for missing the plane's departure would have been valid, if he could have proved he had incurred additional expenses.

Mr D had not mentioned the costs of the 'taxi' until three months after his claim had been rejected, having previously indicated that a friend drove him to the airport as a favour. And despite the receipt, we were not persuaded that he had actually made any payment.

In any event, we considered that Mr D had not proved that he had incurred any 'additional' expenses as a result of missing the flight. He would have had to meet the cost of travel to and from the airport, even if we accepted that he had agreed to pay the driver. We therefore rejected the complaint.

07/12

**n travel – exclusion for unattended baggage – policyholder sitting next to bag but distracted by thief – whether bag 'unattended'.**

Mr N was on holiday in New York. While he was sitting on a subway platform bench waiting for a train, another traveller started a conversation with him. When Mr N looked around a minute or two later, he found his rucksack had been taken from the seat beside him. He claimed for theft of £2,000 of personal belongings and about £400 cash. The insurer rejected the claim on the ground that the rucksack was 'unattended' and therefore specifically excluded from cover.

**complaint upheld**

It could not be said that the bag was unattended when Mr N was in reasonable proximity at the time. Indeed, this was borne out by the circumstances of the theft. There would have been no need for one of the thieves to distract Mr N by engaging him in conversation if the bag had been unattended: the thieves could just have taken it.

The mere fact that a theft had occurred did not prove that property was 'unattended'. If there had been any indication that Mr N had walked away from his bag and returned to find it stolen, it would have been different. The insurer accepted our view that it should meet the claim, subject to the policy limits of £1,500 per bag and £400 total cash, less the policy excess.

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07/13

**n travel – fraud – burden of proof.**

Mrs B’s handbag was stolen when she was on holiday in Spain. She claimed for the bag and contents, including a neck pendant. The insurer asked her to provide receipts and the receipt for the pendant showed a price of £474. After making enquiries, the insurer established that the receipt had been altered. The true cost was £74.

The insurer rejected the claim in full, quoting the policy provision that it would not pay for any claim *‘if it is either in whole or in any part fraudulent’*. Mrs B asserted that she had bought the pendant from a friend and had not altered the receipt, although her friend might have done. The insurer was unable to make contact with the friend and Mrs B could not produce anything from him to support her story.

**complaint rejected**

There was no evidence or other information to support Mrs B’s assertion. Although she alleged that her friend had defrauded her, there was no evidence she had bought the necklace from the friend and she had not initiated any legal action against her friend. Whilst she might be entirely innocent of any attempt to defraud the insurer, our informal procedures were not suitable for the full examination of witnesses that would be necessary to try and establish all the facts of the case. We recommended Mrs B to consider pursuing her claim through the courts, where witnesses could be compelled to attend and undergo a thorough cross-examination.

07/14

**n travel – loss – proof – policyholder failing to provide police report – whether insurer liable for claim.**

Miss K left her wash bag in the aeroplane toilet when travelling to Spain. She submitted a claim for make-up and jewellery valued at £3,200. The insurer rejected her claim on the ground that she had not obtained a written police report of the loss, as required by the travel policy terms. She argued that a report was unnecessary since the police would not be interested, but she stated that she *had* informed the police.

This statement was contradicted by the claim form, in which she said only that she had told the airline crew and ground staff. The insurer made enquiries with the Spanish police. However, they did not recognise the police reference number Miss K had quoted and there was no mention of Miss K in the police records. Nevertheless, the insurer agreed to reconsider the claim if Miss K could provide any evidence that she had reported the loss to anyone.

**complaint rejected**

The burden of proving a loss which is covered by the policy rests with the claimant in the first place. We could not say the insurer was unreasonable in refusing to accept Miss K’s account without independent verification. It was somewhat unusual that she had no other insurance, such as a household policy, to protect such valuable items, and her word alone was not sufficient to validate the claim.

07/15

n **travel – loss – proof – written police report – whether report essential to validate claim.**

Mrs M’s ring was damaged while she was on holiday in Malta. She made a claim for £124, the cost of repairing it and replacing one stone. The insurer refused to make any payment, citing the policy wording which stated that it would not pay *‘for loss or theft of valuables ... and any item valued over £100 not reported to the police’*. Mrs M argued that the requirement was not appropriate in her case, as the police would not have been prepared to document the damage to her ring.

**complaint upheld**

The policy defined valuables as *‘items containing precious or semi-precious stones’*. Although the ring came within the definition, Mrs M had not lost the ring, only one stone. The estimate for replacing it was less than £100 and therefore it was neither a *‘valuable’* nor *‘any item valued over £100’*.

One of the reasons insurers require police reports is to provide independent evidence that a loss has occurred. In addition to submitting an estimate, Mrs M had provided a letter from the holiday group leader confirming that the ring had been damaged. The insurer agreed to meet the cost of replacing the stone and repairing the ring, less the £35 policy excess.

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07/ 16

n **travel – medical expenses – exclusion for pre-existing medical conditions – policyholder required to obtain permission to travel – whether permission could be given retrospectively.**

Mr M went on a long cruise. He was robbed in Singapore and then, two weeks later, became ill with chest pains. He was transferred to a hospital in Jordan, where he was found to be suffering from unstable angina. Subsequently he was repatriated. When the insurer carried out medical enquiries it learnt that Mr M had an extensive history of heart problems. It referred him to the policy conditions and to a declaration he had signed on the policy application form saying he was in good health. These conditions provided that the insurer would not be liable for claims if the policyholder had *‘during the 12 months prior to taking out this policy suffered from any chronic and/or recurring illness of a very serious nature which has necessitated consultation or treatment, and has not obtained permission from their doctor that he/she is fit to travel ...’*.

The insurer rejected Mr M’s claims for medical expenses and curtailment of his holiday. Mr M acknowledged that he had had cardiac problems for many years, but asserted that he was in good health when he embarked on the cruise. He provided letters from his consultants to confirm this.

### **complaint upheld**

The wording of the application form did *not* require Mr M to inform the insurer or the intermediary of his pre-existing medical history, as the insurer had argued. It simply required him to obtain permission to travel from his doctor. The policy document contained similar wording. The exclusion stated that the insurer would not meet a claim from someone who had suffered from a chronic or serious condition in the previous 12 months unless the person's doctor had given them permission to travel. There was no requirement that this permission had to be in writing or presented to the insurer before the holiday.

It was clear that Mr M had seen his GP a week before his cruise. Although it was not clear that Mr M's reason for visiting his GP was to obtain permission to go on the holiday, his GP was certainly of the opinion that Mr M had been fit to undertake the holiday. In the circumstances, we considered Mr M had satisfied both the policy condition and the declaration he had signed on the application form. The insurer accepted our view and agreed to meet both the medical expenses and curtailment claims.

.....  
07/17

- n **travel – non-disclosure – pre-existing condition – insurer repudiating liability for medical expenses – delay in communicating repudiation – whether insurer liable for expenses despite non-disclosure.**

Ms S and Mr C were on holiday in America when Mr C injured his leg. He was hospitalised with deep vein thrombosis, but his condition was exacerbated by liver

cirrhosis, hepatitis and alcoholism. Ms S notified the insurer, but after several days it refused indemnity.

Ms S argued that the insurer's delay had resulted in large medical bills. She said that if it had notified them of its decision more quickly, she could have given Mr C an alcoholic drink and his withdrawal symptoms would have stopped. They could then have taken their flight home.

### **complaint rejected**

It was clear from Mr C's medical notes that he had a long history of alcoholism, fairly severe liver disease and thrombocytopenia. His GP had only reluctantly agreed that Mr C was fit to travel and had advised him to declare his medical history to the insurer. Despite plain warnings in the policy, Mr C had not done so. We considered that he had accepted responsibility for the risk of travelling.

We did not agree that stopping treatment and giving Mr C a drink would have been acceptable. Mr C was not fit to fly and no doctor would have certified him as fit. There was no unreasonable delay on the insurer's part in deciding whether to accept the claim. It had made the necessary enquiries as quickly as possible. In any event, the seriousness of his illness meant that Mr C could not have flown home as quickly as Ms S later suggested, regardless of the insurer's decision.



## 2 innocent non-disclosure

We occasionally receive cases where a policyholder has failed to disclose a material fact. Previously in such cases, where we were satisfied the policyholder did not intend to mislead the insurer, we have often adopted a 'proportional' approach. This has involved performing a calculation to compare the premium the policyholder actually paid with the correct premium (that is, the premium they would have paid had the insurer known the full facts), in order to ascertain what proportion of cover the customer should now receive. However, we are not entirely satisfied that this is an appropriate approach to take as a general rule.

The ABI (Association of British Insurers) Statement of General Insurance Practice requires firms not to repudiate a claim on the grounds:

- n of the customer's failure to disclose a material fact, if that fact was one that a customer could not reasonably be expected to disclose; *or*
- n of misrepresentation, unless it is a deliberate or negligent misrepresentation of a material fact.

The same Statement also requires insurers:

- n to include clear questions on application forms about matters insurers have commonly found to be material; *and*
- n not to ask questions requiring knowledge which the signatory could not reasonably be expected to possess.

In accordance with these principles, if the customer's non-disclosure has been totally innocent, we may, in some circumstances, expect an insurer to pay the full amount of cover, rather than a proportionate sum. We assess each case on its facts, our aim being to ensure each party is treated fairly. Our approach is not in any way designed to protect those who have acted fraudulently and, from experience, we have found there are relatively few cases that we would consider to fall within the innocent non-disclosure bracket.

However, we are likely to consider a non-disclosure innocent when the question the insurer asks is unclear. When the question is clear, we are more likely to maintain a proportional approach. Obviously, when we suspect deliberate non-disclosure in response to clear questions, we will continue our approach of supporting insurers who have repudiated claims.

One example of non-disclosure arises in connection with motor insurance. At some point, most parents consider adding their son or daughter to their motor policies. In deciding whether to allow such an additional driver and what to charge to cover the additional risk, insurers generally use somewhat different standards, though few apply an absolute ban to such drivers. Assessing the risk of the new driver will normally take account of the other cars in the family and the type of vehicle covered. The usual procedure is to ask the policyholder to answer various questions and then make a decision.

If there is subsequently a dispute, then the issue becomes more complicated if the insurer made no record of the questions asked, other than a printed note of declarations. If the customer is not required to sign this, the insurer may find it difficult to establish that the customer has misrepresented the risk. The insurer is under a duty to ask clear questions about matters it considers important – ‘material’ – to its assessment of the risk. But even where it has asked clear questions, if there is no contemporaneous proof, it may find it difficult to demonstrate that it has done so.

We do not have any sympathy with policyholders who obtain insurance for their children’s cars by giving the insurance company false information. However, we do not believe that all parents who have added a son or daughter to their policy as ‘occasional users’ are trying to defraud the industry.

Investigating complaints of this type requires us to evaluate the alleged non-disclosure or misrepresentation, including looking at the questions the insurer asked and the answers they were given, as well as at the explanation for any discrepancies and the insurer’s guidelines for dealing with the risk it was actually going to underwrite. Only where we are satisfied that there was a deliberate non-disclosure or misrepresentation will we agree the appropriate remedy is for the insurer to cancel all cover and refund the premiums. The insurer is entitled to forfeit these if there is clear evidence of fraud.

The following case studies illustrate the range of cases we have considered.

## case studies – innocent non-disclosure

07/18

### n **motor – misrepresentation – owner of vehicle – father insuring son’s car – whether insurer entitled to cancel policy.**

Mr H insured his car, with his son as a named driver. After the car was stolen from a supermarket car park, the insurer investigated Mr H’s theft claim and discovered the car was, in fact, registered in the name of the son, and the son was also responsible for the financing arrangement. The insurer refused to meet the claim and cancelled the policy from its start date.

Mr H admitted that he had taken out the policy in order to reduce the premium by using his no claims discount, but he argued that his son was the main user of the car.

### **complaint rejected**

We accepted that the fact the son was the registered owner of the car was not conclusive. However, the evidence showed clearly that the son – rather than Mr H – was the main user. Mr H had misrepresented the position to the insurer and its decision to treat the policy as if it had never come into force was fully justified.

07/19

**n motor – misrepresentation – whether innocent – whether insured entitled to full indemnity.**

Mr L insured his car in April 2000, with his wife and son named as ‘additional drivers’. The car was stolen a few days later, after being driven by the son.

The insurer concluded, after investigation, that contrary to his declaration on the policy application form, Mr L was not the car’s main user. However, the insurer did not cancel the policy. Instead, it offered to pay a proportional settlement. This was based on the premium it would have charged if it had known the son was the main driver and it was calculated at 52% of the total claim.

Mr L denied that his son was the main user of the car and he argued that the insurer’s investigators had misunderstood the answers he and his son had provided. He contended that the claim should be settled in full.

**complaint rejected**

There was sufficient evidence to satisfy us that Mr L’s son *was* the main user of the car and that the insurer had not misunderstood the answers. Both the son and Mr L had told the insurer that the son was the main user. Moreover, there were a number of discrepancies and inconsistencies in Mr L’s accounts.

The strict legal position was that the insurer was entitled to treat the policy as if it had never come into force and to reject

the claim, subject to refunding the premium. Its offer of a proportional settlement, based on the assumption that all the misrepresentations were innocent, was a fair and reasonable response to the dispute. We were not satisfied that the misrepresentations were innocent and there was no ground for requiring the insurer to increase its offer.

07/20

**n motor – misrepresentation – whether named driver was ‘owner’ of car – whether insurer entitled to cancel insurance.**

Mr D, a police officer who had taken early retirement on medical grounds, took out motor insurance for his new car. He stated that he owned the car and that his family did not own or use any other car. His adult son was named as a driver.

Two days after Mr D took out the insurance, the car was stolen. On investigating the claim, the insurer learnt that the purchase receipt was in the son’s name, as was the finance agreement and the direct debit mandate for the premium payments. The personalised registration number corresponded with the son’s initials. When questioned, both Mr D and his son agreed that the son’s old car had been sold in part exchange towards the purchase price. They did not dispute that Mr D also had another car.

The insurer cancelled the policy, on the ground that both the answers Mr D had given on the proposal were untrue. Mr D argued that his son was only an occasional user of the car and that the investigation did not prove otherwise.

**complaint rejected**

It was very difficult to believe that Mr D, rather than his son, was the car's owner and main driver. Mr D had not been able to explain why it was necessary for him to use the car extensively when he had the use of another car, or why his son would use the car only occasionally when there were two cars in the family. We were satisfied that Mr D had not answered the questions on the proposal form correctly.

If the insurer had known the son was the car's owner, it would not have issued this policy, since it was a policy offered only to retired police officers to cover their own cars. In the circumstances, the insurer was entitled to treat the policy as if it had never come into force.

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07/21

n **motor – non-disclosure – whether clear questions asked – whether insurer entitled to cancel policy.**

Mrs B took out insurance for her car, with her son as a named driver. She was asked various questions, one of which was whether she had 'use' of another car. She later received a printed 'Statement of Facts' which recorded her answer to that question as 'No'.

Almost two years later, her son was involved in an accident. Mrs B completed a claim form, on which she stated that she had 'access' to another car. The insurer cancelled the policy, rejecting the claim and denying liability for damage to the third party vehicle, on the ground that Mrs B had misrepresented the risk. Mrs B explained that she did not normally drive the other car, which belonged to her husband and that she was the main user of this car. However, the insurer contended if it had been aware she had access to another car, it would only have covered this car for a premium of £4,319.

**complaint upheld**

There was no evidence of the questions the insurer had asked Mrs B at the outset, other than the Statement of Facts. We were not satisfied that asking Mrs B if she had 'use of another car' was a clear question. The insurer had issued no guidance as to the meaning of the question and Mrs B had interpreted it as asking whether she wanted the policy to cover more than one car.

We did not accept that the fact of Mrs B's having access to another car made a material difference to the risk she had represented to the insurer when she took out the policy. We were satisfied that she was the main user of the car and that the son was an occasional user. The situation was not altered because she occasionally drove her husband's car. We therefore required the insurer to deal with Mrs B's claim. In addition, we awarded Mrs B £200 compensation for the mishandling of her claim.

07/22

**n motor – total loss – salvage – whether insurer entitled to retain salvage – compensation for wrongful disposal of salvage.**

Miss G's car was damaged in an accident and the insurer settled her claim on a 'total loss' basis. She wanted to keep the salvage, but the insurer refused and passed the car to salvage agents. Some months later, Miss G learnt from the Driver Vehicle Licensing Agency that someone had applied to re-register the car, apparently with a view to repairing it and putting it back on the road. She complained to the insurer and demanded compensation for the additional cost she had incurred in having to buy a new vehicle, plus interest.

The insurer explained that it was unwilling to allow its policyholders to keep cars which were unroadworthy. In this, it believed it was acting both in the public interest and in accordance with industry and government guidelines. However, it accepted that, on this occasion, it should have allowed Miss G to keep her car. In recognition of its error and other minor failings, the insurer offered her £500 compensation.

**complaint rejected**

The salvage of a car remains the policyholder's property until settlement has been agreed. Insurers are not entitled to dispose of the salvage without the policyholder's express permission. Where there is some unusual delay in reaching agreement, the insurer could ask for the

policyholder's permission to dispose of the salvage. This would prevent storage charges accruing, particularly where the only point in dispute is the amount offered.

If a policyholder seeks to retain and repair a car, the insurer should consider the request on the basis of the extent of repairs required. Where the car has sustained structural damage which cannot be repaired economically, then there will be serious issues of road safety to resolve. However, where much of the damage is cosmetic, it would not be unreasonable to agree to a policyholder's request to keep their car.

In this instance, we were satisfied that the insurer's compensation offer was reasonable, in the absence of any evidence that Miss G had suffered financial loss, distress or inconvenience except as a result of the insurer's retaining and disposing of the salvage. The offer was in line with awards we had made in similar situations. By settling Miss G's claim on a 'total loss' basis, the insurer had already paid her enough to enable her to replace her car with a similar one.

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# 3 paying for medical reports

your comments invited  
**please reply by**  
**14 September 2001**

Recently a number of policyholders and firms have sought our view on the payment of fees for medical reports. Before we reach a definite view on this issue, it would be helpful to have comments from firms, customer representatives, the medical profession and other interested parties.

Medical reports are routinely required when assessing claims relating to medical conditions in travel, loan protection and critical illness policies. Typically, policyholders will be asked to support their claim by providing the insurer with a medical report describing their present condition (or in some cases, their medical history). Firms may require the information to help them assess an original claim or whether it is appropriate for a policyholder to continue receiving benefits.

Increasingly, doctors are levying charges for providing such information: typically £30 for a routine report. Practice appears to vary amongst insurers as to whether the insurer or the policyholder is expected to meet such costs.

In general, it is for policyholders to demonstrate that they have a valid claim. However, our initial view is that it represents unreasonable contract terms if insurers require policyholders to provide evidence they can

only obtain at a disproportionate cost, when compared with the likely level of benefit from a successful claim.

The circumstances of the customer making the claim may also be relevant. For example, requiring a policyholder who has been taken seriously ill overseas to obtain and pay for medical reports appears more onerous than asking a patient to obtain a report as part of a routine visit to their doctor.

It is also relevant to consider the nature of the request for a medical report, and at what stage it occurs in the claims process. In essence, the more routine the information required and the earlier in the process of assessing the claim that it is called for, the more likely we are to regard it as reasonable for the policyholder to be responsible for obtaining the information. However, if the insurer is investigating the possible relevance of a policy exclusion then it will be for the insurer to meet any costs.

The following illustrations give examples of situations in which medical reports are needed. We welcome respondents' comments on who they think should, in each case, be paying for the report.

### **illustration 1**

- n The policyholder had taken out a loan protection policy and became ill with a serious heart condition. The insurer accepted the original claim after receiving written confirmation from the policyholder's consultant. After six months, it declined further payments under the policy unless the policyholder obtained, at his own cost, monthly reports from his doctor confirming that he remained unfit for work.

### **illustration 2**

- n The policyholder was taken seriously ill abroad. There was some question about whether the illness pre-existed the policy. The travel insurer required the policyholder to obtain a full report on his medical condition from his doctor.

### **illustration 3**

- n The policyholder made a claim under a permanent health insurance policy. The insurer received initial reports from the policyholder's doctor. However, the insurer became concerned that the policyholder's condition was not of such severity as to justify her continuing absence from work. It asked the policyholder to obtain responses from her doctor to specific questions about her condition.

We would welcome comments on these issues. In particular, it would be helpful if respondents would let us know whether they:

- a) would welcome guidance from the ombudsman on these issues;
- b) believe it is practical to determine the circumstances in which insurers should meet these costs and the circumstances in which policyholders should do so.

## **your comments**

Please let us have your comments by 14 September 2001.

Contact:

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We will set out our conclusions on these issues in a subsequent edition of *ombudsman news*.

## 4 group insurance policies – a question of jurisdiction

We are occasionally asked whether a complaint about a group insurance policy is within our jurisdiction. Group insurance policies are policies purchased by organisations (typically employers) for the benefit of individuals. Typical examples are medical expenses (private health), critical illness and permanent health insurance policies. Other policies including dental costs and travel may be provided in a similar way. The individual does not have a policy with the insurer, but the benefits of the policy will normally flow to the individual rather than to the organisation which has entered into the policy.

We will consider each case individually but, in our experience, most complaints *are* within our jurisdiction. In assessing the complaint, we take into account a number of factors, but the overriding test is whether the benefits of the policy flow to the individual without the employer exercising any practical discretion over the provision of those benefits. Looking at whether the individual is involved in the claims process, and whether benefits are paid (or provided) directly to the individual may offer guidance on this. For example, under an employer-provided private medical insurance policy, the employee typically makes any claim directly to the insurer and discusses it directly with the insurer, and benefits are provided directly to the individual. We would consider this type of policy to be within our jurisdiction.

Even where benefits are paid to the employer, this fact is not necessarily decisive. Where this happens purely for administrative reasons (as is often the case in permanent health insurance) then the dispute is still likely to be within our jurisdiction.

Examples of group policies outside our jurisdiction include cases where the benefit is for the organisation, not the individual (such as a ‘key man’ insurance) or where the benefit provided to the individual is not directly related to the insurance policy. An example here might be where a firm promises its employees extended sick pay under the terms of their employment contract, and then decides to insure itself against some of these costs. The employee’s dispute in such cases would be with the employer – not the insurer.

**...examples of group policies outside our jurisdiction include cases where the benefit is for the organisation, not the individual.**



## case study – commercial insurance

We have always dealt with a minority of commercial insurance policies but anticipate receiving a higher volume after ‘N2’ (1 December 2001 – the date when the Financial Ombudsman Service acquires its full powers). The following case study illustrates a commercial insurance complaint we received recently.

07/23

### n **commercial – contractor’s liability – policy condition – ‘suitable fire extinguishing appliance’ – whether spray bottle met terms of condition.**

Mr S, a contractor, took out liability insurance. In 1997, while two of his employees were working on the exterior of a building, using a blowtorch to burn paint off a window frame and doorframes, the window frame caught fire. They tried to put out the fire with a 5-litre spray bottle of water. This was insufficient to extinguish the fire, so they broke down the door and covered the flames with a duvet. However, their efforts were unsuccessful and extensive damage had been caused by the time the fire service arrived and put out the fire.

Investigation established that the window was not fully sealed, as it had appeared to be. At some time a hole had been drilled through the sealed, double-glazed aluminium frame and subsequently concealed with filler. Mr S stated that the fire would not have spread to the curtains inside the building if this hole

had not been there. He provided an expert’s report supporting his argument.

The insurer repudiated liability on the ground that Mr S had not complied with a policy condition which required ‘suitable fire extinguishing appliances to be kept available’. It argued that the 5-litre spray bottle did not meet this condition as it would only damp down a fire. It also contended that the bottle’s capacity was only 1.25 litres.

### **complaint upheld**

We had to consider whether the spray constituted a ‘suitable fire extinguishing appliance’ in accordance with the policy condition. There was insufficient evidence to determine the spray bottle’s precise size, but we considered that it satisfied the terms of the condition. The policy did not contain any guidance on the insurer’s criteria and we did not agree that the bottle was so obviously inadequate that it was unsuitable as a fire-extinguishing appliance.

**...the policy did not contain any guidance on the insurer’s criteria.**

## 5 interest – new rate

We have been considering the rate of interest we award, where appropriate, in claims we uphold against insurers which are members of the Insurance Ombudsman Bureau.

At present, we add interest to all awards. Unless there is specific information about the particular costs the policyholder has incurred during the relevant period, we use a rate which is equivalent to rates for savings accounts.

An example where we would award a higher rate is where the policyholder has had to borrow money to buy replacement goods or has been charged interest by his lender for failing to meet insured loan payments.

The award is intended simply to recompense the policyholder for the fact that he has not had use of the money; it is not a penalty on the insurer. But if we find that, for example, the insurer's delay in settling the claim has given rise to particular distress or inconvenience for the customer, then we may make a specific award to reflect this - over and above our standard rate of interest.

At present, we award interest in these circumstances at a rate of 6% per year compound (less tax if properly deductible). This is not straightforward for customers or firms to calculate and is out of line with the awards made in the courts and by other schemes in the Financial Ombudsman Service.

We have therefore concluded that a rate of 8% (simple) per annum, in line with the rate presently used in the County Court, would be more appropriate. We will use this rate in all awards made in the insurance division from 1 September 2001 onwards.

**...we will use this rate in all awards made in the insurance division from 1 September 2001 onwards.**

