ANNUAL REPORT 2021

ARBITER FOR FINANCIAL SERVICES

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Wherever used herein, the use of the masculine gender shall include the feminine and/or neuter genders and the singular shall include the plural and vice versa, unless the context clearly indicates otherwise.

Any use of words or phrases to similar effect shall have no significance in the interpretation of this Report, such use being solely for the sake of convenience.

ARBITRU GĦAS-SERVIZZI FINANZJARJI
ARBITER FOR FINANCIAL SERVICES

29 August 2022

The Hon Clyde Caruana BCom (Hons), MA (Econ), MP
Minister for Finance and Employment
Maison Demandols
South Street
Valletta VLT 2000

Dear Minister

Submission Letter

In terms of article 20 of the Arbiter for Financial Services Act (Cap. 555), I have the honour to transmit to you the Annual Report and Financial Statements of the Office of the Arbiter for Financial Services for the year 2021.

Yours faithfully

Dr Reno Borg
Arbiter for Financial Services

The Office of the Arbiter for Financial Services in Malta:

Providing an independent and impartial mechanism of resolving disputes outside of the courts' system, filed by customers against financial services providers authorised by the Maltese financial services regulator.

Competence and powers of the Arbiter for Financial Services

Functions

The Arbiter for Financial Services acts independently and impartially of all parties concerned and is not subject to the direction or control of any other person or authority. The law gives the Arbiter the authority to determine and adjudicate on a complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case. The Arbiter must deal with complaints in a procedurally fair, informal, economical and expeditious manner.

In the review of complaints, the Arbiter will consider and have due regard, in such manner and to such an extent as he deems appropriate, to applicable and relevant laws, rules and regulations, in particular, those governing the conduct of a service provider. These include guidelines issued by national and European Union supervisory authorities, good industry practice as well as reasonable and complainants' legitimate expectations with reference to the time when it is alleged that the facts giving rise to the complaint occurred. The Arbiter's powers under the Act are wide and include the power to summon witnesses, to administer oaths and to issue interlocutory orders.

Adjudication and awards

The Arbiter is empowered to adjudicate and resolve disputes and, where appropriate, make awards up to €250,000, together with any additional sum for interest due and other costs, to each complainant for claims arising from the same conduct. The Arbiter may, if he considers that fair compensation requires payment of a larger amount than such award, recommend that the financial services provider pay the complainant the balance, but such recommendation shall not be binding on the service provider. The decisions of the Arbiter are binding on both parties, subject only to appeal to the Court of Appeal (Inferior Jurisdiction).

Collective redress

The Arbiter may, if he thinks fit, treat individual complaints made with the Office together, provided that such complaints are intrinsically similar in nature.

Scan to download the Arbiter for Financial Services Act

Highlights

- Year in review marks fifth full year of operation since the OAFS was set up in 2016
- Implemented a tailor-made web-based case management system integrated to a new bi-lingual portal that enables consumers to submit enquiries and complaints online
- 814 enquiries were received, a drop of 25% from the number processed in the previous year. The drop belies the complexity of several enquiries that the Customer Relations Officers handled during the reporting year
- Around 44% were enquiries relating to banking and payment services, mainly on dormant accounts, charges, transfers and delays
- A worrying increase in reported payment fraud and scams has been observed
- 167 new formal complaints were registered. This is higher than the number of complaints registered in each of the previous two years and surpasses the average of formal complaints processed between 2016 and 2020
- Just under 70% of formal complaints received were lodged online through the new portal
- 54% of complaints (90) were submitted by non-residents, whilst 46% (77) were from Maltese residents
- Around 64% (107) of complainants chose not to be assisted during the complaint procedure
- Several cases were referred to mediation and many cases have been resolved during such process
- 87 final decisions, of which 82 were final decisions concerning 89 cases, were delivered by the Arbiter for Financial Services. One final decision comprised 60 complainants as the merits of their case was intrinsically similar in nature
- Of these decisions, only 19 decisions (23%) were appealed, with the remaining 63 cases becoming binding on the parties and *res judicata*
- Of the 82 decisions, 16 complaints were upheld, 36 partially upheld and 30 were rejected

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Acronyms / Abbreviations

Act	Arbiter for Financial Services Act (Chapter 555 of the Laws of Malta)
ADR	Alternative Dispute Resolution
ASF	*Arbitru għas-Servizzi Finanzjarji* (Arbiter for Financial Services)
CBM	Central Bank of Malta
CRO	Customer Relations Officer
EEA	European Economic Area
EU	European Union
IDR	Internal Dispute Resolution
IT	Information Technology
MFSA	Malta Financial Services Authority
MiFID	Markets in Financial Instruments Directive (Directive 2014/65/EC)
OAFS or the Office	Office of the Arbiter for Financial Services
PIN	Personal Identification Number
PSD	Payment Services Directive (Directive [EU] 2015/2366)
QROPS	Qualifying Recognised Overseas Pension Scheme
RSA	Retirement Scheme Administrator
SL	Sanction Letter
T&Cs	Terms and Conditions
TTA	Trusts and Trustees Act (Chapter 331 of the Laws of Malta)

Report of the Arbiter for Financial Services

Although this report deals with just one reporting year (2021), we have already been in operation for more than five years during which we had the time to invent ourselves, learn important lessons and focus on offering an efficient service to our clients.

Dr Reno Borg
Arbiter

Technology and innovation

From day one we realised that we had to look outside the box so as to create an institution which is modern, innovative and able to deal with its workload efficiently. We invested in technology and new methods. A direct result of this strategy was the smooth way with which we worked during the pandemic. During the reporting year, apart from using technology to organise mediation sessions and oral hearings remotely, we invested in a case management system not only to cater for our needs but also to better serve the public. Further details about our new case management system are provided further on in this report.

Customer Relations Officers (CROs)

The work carried out by our dedicated team of CROs is very often overlooked. Since our inception, we realised the need of having a team of well-trained and dedicated persons to deal with minor cases and respond to the numerous queries that we receive throughout the year. CROs deal instantly with these cases either directly over the telephone, through emails or even by actually meeting consumers who encounter difficulties in solving their disputes with financial service providers. Our team also provide useful information on our complaints procedure.

In 2021, the CROs processed 814 enquiries and minor cases. In a good number of these cases, the CROs were required to make several enquiries and follow-up calls and emails until a final solution was identified.

Consumers in Malta account for 74% of enquiries. The remaining 26% were enquiries made by residents outside Malta, mostly from Europe.

Mediation

Mediation is the cornerstone of any alternative dispute resolution entity. The Arbiter for Financial Services Act stipulates that disputes should primarily be solved through mediation. Although during the first few years in which we were set up the parties involved were reluctant to resort to mediation, this year we had an encouraging result. We have started reaping the fruit of our insistence for the parties to attempt this amicable way of dispute resolution.

Compared to previous years, the cases referred to mediation in 2021 continued to increase. What is more encouraging is the fact that many cases were resolved during such process. Of the 70 cases referred to mediation, 36 were successfully mediated and an agreement between the parties was reached. Seven cases were withdrawn following mediation.

Investigation and adjudication

Although each case involves two 'conflicting' parties, our process is not entirely adversarial. Apart from the production of evidence by the parties, the Arbiter is empowered by law to conduct his own research and investigation to establish the truth of the matter under consideration. This differs from our traditional approach where the judge or magistrate can decide only on the evidence submitted by the parties. Very often the parties, either through intent or through lack of knowledge, fail to file important documents which are necessary for the proper determination of the case. In these instances, we try to source the documents ourselves, a process which absorbs much of our precious time.

The Arbiter is not just a spectator during proceedings. He actively engages with the parties in dispute to secure procedural fairness, especially for the unassisted party.

Our statue lays down that the Arbiter should proceed informally and economically. This guarantees the avoidance of time lost in unnecessary formalities, which very often alienate the parties from the real points at issue.

The Arbiter has also introduced the principle of disclosure whereby the parties are directed to present all the documents in their possession, even if the filing of such documents may not help their case. In this manner, surprises are avoided, and the Arbiter has the assurance that his decision is based on all the facts pertaining to the case. Through a short discussion with the parties, the list of witnesses is kept to a minimum allowing only witnesses that can relay new and material evidence, thereby avoiding repetition and its consequent time wasting. Written submissions are also kept to a minimum, addressing only the pertinent issues of the case.

In this way, and with the co-operation of the professionals and the parties involved in the process, we have created a procedure that is fast without compromising on fairness. By the end of 2021, only a handful of cases that reached the decision stage had not yet been decided; and this was due to the complexity of the cases themselves which necessitated the careful reading of extensive documentation as well as additional research. At the time of writing, all the cases that have passed through the mediation stage have been appointed for hearing while cases which are ready for decision are being decided as quickly as reasonably possible. In fact, the backlog that we had during the first years due to the influx of 'historical cases' has been dealt with. We are very conscious of the often repeated dictum that "justice delayed is justice denied". However, while satisfied with our achievements in this area, our ambition is to achieve still better results.

During the reporting year, the Arbiter delivered 87 decisions, of which 82 were final decisions concerning 89 cases. Five were either preliminary decisions or clarifications solicited by the parties. One final decision comprised 60 complainants as the merits of their case was intrinsically similar in nature. In this regard, their case was treated collectively in terms of Article 30 of the Act.

Only 19 decisions (23%) were appealed, with the remaining 63 cases becoming binding on the parties.

Private pensions

The number of private pension cases continued to increase. These are mainly cases submitted by expatriates residing in different jurisdictions who bought a pension scheme offered by a service provider authorised in Malta. In the year under review, of the 26 decisions relating to investments, 18 related to private retirement schemes. Indeed, one of these decisions was a collective decision comprising 60 complainants. Such complaints are particularly complex to assess due to the diverse content of each case, the particular merits and the voluminous information that is submitted at review stage.

In a number of decisions relating to private pension schemes, the Arbiter found that the service provider, acting in its dual role of Retirement Scheme Administrator and Trustee of the scheme, did not act in the best interests of the scheme members and did not perform its duties diligently as required by the applicable legislation and the service provider's own guidelines. The decisions were confirmed by the Court of Appeal.

The outcome of these decisions was mentioned in international media and it was quoted as part of a call for evidence on protecting pension savers submitted before the Work and Pensions Select Committee of the House of Commons in the UK. It was also cited in a UK voluntary code of best practice issued by the Pension Scams Industry Group (PSIG) to administrators of registered pension schemes.

This highlights even more the sensitive nature of the work undertaken by the Office and other alternative redress bodies.

Rapid developments in the financial services sector

Many operational aspects of the retail financial system have changed rapidly over these past few years, and the onset of the pandemic has exacerbated these changes. Customers have been expected to embrace tremendous changes overnight to a number of long-ingrained practices. Our CROs have handled various situations where bank clients were asked to pay new or higher fees for many services (without necessarily receiving a superior level of service) or to divulge much more information about themselves and their financial situation, which many consider to be a transgression of their privacy. It is not difficult to understand why some customers may feel puzzled that their financial service provider, with whom they had held accounts for many years, decided to terminate their financial relationship, at times, without any reasonable explanation.

The Arbiter acknowledges that banks and other financial institutions are obliged by law to carry out ongoing due diligence of their clients. However, one should not lose the scope behind anti-money laundering legislation which is intended to curb and fight at source money laundering and the financing of terrorism. Retail clients with small accounts, whose transactions are easily traceable, should not carry the burden of unnecessary bureaucracy which only serves to frustrate them without yielding the desired result. Such precautionary measures should be implemented only where they are truly needed, especially in dealing with professional money launderers.

Personal contact and consumer contracts

It is no surprise that financial institutions have embraced technology and are offering services remotely. There is no doubt that this innovative way of making business has facilitated the lives of millions of clients by giving them access to financial services just through a click on their electronic device. Some retail financial providers have also taken advantage of social media channels to market their products. However, these ought not to replace the personal communication that customers rightfully expect their financial provider to use when communicating important changes to their standard terms or conditions.

Personal contact should not be discarded, especially with vulnerable clients who find themselves lost in today's technological world. Apart from their strategic economic importance, local financial providers, especially banks, have also a valid social function.

The Arbiter notes that very often clients are required to sign lengthy consumer contracts which are highly technical and which the average consumer cannot understand. This practice only serves to create 'onerous contracts' which run counter to the provisions of the Consumer Affairs Act, and which have been criticised even by the Maltese Courts. This practice should change because it is both illegal and unfair. Consumers should be provided with short and simple contracts which they would be able to understand.

Crypto assets

The nature of the crypto assets business is essentially online and has no geographical borders. Indeed, a substantial number of the enquiries we received during the last half of the reporting year were, predominantly, from foreign consumers who sought services from firms that had been licensed only recently or were presumed by the said consumers to have a local licence. The enquiries received were not in relation to investing in crypto assets as such but rather related to fraudulent activity linked to such investments.

Our office has received various complaints about several scams doing the rounds, some of which involve payments to online investment platforms or payments by bank transfer for services or products which remain undelivered.

Scams may take many forms and target both vulnerable and informed consumers alike. During the reporting year, CROs have come across a range of consumers who fell victims to financial fraud, sometimes losing big amounts of money in the process. We have had several calls from customers who claim to have sent money to websites belonging to firms which purport to be licensed by the financial regulator in Malta. Though fraudulent, these sites are so professionally laid out that it often requires an expert eye to spot why they are not as authentic as they look. The text on such websites, along with the graphics, may appear to be well-crafted, sometimes displaying the logo and livery of a reputed organisation, to give an illusion of veracity. The CROs have come across several of these cases and have also alerted the respective financial service provider whose name/site might have been misused.

Consumer education

One of the most effective ways to combat these scams is through consumer education. All stakeholders involved in the financial sector should embark on a common strategy to empower the consumer against these fraudsters through educational campaigns and other means. The OAFS can also give a helping hand by highlighting on its website scam and fraud situations encountered by consumers to serve as an eye opener to prospective investors.

A few thanks

Although we have tried to do our best to offer the best service possible to our clients, we are always open to suggestions and constructive criticism which I am sure will help us improve.

In my report, I attempted to briefly highlight the work which we have carried out throughout the reporting year and the issues faced by stakeholders in an ever evolving scenario. More details about each aspect are found in the ensuing pages of the report.

In concluding this report, I feel obliged to thank the chairman and members of the Board of Management and Administration for their work and continued support. I am also grateful to all the personnel for the dedication and professionalism shown, especially in testing times. I also want to thank the Ministry for Finance and Employment for its continued financial and logistical support.

Overview of the Office of the Arbiter for Financial Services

The legislative framework

The Office of the Arbiter for Financial Services was established in April 2016 with the coming into force of Act XVI of 2016, the Arbiter for Financial Services Act (Chapter 555). The Act sets out the administrative, operational and jurisdictional framework of the Office. It also lays down the functions and accountability of the Office. It provides the necessary legal framework for the appointment, functions, powers and competence of the Arbiter. The appointment of a Substitute Arbiter, where this is necessary, is also provided for.

At the start of 2021, the Act was amended to give more clarity to the definition of financial services provider and to enable the Arbiter to better determine whether a service – in regard to which a complaint is submitted - would constitute a financial service or not. Other than catering for the ever-evolving financial services industry, the definition is also meant to curb the submission of complaints that do not relate to financial services.

The law was also amended to disallow complaints the merits of which are or have been subject to a complaint with an Alternative Dispute Resolution (ADR) entity in any other jurisdiction initiated by the same complainant on the same subject matter. Since the Act had been enacted, the law precluded the Arbiter from taking cognisance of complaints which were or have been subject to a lawsuit before a court or tribunal instituted by the same complainant and on the same subject matter. However, the Office has received complaints whose merits may or have been subject to review by ADR mechanisms in other jurisdictions, which mechanisms would fall outside the definition of a "Court" or "Tribunal". This amendment would therefore eliminate the possibility of double jeopardy, apart from the likelihood of conflicting decisions that may leave parties in legal uncertainty.

Designated financial Alternative Dispute Resolution (ADR) entity

By virtue of Legal Notice 137 of 2017 (Arbiter for Financial Services (Designation of ADR Entity) Regulations, 2017), the Minister for Finance, as the competent authority for the purposes of the ADR Directive, appointed the Office of the Arbiter for Financial Services as the ADR entity for financial services in Malta. As a result, and in regard to alternative dispute resolution bodies in relation to financial services complaints, Malta is fully compliant with the requirements of the said Directive 2013/11/EU, and has joined several other certified ADR bodies in the EU and EEA with similar competences in financial services complaints.

Role of the Board of Management and Administration

The Board of Management and Administration is appointed by the Minister for Finance and Employment. Its functions include:

1. provision of support in administrative matters to the Arbiter in the exercise of his functions;
2. monitoring the efficiency and effectiveness of the Office and advising the Minister on any matter relevant to the operations of the Office;
3. recommending and advising the Minister on rules regarding the payment of levies and charges to the Office by different categories of persons, the amounts of those levies and charges, the periods within which specified levies or charges are to be paid, and the that penalties are payable by a person who fails to settle on time or in full the amount due; and
4. collecting and recovering the levies and charges due.

The Board is not involved in the complaint process.

On an annual basis, the Board, in consultation with the Arbiter, is required to prepare a strategic plan as well as a statement with estimates of income and expenditure for the forthcoming financial year. The Strategic Plan for 2022 was presented to Parliament and is available on the Office's website.

The Board convened seven times in 2021; all members attended the meetings.

The term of office of the Board of Management and Administration expired in April 2021. The same members were re-appointed for a period of one year up to April 2022.

Board of Management and Administration

Chairman
Geoffrey Bezzina

Members
Peter Muscat
Dr Anna Mallia

Secretary
Valerie Chatlani

The appointment of the Board of Management and Administration expired on 28 April 2022. On 2 June 2022, the Minister for Finance and Employment reappointed Mr Geoffrey Bezzina and Mr Peter Muscat BA, ACIB (London) as chairman and member respectively for a further period of three years up to 1 June 2025. On 12 July 2022, the Minister appointed Mr Antoine Borg FCCAA FIA CPAA as the new Board member for the same term.

Administrative Report

Geoffrey Bezzina
Chairman
Board of Management and Administration

The year under review marks the fifth year since the Office of the Arbiter was initially set up. It is still a relatively young organisation, but it has made huge strides in the financial services sector in Malta and beyond, as the Arbiter for Financial Services has clearly described in his report.

The reporting year has been an important year for the Office as we maintained our investment in and use of IT applications, especially in relation to remote mediations and hearings. In parallel, we implemented a case management system that was specifically tailored to our needs.

Our previous year's annual report provided a general overview of the new system's various functionalities, along with its integration of a front-end interface enabling consumers to lodge complaints and enquiries online. Such system also incorporates a new bi-lingual website (refer to 'Case and file management system' across the page).

Decisions of the Arbiter

The Arbiter's decisions are uploaded in their entirety, redacted only for the names of the complainants. They are also categorised to enable users to search through over 550 decisions that the Arbiter has delivered since 2016. Even the output of results can be selected to appear in two modes, another feature that complements the way the Arbiter's decisions are presented and this in an effort for researchers, consumers, financial services providers, regulators and other stakeholders to have easier access to the growing body of financial services ombudsprudence. However, we are aware that we can do more to disseminate further the Arbiter's decisions. Case summaries can be an important way to share key aspects of decisions but presently their dissemination to a range of stakeholders may be uneven. The Arbiter's decisions should not merely be seen as the culmination of an adjudicative procedure to resolve disputes; they should also be a key source of learning in a framework that feeds into the understanding and implementation of rules and regulations as well as adjunct procedures.

Providing guidance to consumers

The implementation of the case management system is simply a tool for the public to have better access to our services. However, consumers expect to be given all the guidance they can get about the complaint procedure – from the actual articulation of the complaint up to the appeal stage. Many customers who approach us with a complaint do so without any professional assistance. The law itself allows for complainants to be unassisted but requires the Arbiter to ensure that hearings still remain fair for the parties.

Apart from responding to various enquiries about the different stages of the complaint process, our staff have also provided guidance to customers to facilitate the completion and submission of the complaint itself so that it meets the criteria envisaged by law. Our focus has always been to enhance accessibility to customers who approach our office and to alleviate their concerns about a process that, for most, may appear to be daunting or confusing. Our efforts over these years have provided us with a fairly good overview of the challenges and expectations that consumers harbour when approaching an organisation that is purposely set up to listen to their grievances, and to provide assistance and answers that serve their interests.

We therefore need to scale up our resources and efforts to improve accessibility for customers. If consumers feel intimidated to proceed with their complaint, this is indicative of barriers that need to be analysed and addressed. It is normal for many consumers to be

Case and file management system

As with any system that is newly implemented, several teething problems were encountered in the initial stages of our system's deployment, but these were dealt with quickly and efficiently by our software developers. In parallel, we were also required to reassess a number of internal processes, necessarily shifting much of our work from a manual to an IT-based environment. Adapting to new changes is not always easy but it is reassuring to note that the staff rose up to the occasion and adapted well to changing or implementing new processes following constructive discussions held internally, and this apart from feedback received from the users themselves in relation to the complaint submission process.

Although our initial set of specifications were relatively quite detailed, it was obvious that further enhancements would have been required not only to improve the system but also to add new features and functionalities that improved our processes and, equally important, the user experience at front-end. Over the first few months, staff not only became conversant with the features of the system, but they were themselves prime motivators of a number of enhancements and design tweaks. Such enhancements improved staff efficiency, focusing less on menial processing and more on providing a better service to the stakeholders that engage with us daily.

The system is rich in features and functionalities, but there are initial plans to continue improving on it in future. Indeed, our aim is to enable an environment for both the complainant and the provider, and their respective professional advisers where applicable, to have on-demand access to the electronic version of the case documentation at various stages of the complaint procedure and for the relevant parties to receive notification of newly uploaded documentation as it is made available without resorting to email exchanges and attachments that often go astray or blocked for exceeding mailbox size. Indeed, our plan is for an integrated and efficient case management system that grows with the needs of the office and, more importantly, that efficiently meets the standards expected by stakeholders.

Our staff continued to receive training on the use of the system during the first few weeks of the system's implementation. The Board's decision to have a web-based system meant that all staff members were able to access the system, wherever their location. Indeed, this had proved beneficial as, in 2021, we were also required to momentarily shift to working remotely following the health authorities' recommendations. As the system and the database, are hosted on a hybrid cloud system, access to the system is successful only through robust user authentication, thus ensuring full data integrity.

dissuaded from challenging their financial services provider; but the creation of bodies such as the OAFS is precisely to facilitate access to justice by consumers in an informal and bias-free environment, that strips down excess formalities and unnecessary delays, whilst still respecting the rights of the parties to a fair process.

The OAFS is one of several alternative dispute resolution bodies that have been set up in Europe and indeed around the world for consumers to exercise their right to have their complaints resolved quickly, inexpensively and fairly, without removing their primary right to refer to the Courts if they wanted to. However, it is a known fact that for many consumers, the availability of such alternative dispute resolution bodies is the only realistic option to have their disputes resolved in an efficient and cost-effective manner.

International participation

The OAFS is an active participant in two international networks composed of out-of-court dispute resolution bodies tasked with resolving financial services complaints.

Since 2017, the Office has been a member of FIN-NET, the network of cross-border financial dispute resolution between consumers and financial services providers in the EU and EEA. It was set up by the European Commission around 20 years ago to promote cooperation among national consumer redress schemes in financial services and to provide consumers with easy access to alternative dispute resolution procedures in cross-border disputes concerning the provision of financial services. FIN-NET has 60 members in 27 countries.

Indeed, during the reporting year, we had several instances where local consumers were in dispute with financial firms which were authorised in the EU and which offered their products or services online in Malta. This is perfectly normal and at law, as financial services licensed in the EU may offer their services across the region without the need to have a licence in each host Member State where they operate. Although we cannot accept complaints against such firms (as they would not be authorised by the financial services regulator in Malta), we can certainly inform the consumer of his right to seek assistance and lodge a complaint with the edresss mechanism where the financial services provider is authorised. In such situations, we provide all the necessary contact details of such redress body apart from drawing the customer's attention to provisions in the relevant terms and conditions which would specifically outline the redress mechanism that is applicable in such situations.

We are also active in the Steering Group, chaired by the European Commission (DG FISMA), which prepares the agenda for FIN-NET's bi-annual plenary meetings. Our meetings during the year, both held online, served as an opportunity for redress mechanisms to share experiences about common complaint trends, but participants were also briefed by EU officials on various legislative and non-legislative financial services developments in the EU.

The Office Is also a full member of the International Network of Financial Services Ombudsman Schemes (INFO Network). The network is the worldwide association for financial services ombudsmen and other out-of-court dispute resolution schemes that resolve complaints brought by consumers (and, in some cases, by small businesses) against banks, insurers and/or other financial services providers. The network facilitates cooperation among its members to build expertise in external dispute resolution by exchanging experiences. Our office was also invited to share its experience with the implementation of the case and file e-solution system, a topic that has interested a number of nascent ADRs in this field.

Looking ahead

The pandemic has accelerated the pace of our office's digital transformation. The adoption of IT applications and systems since 2016, when we set up our offices in a relatively short period of time, has made remote working easier to implement and adopt, leading to better coordination of work streams within the office. The public IT infrastructure to which we are linked has also delivered a robust platform for our services to be provided seamlessly and securely.

As we enter our sixth year of operation, we are determined to step up our strategy to enhance our visibility and accessibility for the benefit of consumers. This requires further investment in recruiting additional and training additional staff to contribute towards the attainment of such aims.

Substantial work has already been done in the preparation of moving offices at the end of 2022. Although the pandemic had thwarted our efforts to move into such new offices in 2020, we took the opportunity to engage further with the landlord to improve on the safety and well-being environment of the intended office space in which we will be housed, apart from ensuring that the décor is more befitting our setup. We are grateful for the immense help that we have been provided by staff from the Ministry's corporate services and IT departments in the logistical and other ongoing preparations for our relocation.

On behalf of the Board, I would like to thank our team for their work and dedication. I am also grateful for the annual financial contribution that is made by the Ministry for Finance and Employment towards the management and administration of the Office. Lastly, I thank the Arbiter himself for his leadership.

Staff complement

Apart from the Arbiter for Financial Services, the Office is composed of the Chairman, registrar (investigations and adjudications); two customer relations officers (one of the officers is also the secretary of the Board); two case analysts; an officer in charge of mediation; an administrative assistant; a handyman and a receptionist/messenger.

Back row (left to right)
Paul Borg, John Francis Attard, Robert Higgans, Samantha Sultana, Gaetano Azzopardi, Francis Grech

Front row (left to right)
Valerie Chatlani, Rita Debono, Dr Reno Borg, Geoffrey Bezzina, Ruth Spiteri

Operational Review

Enquiries and minor cases

The OAFS offers both an informal and a formal mechanism for consumers to submit their grievance against a financial services provider or in relation to a financial product or service (refer to Annex 1 for a schematic description of these processes).

The informal process deals with minor cases and enquiries. It uses information, negotiation and conciliatory techniques for an amicable resolution of such cases. A major component of this process is the provision of information to customers, especially on the formal complaint handling mechanism. This latter mechanism is discussed at length in the next section of the Annual Report.

Over the course of the year, there were several occasions in which the Office's Customer Relations Officers (CROs) actively engaged with the financial services provider concerned to assist in the resolution of minor cases and enquiries in an informal manner. This section provides a narrative of a number of enquiries processed by the CROs during the reporting year and includes a summary of some cases to show how the OAFS approached different situations in which it was asked to intervene.

Further analysis of the type of enquiries and minor cases processed in 2021 is available in Annex 2.

Our approach

A team of experienced CROs is responsible for handling enquiries and minor cases on financial services submitted by customers. The CROs deal with a range of common aspects of financial services – that is, banking, investment services, private pensions and insurance – but also provide information about the Office's complaints procedure.

Most often, enquiries relate to what we term as minor cases. Depending on the situation at hand, the CRO concerned may recommend a possible remedy or a course of action. Such response would normally be based on similar experiences also brought to the Office's attention by other customers in preceding enquiries.

Depending on the nature and complexity of the issue, it is customary for the CRO to direct the customer to contact the respective provider again, offering basic information which the customer could consider when dealing with the provider. The CROs have built a working rapport at arms' length basis with many compliance or complaints officers at various financial services providers. These officials are the CROs' first port of call when they need to be contacted following an approach by a customer for assistance.

In many cases, the CROs would volunteer to contact the respective financial services provider to elicit their initial views on the matter. This approach is usually pursued when the enquiry would present itself as being particularly uncommon or somewhat complex.

In a number of cases, the initial enquiry would need to be followed up with an email (or a letter, in the remote instance where the customer does not have email access) to allow the customer to provide further details and supporting documentation related to the issue in respect of which the OAFS was asked to intervene.

It may also be the case that the customer would not have provided all the relevant information to the CROs. This may happen when the customer may have been unable to source such information from the provider concerned, or where there are gaps in information as a result of various factors which are beyond the customer's control.

Before contacting the relevant financial services provider, the CROs would assess the merits of such enquiries in an attempt to identify and recommend (where possible) a practical solution to the issue at hand. In certain circumstances, the CROs may intervene with the provider to get a situation sorted out. We are pleased to note that many providers are amenable to cooperate with the CROs and will consider suggestions

or recommendations, especially if the latter's informal intervention would lead to the positive conclusion of minor cases.

In many situations, the CRO's informal intervention can break an impasse which might have existed between the parties concerned. Many customers reached out to our Office as they were either unable to get through to their financial service provider, or the expected response time from such provider was taking inordinately long. This occurred mainly during those periods where the staff of many organisations throughout Malta were working almost exclusively remotely. In these cases, the CROs alerted their contacts at the respective providers requesting that they reach out to the customer who made the original enquiry. There have never been any cases in which our contact with a financial services provider in such situations has been disregarded or given short shrift. Although the CROs may not always receive feedback from the customers themselves, providers keep our CROs updated with their efforts to reach out to the respective customers, and one is pleased to note that the majority of cases are resolved within a short time when the customer makes initial contact with the Office.

At times, some particular situations may be too complex to be determined at this informal and conciliatory stage. When this happens, the CROs will propose a specific course of action to the customer (such as seeking legal or other professional help). Often the case is escalated to the next stage, that is to a formal complaint.

Many aspects of the retail financial system have changed rapidly over these past few years, and the onset of the pandemic has exacerbated these changes. While those working in this industry may have managed to keep abreast with such changes, the effect of such transformation and the speed with which users have been required to adjust to it have left many bewildered, frustrated and, possibly even marginalised. Customers have been expected to embrace tremendous changes overnight to a number of long-ingrained practices that some financial firms may not have bothered to update for years, pay new or higher fees for many services (without necessarily receiving a superior level of service), and divulge much more personal information about themselves and their financial situation which many believe may be a transgression to their privacy. It is not so difficult to understand why some customers may feel puzzled that their financial service provider, with which they had held accounts for many years, decided to terminate their banking relationship at times without any reasonable explanation or were being requested to present copious documents, often at an expense, simply to close an account where the balance is small or the transactions in that account easily traced to source.

Our approach when confronted by such aggrieved customers is, first, to calm down the person. In parallel, our CROs seek to impart information to the customer as to the reasons why some providers may have taken the decision or behave in the way they did. Our CROs have spent considerable time and effort explaining why financial providers are now requesting more information about their customers' wealth and financial situation. Many times, customers have accepted the CROs' explanation and the information provided. It is thus regretted that an ongoing (and repetitive) campaign to inform and educate consumers about the profound changes to the financial system, and its impact on consumers, is absent. Clearly, a national effort to ensure that all customers are not disadvantaged in terms of their digital knowledge and financial literacy should be pursued.

Naturally, many customers also contact the Office for the purpose of enquiring about its complaints procedure. Although some customers seek the services of a professional person when lodging a complaint with the Office, several customers choose to submit a complaint unassisted. Apart from addressing all enquiries that are made by such customers, the CROs actively encouraged them to make use of the new online complaint submission facility that was rolled out at the start of the reporting year.

Analysis

As we have had the opportunity to observe in the preceding annual reports, although it would have been quite normal for customers to reach out to us physically by visiting our offices, we preferred to exclusively have customers reaching out to us by phone, WhatsApp or email. We explained why we took this decision. Naturally, we were also mindful that some customers simply had to be invited to come to our offices as, in such cases, there will always be some exceptions to the rule. In such situations, the necessary health precautions were taken, to the benefit of all parties concerned.

In 2021, the CROs processed 814 enquiries, a drop of 25% from the number processed in 2020. The drop belies the complexity of several enquiries that the CROs were required to handle, and the several follow-up calls and emails until a final solution is reached.

Around 74% of enquiries were made by consumers residing in Malta. The remaining 26% of enquiries were made by consumers outside Malta, mostly from Europe. Over 38% of enquiries were made by phone, followed closely by enquiries submitted through our portal (31%). In 64% of the cases, the OAFS provided general information to the customer. In 35% of all enquiries received, the CROs were required to intervene and, on the basis of the CROs' analysis or feedback received, the customers appeared to be satisfied with the outcome or level of service provided. On average, it took around 46 days for enquiries to be resolved.

It is positive to note that, in many cases, the initial informal intervention of this Office with the service providers concerned resulted in the positive conclusion of the case, and this to the mutual satisfaction of the parties. This practical approach would avoid the escalation of a case to a formal complaint status.

CASE STUDY

Credit card
SMS message scam

The complainant had inadvertently fallen victim to the growing incidence of criminal fraud and scam attempts and this after replying to a supposedly authentic SMS purportedly sent to him by a courier service company. This led to a personal financial loss of a sizeable amount through several fraudulent transactions on their credit card. Once they had become aware of the matter a few days later, the complainant had reported the incident to the bank concerned and provided all the requested documentation in order to substantiate their case. On its part, the bank had referred the case to its correspondent foreign bank in an attempt to retrieve the complainant's funds. However, it had pointed out from the outset that there was no guarantee that its request would be accepted or that the illicit funds would actually be returned.

The OAFS was averse to the possibility that the bank's continued handling of the case might stall with the passage of time and that no tangible progress would be taking place. It therefore continued to monitor the case periodically and liaised constantly with the bank in order to gauge the current status of the case from time to time.

Meanwhile, it kept the complainant fully updated about its continued efforts to attain the satisfactory solution to their unfortunate case. The continued effort put in by the OAFS eventually paid off. The bank finally accepted to refund the complainant's financial loss in full, amounting to just over €3,000. The amount was duly credited to the complainant's card account.

Banking and payment services

Around 44% (360) were enquiries relating to banking and payment services. Other than enquiries relating to general information matters, the four main issues handled related to dormant accounts, charges, transfers and delays relating to the processing of inheritance-related documents.

A number of enquiries peak and abate, while others generally maintain a low but persistent trend. For instance, at the beginning of the reporting year, the Office had several enquiries relating to charges imposed on dormant accounts and delays being experienced by heirs for the processing of documents relating to inheritance distribution of bank funds. The latter category of enquiries was persistent between the second and third quarter of the year, but then dwindled during the last quarter. On the basis of repeated enquiries received over the issues surrounding the delays that heirs were experiencing, the CROs immediately engaged with the respective banks on the matter. Many consumers who called the Office claimed that they were unable to talk to officials at the respective banks' inheritance units. We explained that, in such situations, the interlocutor between the bank and the heirs is the notary appointed by the latter. Divulging of information telephonically to the heirs would not only be in breach of confidentiality, but also a time-consuming and often repetitive task if it involves speaking to multiple heirs within the same inheritance case. Through our informal intervention, the involved banks expedited review of the respective inheritance file and several cases were closed within two or three weeks of the initial contact with the OAFS, depending on the complexity of the case.

Over the course of these last few years, banks have been required to review savings and current accounts opened by customers and identify those accounts in which there were no transactions in the previous year or two, or the balance (sometimes a meagre amount) may have been sitting idle in that account for relatively much of the same time. Many account holders received letters from their bank requesting them to decide whether they wished to retain the account open; and if so ensure that they make a minimum number of transactions on a yearly basis and/or keep a minimum balance. Otherwise, they risked having their account blocked or a charge levied on their account.

Account holders were given a time limit by which they were required to inform the bank as to their decision. Failure to do so would have led the bank to block the account and disallow any future transactions being processed through such account. A holder of such a blocked account would have also been required to go through a due diligence process for their account to be reactivated.

Not all banks employed the same techniques to nudge their account holders to take action on such dormant or low-balance accounts. The prevailing approach taken by banks to inform account holders appears to have been similar in that a personalised letter (in both Maltese and English) was sent in sufficient time to the respective customers. The majority of customers who contacted the Office were surprised to see charges deducted from their account or to be unable to transact on that account, claiming that their bank did not inform them of such action. The Office does not always become knowledgeable in advance of initiatives taken by banks in this regard, and always engages with the respective provider to understand the event that would trigger such customer's reaction.

Banks should not refrain from properly and clearly informing account holders about any changes to procedures or practices relating to savings and payment accounts, especially when such praxis would have become a routine custom over the years and may require some time to become the accepted new norm. Moreover, although some banks have taken advantage of social media channels to market their products, these ought not to replace the personal communication that account holders rightfully expect their bank to use when communicating important changes to their standard terms or conditions.

The same can also be said in regard to the manner in which some banks inform their account holders of changes to their tariff schedule. One cannot but generally observe that it has now become the norm for charges to be increased or new charges to be introduced, with very few instances of charges being reduced. As to the introduction of new and revised charges, it is a legal requirement for financial services providers to inform their customers in a durable medium sufficiently in advance of such changes coming into force. Technically, such a unilateral change in tariffs gives the account holder the right to terminate the relationship at no charge if they are unwilling to accept the change as announced by the bank. How, and to what extent, such legal right is made known or exercised remains to be seen.

One observes that bank charges have now evolved to such an extent that some banks have divided their long tariff schedules into separate shorter ones distinguished in different categories. The problem is that, sometimes, one may hardly find a short explanation to describe the contents of such tariff schedules, rendering the identification of the appropriate fee a time-consuming and frustrating exercise on the presumption that the account holder actually manages to find what they were looking for. Moreover, one cannot fail to observe that some charges are written in a way which only bankers might be able to understand. Alternatively, some charges are vaguely labelled. This renders it difficult for retail account holders to understand such charges and defies the purpose for which such tariff schedules are issued. Once again, there is always opportunity to provide more clarity to the way tariffs are described, and relayed, to customers.

CASE STUDY

Travel insurance
Application of excess

The complainant and his family (two adults and three children – five persons in all) had to necessarily cancel a planned holiday overseas for health reasons. They submitted a claim to their travel Insurer for the reimbursement of the airline tickets, amounting to €425.

The insurer concerned accepted to settle the said claim but only after deducting a claim excess (€58) five times in accordance with the number of persons involved in the trip. This would have reduced the compensation provided to a mere €134)

The OAFS intervened in the case and initially approached the insurer concerned to discuss the matter amicably in order to possibly identify a practical solution to it. Failing that, the case would have been escalated to a formal complaint for the Arbiter's consideration and eventual adjudication.

During the ensuing discussion, the OAFS repeatedly referred to the travel policy document. While accepting the principle that an excess had to be applied in the settlement of the claim, it highlighted the fact that the excess application wording itself was unclear and did not appear to support the insurer's intention to subtract five separate excesses in respect of the same claim.

To support its contention that it was in the right, the insurer concerned provided a grammatical explanation of the policy text which, in its view, backed its intended claim settlement.

However, the OAFS pointed out that the claimant was a layman who could not be expected to fully grasp technical Insurance terminology with which he was unfamiliar. This was even more so if such understanding depended on grammatical explanations.

At the end of a prolonged discussion, the OAFS successfully secured the insurer's agreement to revise its intended claim settlement and apply just one single excess.

This improved the claim settlement to €368, which the complainant was quite pleased to accept.

Finally, one aspect which has been rearing its head during the last quarter of the year under review relates to reports of several scams doing the rounds, some of which involve payments to online investment platforms, often involving purchases of crypto currency or other investments – often quite risky - or payments by bank transfer for services or products which remain undelivered.

Scams may take many forms and target vulnerable and informed consumers alike. During the reporting year, we have come across a range of consumers who fell for some sophisticated fraudulent schemes, in the process leaving them powerless and nursing financial losses, sometimes of big amounts.

For instance, we have had several calls from customers who claim to have sent money to websites belonging to firms which purport to be licensed by the financial regulator in Malta. These websites are fraudulent but are so professionally laid out that it often requires an expert eye to spot why they are not as authentic as they look. The text on such websites, along with the graphics, may appear to be well-crafted, sometimes displaying the logo and livery of a reputed organisation, to give an illusion of veracity. The CROs have come across several of these cases and have also alerted the respective financial service provider whose name/site might have been misused.

Our office has received multiple reports from customers who received an SMS that appeared to be a genuine message from a bone fide company. The SMS alerted them to something requiring their urgent response and provided a shortened hyperlink. The hyperlink led to a fake website that looked very similar to the one belonging to the genuine company. Customers who keyed in their card details had their accounts debited with multiple transaction in minutes.

Smart phone usage has become widespread. The immediacy by which users have come to reply to messages received over their phones makes such fraud attempts harder to detect. The problem is that, in some cases, the OAFS simply cannot do anything other than to encourage customers to report the matter to their respective enforcement authorities, who are better placed to investigate such matters.

Although card payments may, in some instances, be refunded following a chargeback process, the return of all funds withdrawn may not always be successful. The same can be said when sending funds via the banking system. Many customers believe that sending a bank transfer is a guarantee that the service or product being paid for will be delivered, and that the remitting bank would have access to details of the beneficiary account to which funds are sent, even if this is an account held with another bank elsewhere. It is incorrect to reason so and a case determined by the Arbiter during the year (which is also summarised on page 35 of this report) should be yet another eye-opener for those who believe that bank transfers may be successfully reversed or claimed back at one's whims.

It is a known fact that many scams remain unreported, especially when customers would have lost a substantial amount of money. One cannot completely eliminate fraud, but attempts to minimise fraudulent incidents should be explored. Consumer education is an important effort but only part of the story. As fraudsters are always a step ahead with their schemes, financial and other stakeholders should engage better to raise awareness and employ measures – as far as reasonably possible – to influence consumer behaviour and alert users not to react impulsively and risk falling into such traps.

Investments and pensions

The majority of enquiries received under this sub-sector of financial service activities (130, 16% of total enquiries) related mainly to crypto asset transactions.

The nature of such business is essentially online and spans no geographic borders. Indeed, a substantial number of the enquiries we received during the last half of the reporting year were, predominantly, from foreign consumers who either sought services from firms that had been licensed in Malta during the year in review, or were presumed by the said consumers to have a local licence. The enquiries received were not in relation to investing in crypto assets as such but rather – and this in line with what has already

been discussed above – related to fraudulent activity linked to such investments that enquirers realised (often quite late in the day) they had fallen victim to.

This is not only a local phenomenon. Scams relating to crypto investments have been observed to have arisen exponentially all over the world. Lured by potential gains from a hyped-up crypto industry, many people from all over the world switched to investing in crypto on promises of better and quicker or higher returns (but before the heavy losses experienced during the first half of 2022).

CASE STUDY

Motor insurance
Valuation of vehicle

The complainant was involved in a road accident, for which they were not at fault. Their six-year-old car was so seriously damaged that the insurer of the liable vehicle declared it to be beyond repair, labelling it a wreck. It offered a settlement of €3800, with the claimant retaining the vehicle. It also directed the latter to sell the damaged vehicle to a local garage which the insurer had specifically identified for this purpose.

The motorist was very unhappy with this proposed settlement and requested the intervention of the OAFS.

In its assessment of the case, the OAFS observed that the damaged vehicle was never actually inspected by the insurer's assessor, who had merely relied on the pictures sent by the repairer. This precluded the possibility of the assessor correctly determining the damaged vehicle's actual material condition (both internally and externally) and therefore its proper market value at the time of the accident. Moreover, the claimant was just a 22-year-old with no experience in the motor trade sector and certainly not in a good bargaining position when selling the wreck.

The protracted discussions held by the OAFS with the insurer concerned eventually had a positive outcome. The complainant was offered a choice between two options where, in both cases, the insurer would take over the wreck itself:

- *A car, identical to the complainant's make and model and of approximately the same age and mileage; or*
- *The payment of €6,300 in full and final settlement.*

The complainant happily opted to take up the second option and was compensated accordingly.

Many of the stories our CROs have encountered follow similar patterns – an online user befriends someone on social media and is lured by the latter into investing in crypto. The promises of substantial profits with abundant support appears to be authentic, especially if it is offered at no charge. Such 'crypto experts' approach users in a way that they make their victims feel comfortable talking and working with them.

One consumer, a Maltese, was particularly impressed that he found a 'crypto expert' who was chatting with him in Maltese only to realise – at a much later stage – that the fraudster was using an instant online translation service whilst chatting. Some users may also – at a huge and incalculable risk – allow the 'expert' access to their PCs via desktop sharing applications. The expert would guide the user to transfer money to a licensed crypto exchange, which would then be invested in crypto investments and held in digital wallets which the user thinks belong to him. When the user tries to withdraw his holding from such digital wallet, the 'expert' comes up with a number of excuses why this would not be possible. For instance, the CROs have come across situations where the user was asked to transfer further funds to the account as the amount on balance was insufficient to allow a withdrawal. Rather than raising a red flag, some consumers actually send further money. Sometimes, the digital wallet into which funds are deposited end up belonging to the fraudster rather than the user; the former then sparing no time to transfer the bounty to anonymised digital wallets which are often not easily traceable.

CASE STUDY

Motor insurance
Accident involving a foreign-plated truck

The complainant requested the intervention of the OAFS in respect of their case, which had been stalled for quite some time without any tangible progress taking place.

They had been involved in a road accident with a foreign-plated truck, for which the latter was at fault. Since their vehicle was insured on a comprehensive basis, their insurer had duly repaired the damaged vehicle. However, the complainant had been required to pay a €500 excess, apart from also being out of pocket by an additional €150 for the cost of hiring a replacement vehicle while their car was being repaired.

The complainant had been promised by their insurer that the said amounts would be refunded in full once it

recouped its outlay from the Malta Green Card Bureau (MGCB). The latter had taken over the handling of the claim on behalf of the foreign insurer which had not appointed a representative in Malta.

The MGCB was contending that it could not reimburse the claim payment to the insurer concerned before it had recovered such expense from the foreign insurer covering the foreign vehicle.

In the light of the foregoing, the OAFS briefed the local Insurer concerned about the international motor insurance scenario within the Green Card system. It highlighted the fact that the MGCB was bound by an international agreement involving all Bureaux which guaranteed that it would be fully paid and refunded (together with a handling fee) within a predetermined time frame. Such refund would have been made by the foreign bureau of which the liable insurer was a member. This precluded the MGCB from employing any delaying tactic vis-à-vis the local insurer concerned.

The foregoing briefing served the local insurer quite well. It soon reverted to the OAFS with the information that it had retrieved its outlay from the MGCB in its entirety, apart from confirming that it would be refunding the complainant accordingly.

This was duly done, and the respective case file was then closed.

Indeed, it bears to be recalled that crypto-asset transactions are registered on blockchain, a decentralised and unregulated operating technology, that guarantees transparency of operation but not that of operators who remain anonymous. Indeed, the challenge for users who fall victim of such scams is the difficulty they encounter to establish the identity behind a digital wallet in which their funds are deposited.

There is certainly scope, once again, for educational campaigns intended for consumers to be alert when being befriended by people claiming expertise or experience in crypto assets. The illusion of reality is often to blame for the many scams that consumers fall prey to.

During the year, the CROs were also asked by consumers for information about the state of play of their holdings held with firms whose assets had been suspended pending regulatory or legal outcomes, or issued by entities which suspended valuation following protracted restructuring periods, among other reasons. The CROs provided the necessary information, though this was not always possible as sometimes such information might not have been directly available to the OAFS. Some consumers were also calling the office to seek reassurances as to payment or indicative dates by when they would have been able to access their funds. Categoric reassurances can never be provided and the CROs provide information as it has been relayed to them by the providers themselves and from other information available in the public domain.

CASE STUDY

Home insurance
Damage sustained by burst pipe

The complainant approached the OAFS lamenting the fact that their claim for compensation, in respect of the damage sustained by the water piping system, had been scaled down by the insurer concerned to a mere €500 even though all the supporting documentation requested by the said insurer had been provided.

Based on the information and the documentation provided by the complainant, the OAFS assessed the merits of the case and although the complainant did not adhere to the policy in its entirety, the OAFS assisted the complainant and engaged at length with the insurer concerned so as to identify a practical solution. Such discussion eventually resulted in a partially positive outcome. The insurer concerned offered an improved settlement of €750, on an ex gratia basis and without prejudice to any future claims.

Noting that the said amount would go some way to offsetting the overall repair cost incurred, the complainant accepted the settlement.

Insurance

The number of enquiries relating to insurance matters amounted to 265, around 33% of the enquiries received.

Several issues continued to manifest themselves even during this reporting year. These included issues relating to the manner insurers estimate the value of motor vehicles when deciding if it would be worth repairing an accidented vehicle or declaring it beyond economic repair, the delays for the procurement of replacement parts caused by problematic supply-chain issues especially for parts that need to be imported, and enquiries from individuals who would not be covered by a comprehensive motor insurance policy and would therefore be claiming on the policy of the tortfeasor.

There were also a number of enquiries relating to home and travel insurance.

Similar to previous years, the OAFS received multiple enquiries in respect of pet insurance. In such cases, the CROs engaged with the providers concerned and, in the majority of cases, the insurers concerned agreed to honour the claim after the claimants had referred their case to the OAFS at enquiry stage.

CASE STUDY

Pet insurance
Cost for veterinary care

The complainant's pet dog ingested some high phosphorus cattle feed while out on a walk. This was contained in a bucket which was left by the side of a public path. The dog was on a lead while passing through a gate. As the policyholder turned to close the gate, the dog stuck its head in the bucket and ingested its contents. This resulted in a digestive upset and caused it to vomit repeatedly in the ensuing hours, requiring veterinary care.

The insurer concerned declined the claim on the grounds that the claimant had not exercised due care and attention or taken all reasonable precautions to prevent the happening of the accident. In the insurer's view, such care and attention would have been properly provided if the dog would have been muzzled. The insurer actually contended that the claimant had disregarded the advice given in this respect by a vet.

In its intervention, the OAFS highlighted the following aspects of the case:
a) The use of a muzzle had indeed been discussed by the complainant and their vet. However, no specific advice had been given by the latter to actually have the dog wear one. This was recorded in the dog's clinical records.

b) There was only a single previous case in the dog's history, which had happened several years before, where it had ingested something while out on a walk with its owner. This contrasted with the insurer's assertion that the claimant was aware that its dog was known to regularly ingest things while out on a walk.

c) The wearing of a muzzle would not have prevented the accident. Muzzles are designed to "provide plenty of room for panting, drinking and eating". The ingested material was of a fluid nature.

The OAFS persisted in its stance during its protracted discussion of this case with the insurer concerned. This resulted in the latter's payment of £483 to the complainant, net of the applicable policy excess.


FEEDBACK

The formal complaints' process

Consumers, whose complaints cannot be resolved amicably or which involve complex issues that may require investigation, may lodge a formal complaint with the Office. Unlike the enquiry/minor case complaint process discussed in the previous section, this complaint procedure essentially involves four phases – registration, mediation, investigation and award (schematic description of these processes is available in Annex 1).

Although in this report we describe the complaints that require adjudication as 'formal', in reality the procedure is straight forward and is kept as informal as possible, keeping in mind the informality required by the Act and that our forum is consumer oriented.

Annex 3 provides further analysis of the formal complaints received and decisions delivered by the Arbiter in 2021.

Initial review of newly-submitted complaints

Following implementation of the web-based case management system during the first few days of 2021, a number of processes that were implemented and refined over the years for the intake and initial assessment of formal complaints were redefined to cater for the lodgement of complaints online through the OAFS' new portal. Indeed, the number of complaints submitted online surpassed the number of complaints submitted physically, mostly by mail.

A formal complaint submitted to the OAFS, which must be word-processed, passes through an initial review assessment before it is registered. Administrative staff, with the assistance of the Customer Relations Officers, assess newly submitted complaints as soon as practicable and engage with the complainant to ensure that the submission is complete and meets the minimum criteria required by law.

Key documentation in support of the complaint – such as policy wordings and schedules, proposal and application forms, contract notes or other legal documents – may usually be requested.

There may also be instances where the complaint review is temporarily stalled as the complainant would not have initially lodged a complaint directly with the financial services provider concerned prior to submitting a complaint to the OAFS. The Act requires that a financial services provider is given reasonable opportunity to review a complaint before it is submitted to the OAFS. Staff would then request the complainant to exhaust the internal dispute resolution (IDR) mechanism with the provider prior to progressing further with the complaint. Naturally, where the IDR mechanism has been undertaken, a copy of the complaint letter to the provider and its reply (if available) is requested as part of the complaint documentation.

The Act does not prescribe a form by which a complaint is required to be submitted. However, a structured complaint form is made available to consumers to enable them to put forward their argument coherently. Eligible customers may therefore lodge a complaint using a fillable pdf form or log into our website and submit a complaint online. The online facility allows users to upload documents in a number of mainstream formats, such as pdf or image.

During the year under review, the OAFS registered 167 new formal complaints. This is higher than the number of complaints registered in each of the previous two years and surpasses the average of formal complaints processed between 2016 and 2020. Just under 70% of complaints (116) were lodged online through the new portal. The remaining 51 complaints (30%) were submitted by mail and email.

Slightly less than half of the complaints received were insurance-related (81, 49%). This marks a slight drop compared to the previous years, but nonetheless, the number of complaints in this sector is still significant. Life-insurance related complaints constitute a significant segment of complaints under this sector.

Slightly less than 30% (48) of complaints were investment related, an increase of 41% over the previous years. Complaints relating to personal retirement schemes form the major number of complaints under this sector.

Although banking services and payments-related complaints were the lowest registered of the three sectors (38, 23%), the number of complaints received during the reporting year was 73% higher than that

registered in the previous year. Indeed, this was the most significant increase in the number of complaints of the three sectors compared to the previous year.

The majority of complaints in this sector relates to cards or transfers and were against payment services providers (which would normally carry out such activities under a financial institutions licence).

Early assessment of complaints

An early assessment of complaints has enabled the OAFS to offer an enhanced consumer service and ensures that the complainant is fully informed and aware of the extent of investigatory powers vested in the Arbiter through the legislation. Issues of a jurisdictional nature are decided by the Arbiter. When decisions of this nature are issued and published on the OAFS website, prospective complainants who raise issues of a similar nature to that determined by the Arbiter are directed to the decision to enable them to form an informed opinion as to whether they should proceed with their complaint or stop the process. New decisions therefore feed into the initial review stages of the complaint process, thus ensuring that similar cases are dealt with up-front and customer expectations are managed at the opportune time.

The Office is unable to accept complaints against providers which are authorized in any EU member state other than Malta, even if the service has been offered from Malta on a cross-border basis or from a locally established branch (under a freedom of establishment basis). In such cases, the complainants are directed to contact the financial redress mechanism in the jurisdiction where the relevant provider is licensed or domiciled. Staff have been able to direct quite a few complaints to the jurisdiction where a number of neobanks and other online payment providers are registered and have offered their service across the EU and beyond.

Both natural persons and micro-enterprises – which the Act includes in its definition of 'eligible customers' - may lodge a complaint with the Office. A micro-enterprise is an enterprise which employs fewer than ten persons and whose annual turnover and/or annual balance sheet total does not exceed €2,000,000.

The Office is unable to accept complaints the merits of which are or have been already the subject of a lawsuit before a court, tribunal or an alternative dispute resolution mechanism located in any other jurisdiction initiated by the same complainant on the same subject matter. If this aspect is identified at the initial assessment stage, the complainant is informed of the reason(s) why the complaint cannot be pursued further.

Such customers must either be consumers of a financial service, or to whom the financial services provider has offered to provide a service or who have sought the provision of a financial service from a provider. This means, therefore, that motor insurance third-party liability complaints, or home damage disputes submitted against insurers of alleged tortfeasors, cannot be lodged with the OAFS.

The case management system implemented during the reporting year enabled staff to capture and collate statistical data even for submissions which did not reach registration stage. During the reporting year, 52 submissions did not proceed to registration.

Of these, 24 submissions were resolved following the intervention of the Customer Relations Officers with the financial services provider concerned, and 28 submissions were rejected. In the latter category, seven submissions were rejected as the firm against which the complaint was submitted was not authorised by the MFSA and 13 submissions were rejected as the complainant failed to pursue their submission following preliminary observations made by OAFS staff. One complaint was referred to an ADR body in another Member State as the complainant preferred to engage with that other ADR body for proximity and language reasons. Two complaints were rejected as the merits of their case were being dealt with in another redress forum elsewhere. One complaint was refused as it was made against a corporate service provider.

Complaint registration

The law prevents the Arbiter from assessing complaints if the financial services provider has not been given a reasonable opportunity to review the customer's contentions prior to the latter's filing of a complaint with the Office. In this regard, a customer should initially write to the financial services provider outlining the contentions and allow a reasonable time (15 working days) for the latter to respond in writing. The complainant's letter, together with the financial services provider's response, should be attached to the complaint form. The Office may also consider complaints if the

provider has been given the opportunity to review a customer's complaint but still fails to provide a response within the said reasonable time period.
The charge for lodging a complaint with the Office is currently €25, which is reimbursable in full if the complainant decides to withdraw the complaint or if the parties to the complaint agree on a settlement of the dispute before a decision is issued by the Arbiter.

Once a complaint is accepted and processed by the Office, it is transmitted to the provider by registered mail for its reply. The provider has 20 days from the date of delivery to submit its reasoned response to the Office.

A copy of the provider's response is sent to the customer. Contemporaneously, the complainant and the provider are invited to refer the case to mediation. It is a requirement of the law that, where possible, cases should primarily be resolved through mediation.

Complaints submitted during the year were predominantly filed by individual persons (135 complainants). A further 27 complaints were lodged jointly, while a further five complaints were lodged by micro-enterprises.

54% of complaints (90) were submitted by non-residents (mainly from the UK) whilst 46% (77) were Maltese residents.

Around 64% (107) of complainants chose not to be assisted during the complaint procedure. It must be clarified that it is at the option of the complainant to choose whether to be assisted, or otherwise, during the process. Many times, complainants identify a family member to assist them in the process.

Mediation

All complainants are offered mediation as an alternative method of resolving their dispute.

Mediation is a process whereby the parties to the complaint try to reach a consensual solution with the assistance and support of a mediator. It is generally accepted that the earlier a dispute is settled, the better it is for everyone involved. The law specifically states that, whenever possible, complaints should be resolved by mediation. Indeed, the Office strongly encourages parties to a complaint to refer their case to mediation and it has a specific officer assigned to coordinate and conduct this process.

Mediation is an informal process that is confidential and conducted in private and, if pursued, it will not compromise the parties' standing if it fails.
Mediation can only occur if both parties to the dispute agree to participate. It is, thus, not obligatory and either or both parties may reject it. If that occurs, the case file is handed over to the Arbiter for the next stage of the complaint procedure.

Mediation may not necessarily relate to an issue where compensation is being demanded. It may also serve for both parties to a dispute to seek further information from each other (mostly from the provider) in relation to the contentions being made. Most often, complaints arise because of inadequate communication or a severe lack of engagement by the parties at the early stages of a complaint. Indeed, several mediation sessions held during the year were successful because they served as a forum for the parties to discuss and resolve their disputes informally and with the intent of finding a common ground. Mediation was rarely successful when any of the parties was unwilling to change its position.

If the complainant and the provider agree on a settlement during mediation, what has been agreed will be written down and communicated to the Arbiter. Once it has been signed by both parties, and accepted by the Arbiter, that agreement becomes legally binding on both the complainant and the provider. This concludes the dispute, thus ending the complaints process. The complainant will be reimbursed the complaint fee of €25.

Mediation sessions during 2021 continued to be held remotely. Alternative arrangements to conduct mediation via tele-conferencing are also in place to cater for the possibility that the parties would not have internet access.

The cases referred to mediation in 2021 continued to increase, compared to previous years. What is more encouraging is the fact that many cases are being resolved during such process. Of the 70 cases referred to mediation, 36 were successfully mediated and an agreement between the parties was reached and seven cases were withdrawn following mediation. There were several cases at year end which were either pending appointment for mediation or where parties were still undecided which avenue to pursue following a mediation session.

The figures above relate only to outcomes in 2021 and include around 17 cases that were brought forward from 2020.

Investigation and adjudication

If mediation is refused or is unsuccessful, the Arbiter will commence the procedure for the review of a complaint.

The law requires that at least one oral hearing is convened for each case that is referred to the Arbiter. During the year under review, all hearings were held remotely using web-conferencing software. Convening hearings remotely allows the Arbiter and all parties to the complaint to make best use of the time and resources available for hearings, without in any way impinging on the fairness of the process. As hearings are recorded, the summary of such hearings is much more detailed. This is beneficial during the investigation stage, which follows after the case file is put for decision.

The parties submit their case supported by oral and/or written evidence. They also have the possibility of bringing forward witnesses and filing a note of final submissions. Following amendments to the legislation, all documents are now being submitted and exchanged electronically.

During the first hearing, the Arbiter hears the complainant's side of the dispute including oral and written evidence, and the cross-examination of the complainant. During the second hearing, the provider submits its evidence and is cross-examined. Final submissions can also be made by the parties. Normally the whole process is finalised within a few weeks until the case is adjourned for decision.

The Arbiter can award compensation up to a maximum limit of €250,000, together with any additional sums for interest and other costs. He may also make recommendations for amounts exceeding this limit.

Findings and awards

The Arbiter's final decisions are accessible on the Office's website in their entirety, except for the complainants' identity which is pseudonymised. The parties to the complaint are invited to a sitting in which the Arbiter delivers the decision, although they are not obliged to attend. A copy of the decision is sent by the OAFS to both parties.

Either party may request the Arbiter to give a clarification of the award, or request a correction to any computation, clerical, typographical or similar errors within 15 days from the date of the decision. A clarification or correction is issued by the Arbiter within fifteen days from receipt of a party's request.

Decisions reached by the Arbiter may be subject to appeal, by either party to the complaint submitted to the Court of Appeal (Inferior Jurisdiction). Appeals are required to be filed within 20 days from the date of the Arbiter's decision or from when a clarification or correction is issued by the Arbiter, as applicable. Details of the parties to appealed decisions are published in full on the Court of Justice website.

When no appeal is made by either party, the decision taken by the Arbiter becomes final and binding on all parties concerned.

At times, the Arbiter may be required to issue a preliminary decision, usually at the early stage of a case hearing. Such preliminary decisions deal with legal pleas, such as when the service provider alleges that the Arbiter does not have jurisdiction to hear the case.

In the reporting year, the Arbiter delivered 82 final decisions concerning 89 cases. One final decision comprised 60 complainants as the merits of their case was intrinsically similar in nature. In this regard, their case was treated collectively in terms of Article 30 of the Act. A summary of this decision, along with several others delivered by the Arbiter during the year, feature in the next section of this report.

Of the 82 decisions, 16 complaints were upheld, 36 partially upheld and 30 were rejected. 46 decisions were in English, while the remaining 36 were in Maltese.

A further five preliminary decisions or clarifications were delivered.

Only 19 decisions (23%) were appealed, with the remaining 63 cases becoming binding on the parties and res judicata.

Average duration of cases

One of the aims for which the OAFS was setup was to give consumers of financial services a forum that decides cases expeditiously. This is also the spirit of the ADR Directive and the Act.

Whereas some cases may be decided within a short time, other complex cases require extensive research and reflection before a final decision is published.
A handful of cases took much longer for the hearings to be convened. Moreover, in such cases, the parties presented voluminous supporting documentation which required a substantial time to review. In such cases, the time taken to issue a decision is lengthier compared to the remaining decisions, exacerbating the difficulty that is often encountered between the speed with which the Arbiter would like to issue decisions and the detail that is required to be included in the final decision.

If one had to consider the time-frame for decisions as specified by the ADR Directive, the number of days taken from the date the file was complete up to the date of decision averaged 205 days for banking-related and 121 days for insurance-related complaints.

In the year under review, of the 26 decisions relating to investments, 18 related to private retirement schemes. Indeed, one of these decisions was a collective decision comprising 60 complainants. These latter complaints are particularly complex to assess due to the diverse content of each case, the particular merits and the voluminous information that is submitted at review stage. Such complaints took average of 365 days for the final decision to be issued. This is a substantial improvement compared to that noted the previous year for such segment of complaints. The remaining eight investment-related complaints took an average of 279 days. This is also within a shorter time-span compared to that taken for similar complaints in the previous year.

Overall, cases are being decided in a reasonably short time and this considering the amount and complexity of the cases and the limitations of a small office. As at year end, the Arbiter had only a small number of cases awaiting decision.

Highlights of decisions delivered by the Arbiter

Arbiter's decisions online

Comprehensive access to the full text of the Arbiter's decisions in their original language is available through our internet portal. Over 550 searchable decisions are available online.

Users may refine their search as required by selecting from a number of filters, such as the name of the financial services provider, the language of the decision, the decision year, decision date, the sector, the decision outcome, and whether the decision has been appealed or not.

The published version of the decision excludes the names of the complainants, which are however identified by unrelated alphabetical letters.

The database of the Arbiter's decisions is also updated periodically with the relevant case reference numbers of appeals to the Arbiter's decisions lodged with the Court of Appeal (Civil Inferior). Users can also refine their search between appealed and non-appealed decisions.

The aim of the OAFS is to provide a comprehensive research tool for academia, the financial services industry, consumers, and other stakeholders in an effort to feed into a growing base of retail financial services jurisprudence in Malta.

A selection of case summaries

The Act requires the OAFS to publish a summary of the decisions delivered by the Arbiter.

During the year under review, the Arbiter delivered 82 final decisions concerning 89 cases. One such decision comprised 60 complainants as the merits of their case were intrinsically similar. In this regard, their case was treated collectively in terms of Article 30 of the Act.

This section includes highlights of 32 decisions related to banking, insurance, investments, and private pensions. The summaries are meant to identify the main aspects that arise from each case and the observations made by the Arbiter in his decisions. The collective decision, that relates to a pension complaint, is also summarised.

Acronyms and abbreviations are defined on page 8 of this report.

Banking and payment services cases

'Secure payment' effected to an unverified person (ASF 048/2020)

COMPLAINT REJECTED

International bank transfers; meaning of the term 'secure payment'; payer's and bank's duties when affecting transfers via the banking system.

The complaint relates to a bank transfer to a retailer in Vietnam. In his complaint, the complainant claimed that:

a) He had not been given reliable service by the bank when he sought its services to transfer funds to a third party in Vietnam.

b) He had purposely visited the bank in person to make a 'secure payment' and his payment for bank charges, of which he had been made aware, was in confirmation of his understanding that the payment would be secure.

c) He had intentionally refrained from effecting the payment through internet banking as he had understood that the same transfer done by the bank at its branch would have been more secure.

d) He had expected the bank to inform him in good time before the transaction that there was no guarantee that the payment could not have been stopped and that Vietnam was a risky jurisdiction.

He claimed financial compensation from the bank for failing to provide him with 'a due professional duty of care'.

In its reply, the bank stated the following:

a) The complainant, out of his own volition, made a transfer of £4,832 from his own personal account to another account in Vietnam, details of which were procured by him.

b) Two months after the transfer, he called the bank to cancel the payment.

c) As the transfer was authorised by the customer, it had been processed immediately.

d) The bank investigated the transfer and informed the customer that it was unable to reverse it.

e) The complainant was obliged to carry out a due diligence check of the party with which he intended to transact, and should thus not expect the bank to carry this risk itself.

f) In terms of the relevant rules, whether the transaction is carried out by the bank itself or by the account holder himself through electronic delivery channels, the same information would be required for the transfer.

The bank thus rejected the complainant's request for the reimbursement of his financial loss.

In his decision, the Arbiter noted the following:

1) The complainant did not inform the bank of what he meant by secure payment but neither did the bank let him know of what the same term meant for the bank.

2) The bank still investigated the transaction after the complainant called to stop the payment, two months after its effective date. The receiving bank in Vietnam confirmed that it had credited the account of the beneficiary and that it had contacted the beneficiary, who however refused to reverse the transaction. The service provider was unable to do anything further.

3) The controversy related to the definition of 'secure payment', which the complainant never explained or described. It was ultimately the complainant's responsibility to tell the bank what he intended by the term 'secure payment' and to enquire whether it was able to offer the service that the complainant was requesting or had in mind.

4) No evidence was provided that the complainant had made a condition in the transaction to enable him withdraw the payment after two months from its effective date. Had the complainant made such a request, it would have been highly likely for the bank to refuse to carry out the transaction as it was not possible to reverse a bank transfer after two months from its effective date.

5) As long as there is no specific agreement between the bank and its client for the former to carry out due diligence checks on the beneficiary of the funds, it was humanly impossible for the bank to verify the beneficiary of each payment. The client should be responsible for verifying the businesses with whom it wishes to trade.


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6) At no stage was the complainant given any guarantee that he would receive his shipment upon payment, which guarantee the bank was not in a position to give.

7) At the end, the bank effected a secure payment as the transfer was made to a renowned bank, which in turn transferred the funds to the merchant as indicated by the complainant himself.

The complaint was rejected.

The decision was not appealed.

Processing of payments to a fraudulent third party (ASF 009/2021)

COMPLAINT REJECTED

Online payment to a fraudulent website; the concept of 'eligible customer'; competence of the Arbiter in terms of the Act; relationship between the complainant and the service provider; application of the PSD.

The complainant stated that the provider had processed several payments on her behalf to a third party which turned out to be unregulated and fraudulent. She contended that the service provider had not cooperated with her to recoup such payments and had refused to retrieve the moneys and/or to reimburse her for the payments made.

The complainant further contended that the provider had failed to carry out a due diligence exercise about the said third party, as per the financial regulatory requirements; and this to ensure the protection of payers from fraud and money laundering.

There had been five transactions – carried out between October and December 2019, totalling $12,300 in all – for which the complainant was seeking redress.

In her complaint form, the complainant had also requested the Office of the Arbiter to conduct a fraud investigation on the provider in relation to the aforementioned payments.

On its part, the service provider contended that:

a) The complainant was not an eligible customer in terms of the Act and there was no direct relationship between the provider and the complainant. The complainant had never been its client, nor had it ever offered to provide a financial service to her. It was therefore not the right defendant in the case brought forward by the latter.

b) The complainant's proper contractual relationship was with a merchant which owned a site that was now pulled. The latter could never have been onboarded by the provider since it was based in Saint Vincent and The Grenadines while its own operational area was strictly confined to Europe.

c) The complainant was targeting the provider because she had been unable to retrieve her outlay from the rightful defendant. She was wrongfully expecting the provider to make good for the shortcomings of third parties.

d) The complainant's allegation that it failed in its regulatory obligations when onboarding clients were unfounded.

e) The complainant was seeking redress from an alleged regulatory breach which had not necessarily resulted in the complainant's financial loss.

In his deliberations, the Arbiter noted that:

1) Essentially, the said complaint concerned (i) the complainant's contention that the provider should have implemented adequate due diligence checks on the merchant concerned and that this would have prevented the fraud allegedly perpetuated by the latter and (ii) the provider did not assist her to retrieve the payments made to the merchant.

2) The complainant had not provided any evidence of the existence of a contractual relationship with the provider. There was similarly no evidence of any contract and/or contact between the complainant and the provider in respect of the disputed payments.

3) In her testimony, the complainant had admitted that she had learned of the provider's role in the payment process after initially liaising with her bank about her case.

4) In the case under review, the provider's role consisted solely of processing the payments, but not as the payment services provider of the complainant. The disputed payments had been initiated by the complainant through the card account she held with the said bank.

5) The disputed payments did not entail any incorrectly executed payment transactions and had been clearly consented by the complainant. The complainant did not raise the issue that the funds had not reached the merchant concerned.

6) It had not emerged that the merchant identified by the complainant was actually the provider's client. Nor had the complainant clearly shown any link or connection between the latter and the merchant.

7) The complainant had not shown, clearly and conclusively, that she had a valid case against the provider. No specific or adequate provision from any applicable legislation and/or regulation had been produced by the complainant to prove the provider's obligations and duties towards her in the context of the case under review.

8) The said case did not relate to issues involving the responsibility of payment service providers, as envisaged in the PSD. It did not relate to losses involving unauthorised payment transactions, non-execution, defective or late execution of payment transactions. There is therefore no basis for the complaint to be considered within the parameters of the said directive.

9) The complainant was not a customer of the provider. She had not sought a financial service from the provider nor had the latter offered to provide such service. In this regard, the complainant was not an eligible customer as defined in Article 2 of the Act.

In the light of the foregoing, the Arbiter determined that he had no competence to deal with the complaint.

The decision was not appealed.

Unauthorised use of credit card (ASF 058/2019)

COMPLAINT REJECTED

Unauthorised transactions affected by card; bank's responsibility in terms of CBM Directive 1; Use of PIN to affect transactions; gross negligence.

The complainant noticed a number of unauthorised transactions affected on his card totalling €5,335. He was only made aware of the transactions when the beneficiary (who was known to him) indicated that he had stolen the money from his account. At that point, the complainant called the bank to cancel his debit card which had not been physically stolen. The operator confirmed that a substantial amount of his money had already left the account. A claim with the bank for a refund was rejected without offering any reasons.

He lodged a complaint on several grounds, namely that the bank had failed to alert him of unusual and suspicious activity on his card or to block the transactions. He also complained that the bank's investigative team had failed to record and collect all relevant details of the case before deciding to reject the claim. The bank had also failed to provide a legal reason under the PSD to reject the disputed transactions claims.

The complainant requested a refund of the disputed amount and a further €5,000 for the distress caused to him by the bank.

In its reply, the bank rejected the complainant's contentions and claimed that:

a) The transfers of which the complainant sought refund were authorised via the card's 3D secure system, which is subject to client authentication, thereby ensuring the authenticity of both peers, the bank's IT server and the client, using digital certificates.

b) None of the transactions could be revoked as the transfers had already taken effect.

c) The complainant had informed the bank that his personal details (which included his personal security verification details) were left in his wallet and that this was found by third parties who were his house guests. This would amount to gross negligence in terms of the PSD on the basis that the complainant had allowed the house guest unfettered access to his personal data.

In his deliberations, the Arbiter observed the following:

1) Card theft/fraud materialises when the card or card details or security codes are obtained without the cardholder's consent and used to make 'unauthorised' transactions for the abuser's benefit or for the benefit of another person.

2) In terms of the PSD, in the case of unauthorised transactions, the bank is obliged to 'refund the payer the amount of the unauthorised payment transaction immediately' unless the bank has proof that the card user had acted fraudulently. It has been widely held that for a

transaction to be authorised there must be the consent of the card user for that transaction. The PSD basically states that if a cardholder has not authorised a payment, the bank should refund the money.

3) However, this is not a *carte blanche* to the cardholder and there are certain limitations. The payer would not be entitled to a refund if the transaction was carried out by the payer acting fraudulently or failing to fulfil his obligations for the use of the card with intent or gross negligence.

4) There was no proof that the complainant in any way acted fraudulently. However, an assessment was required to be made as to whether the complainant was responsible for gross negligence. As neither the PSD nor the CBM Directive define 'gross negligence', recital 72 of the PSD ought to be considered.

5) The recital basically explains that keeping the credentials used to authorise a payment transaction beside the payment instrument in a format that is open and easily accessible by third parties is a form of gross negligence.

6) From the facts of this case, it was reasonable to conclude that the complainant had allowed his card details and its security features to be easily accessible to third parties, in this case, to his ex-partner. The complainant admitted that his ex-partner had easy access to his wallet and to his card. Nor did he exclude that his ex-partner and himself had made online transactions together.

7) Moreover, the example given in the PSD recital of what constitutes gross negligence tallies with the facts of this case. The complainant's partner had abused of the situation and defrauded the complainant.

The Arbiter thus rejected the complaint.

The decision was not appealed.

Claim on a purchase protection insurance policy bundled with a credit card (ASF 075/2019)

COMPLAINT UPHELD

Juridical interest; discordance between promotional and contractual information issued by providers; application of provisions contained in contractual documentation; responsibility on the relevant financial service providers to provide all information necessary to their consumers.

The complainant purchased a watch on his way to Malta from Switzerland using a premium credit card issued by his bank. Two weeks after the acquisition, the watch suffered damages and the glass had to be replaced. According to the purchase protection information guide that the bank had provided him when he subscribed to the premium card, he was obliged to repair the watch at a local agent for the claim to be accepted. He further claimed that:

a) His claim on the purchase protection insurance cover was refused by the bank's insurance brokers as they remarked that the watch had not been completely purchased by the card.

b) It was not his fault that the entire payment was not funded by his card. He had attempted to do so but the transaction was refused. Half of the amount was paid through the card, while the remaining balance was paid in cash.

c) The product information guide provided by the bank did not, however, specify that the claim eligibility was dependant on the entire purchase being done through the card. Moreover, his contractual agreement was with the bank and not the insurance brokers. He knew that there was insurance cover in place but was not privy to its terms and conditions or to the agreement which existed between the bank and the insurer concerned.

d) The credit limit for his premium card should have been set at €7,000 according to the bank's literature outlining the card's benefits. For some reason, the bank had never increased such amount beyond his current €6,000 limit. Had the bank done so, he would have had sufficient funds to enable the purchase to go through successfully.

The complainant sought compensation for the repair cost (€290) of his watch.

The policy's underwriters, the bank and its insurance brokers rebutted the complainant's contentions. They claimed that:

a) The purchase protection insurance policy specifically required the purchase of the goods or services to be affected entirely by card. As the purchase was not entirely paid for by card, the claim could not be entertained.

b) The credit limit on premium cards had been rounded up following Malta's conversion to euro, and cardholders were able to apply for a higher limit. Although the card limits were increased to €7,000, such limit was not automatically increased for all cardholders. The complainant could have applied for a higher limit but did not do so. It was therefore frivolous and vexatious for the complainant to expect the bank to pay on the basis that he should have had a higher credit limit on his card.

c) The product information guide was issued by the bank. It specified that to qualify for protection, the cardholder was required to pay for purchases with its card. The document also stated that the policy was underwritten by the insurer and arranged through an insurance broker (both specified). The bank could therefore not be held responsible for a claim under an insurance policy. Only the insurer could determine eligibility under the said policy.

In his deliberations, the Arbiter observed the following:

1) The bank's claim that the complaint was vexatious was turned down on the basis that the complainant had relied entirely on the bank's information guide for a list of the card's benefits. He should have therefore been provided with such benefits.

2) There was a juridical relationship between the complainant and the bank, the latter providing a guide on the benefits of the card and the former accepting the terms and conditions that had been provided by the bank upon card acceptance.

3) On the basis of technical evidence provided by the bank, it emerged that the cardholder did not have sufficient funds in his card account for the entire transaction to succeed. Indeed, when an attempt was made for half of the amount, it was successful as the cardholder was in sufficient funds. It was not the bank's fault that the first transaction did not go through successfully.

4) The product information guide that was presented to the cardholder by the bank had prominently displayed a series of benefits, other than a higher credit limit. One of such benefit was purchase protection insurance. Such benefit appears to have been a major selling point for the bank as it featured quite prominently on that information guide. However, the cardholder was merely required to pay for purchases using the card. There was no other reference or qualification to that effect.

5) The bank did not provide evidence that such insurance policy had been actually provided to the cardholder. Rather, the only evidence provided was that submitted by the complainant in which he claims that he was only provided with the product information guide.

6) On the other hand, the policy of insurance specified that for a purchase to be covered, the entire amount had to be paid by card. Anyone with access only to the product information guide could not have known of this qualification as it was only contained in the insurance policy. The complainant only became aware of the insurance policy requirement after he had submitted the claim.

7) It was indeed a shortcoming on the bank's part to market the benefits applicable to a card without providing sufficient information to cardholders to enable them understand the limitations of such benefits. The bank should have used more precise language in the product information guide to explain the card's benefits and their limitations. The cardholder should thus not suffer from the bank's shortcomings in this regard. The fact that the product information guide made a reference to the name of the insurer and the broker was not sufficient as this did not provide useful information about the insurance policy.

8) In this case, the contractual relationship between the cardholder and the bank stemmed from the product information guide, which also raised the legitimate and reasonable expectations for the consumer of the benefits accruing from the card and its usage. It was thus reasonable to expect the bank to honour such expectation.

The Arbiter therefore upheld the complaint and ordered the bank to pay the complainant the sum of €290.

The decision was not appealed.

Excessive interest raised on a loan account (ASF 043/2020)

COMPLAINT REJECTED

Adherence to sanction letter conditions; bank's right to charge additional interest in accordance with the terms of a sanction letter.

The complainant, a micro-enterprise, claimed that its bankers imposed higher interest on its loan account balances which was excessive, not legally due and not in conformity with banking practice. Such excessive interest,

amounting to around €41,000, was raised between August 2015 and December 2016 over two loan accounts, of which the bank had refunded €10,000. In its submissions, the complainant claimed that:

a) The bank charged it excessive interest for its failure to procure a contractors' all risks insurance policy. It claimed that this was incorrect as the policy was required to cover a particular construction project where, in any event, works were stalled between May 2015 and December 2016 pending planning permits. The bank was informed by the insurance company that there was no scope in having such a policy in place when no works were being undertaken.

b) The bank was convinced that this was the case as it refunded €10,000, apart from verbally also committing itself to set-off the remaining €30,597 in processing fees from future loans or refund the amount if such loans never materialised. Such payment, however, had not been made.

c) Normal and penalty interest were additionally raised by the bank. These were excessive, not legally due and not in conformity with practice. It thus requested a refund of such additional amounts.

In its reply, the bank confirmed that:

a) Additional interest had indeed been raised due to the fact that the complainant had failed to pledge in its favour a contractors' all risks insurance as was required in terms of the sanction letter. Indeed, it claimed that such a requirement was imposed in two sanction letters, one issued in 2013 and a further one in 2014)

b) The policy was required to be pledged during the construction and finishing of the whole project. It further claimed that the company was not in a position to unilaterally amend the requirements of the sanction letter and the additional penalty interest raised was outlined in detail in the sanction letters issued to the company.

c) The refund of €10,000 was a gesture of goodwill and offered on an ex gratia basis. It could not be interpreted, as the complainant had done, that the refund was an admission of guilt by the bank for raising further interest.

d) The additional interest that it charged the company was in full conformity with the sanction letter. The company had failed to set off repayments from the sale of apartments within a stipulated time period. It said that as the company failed to effect payments to the bank in accordance with the sanction letter, it exercised its rights under the said contract to apply penalty interest, and this after allowing an extension to the payment deadline. The company took 12 years to repay its dues, when the contract stipulated a relatively short repayment programme.

In his deliberations, the Arbiter made the following observations:

1) As to the complainant's claim that the contractors' all risks policy was not required to be bound during a particular period of time, he observed that the company did not contradict the bank's contention that such a policy had not actually been pledged.

2) Although the complainant claimed that the bank was able to verify directly with the insurer that such a policy was not required as works had temporarily halted, the bank was able to provide evidence to counter the complainant's version. Indeed, the requirement of a contractors' all risks policy had featured in all sanction letters issued to the company over the years, apart from the various reminders it had sent to the company to that effect. The company actually regularised its position and pledged the policy to the bank in 2017, around 10 years after it was obliged to do so and had actually done so when penalty interest was being charged to the loan account.

3) The complainant's argument that a policy was not required was rejected by the Arbiter. The company was not in a position to unilaterally alter the sanction letter and not adhere to its requirements. The bank had every right to expect that the conditions of the sanction letter were respected, given the substantial amount of the loan. Moreover, the complainant never requested the bank to waive such a requirement. The Arbiter noted that the company was doing substantial business with the bank's support, which was also being flexible in its commercial relationship with the company.

4) The bank, thus, had every right to impose additional interest as a penalty and the complainant failed to provide satisfactory evidence to prove that the bank-imposed interest was beyond what was stated in the sanction letter.

5) As to the additional normal and penalty interest, the bank claimed that it was in its powers to levy such additional interest as the complainant remained in default of its contractual obligations until it closed its loan account in 2019, after many years from the sanction letter's original term.

6) The complainant had indeed confirmed that there were several occasions in which repayment had been missed. Thus, the company was not in a position to complain against the bank, especially when it had failed to repay a substantial amount of money by a specified date. If it were not in a position to honour its obligations, it ought to have discussed that with the bank rather than simply attempt to unilaterally change the conditions, of which it had always been fully aware.

To summarise, the complainant would have been able to avoid paying the additional penalties had it provided the bank with a pledge on a contractors' all risks insurance policy as it was required to do. Likewise, the company could also have avoided the repayment of additional interest had it honoured its loan repayment schedule as agreed with the bank.

The Arbiter thus rejected the complaint.

The decision was not appealed.

Application of processing fees for an aborted loan facility (ASF 056/2020)

COMPLAINT PARTIALLY UPHELD

Tariffs applicable when a bank issues a sanction letter; informing a loan applicant in sufficient time of all relevant charges and the extent of their application; bank's right to get compensation for work done in preparation of a sanction letter.

The complaint related to the application of processing fees following the issue of a sanction letter (SL) by the bank for a loan facility which the complainants eventually did not pursue. The complainants summarised their contentions against the bank as follows:

a) They had approached the bank for a loan to finance a project, in respect of which they applied for EU funds.

b) After meeting with bank representatives to discuss the loan requirements, they asked the bank to issue a SL. However, the bank first issued a Letter of Intent that specifically stated that the necessary funds would be loaned out to the applicants. They claimed that such letter was however of no use to them in their application to the EU.

c) They requested the bank to send them a draft version of the SL to enable them to go through it and examine its conditions. The SL was eventually issued. In that document, the bank had stated its availability to offer them a loan of €450,000. The bank had emailed them the SL in what they claim was a hurried process.

d) Although they had always informed the bank that they were still considering the whole project, the bank still charged them a processing fee, even though the issue of the SL had been delayed and they disagreed with the amount, dates and fees as outlined in such SL.

e) They denied that the bank had made them aware of the processing fees. Apart from that, they were unable to present the SL to the EU in time since such document had not even been prepared by the deadline. They claimed that the bank did not ask them to submit an application granting them the possibility to have a draft sanction letter, a right which arises under EU law.

f) Although their application for EU funds was not approved, the bank still charged them a processing fee of €2,250 which they feel is exorbitant and based on an amount that they did not require.

They requested the Arbiter to order the bank to refund the full amount of the fee which it had debited to their account.

In its reply, the bank countered the complainant's arguments and claimed that it had always made them aware of the processing fee for such facility.

In his decision, the Arbiter concluded that:

1) The exact amount on the loan was never stated. The bank had issued a letter of intent, rather than a SL, as a commitment fee would have been incurred. The complainants had enough savings at their disposal, but a SL would have enabled them to put through a stronger case when applying for funds.

2) Although the bank claimed that it had always informed the complainants about the processing fee since the early stages of the application process, such fee was obviously linked with the actual take-up of the loan.

3) The actual loan take-up was intrinsically linked with the successful grant of EU funds. The bank was professionally correct to opt for the issue of a Letter of Intent rather than a SL for the purpose of the loan application, in order for the complainant to save on fees.

4) There was a lull of two months between the issue of the letter of intent and the bank's email to

the complainant with its tariff list. It was therefore doubtful that the bank had informed the complainants of the processing fee from the very early stages of the application. In addition, no evidence was presented to indicate that the complainant accepted or refused such charges, or that they accepted the conditions in the SL.

5) At no point did the bank provide evidence that the complainants had solicited the issue of the SL in January. The issue of the SL in January was done on the bank's initiative. As the bank was aware of a pending EU fund application, it would have been reasonable for the bank to ask the complainant about the stage of the application before issuing the SL.

6) Although the complainants were not sufficiently convincing when they claimed that they were not aware of the loan amount, the bank had rushed to issue the sanction letter even if it was aware of the funding application on which the loan depended.

7) The said processing fee was described by the bank to the complainant as follows: "Processing Fee: €2,250 (0.5% of the facility)". The fee was linked to the facility, which never materialised.

Although it was not fair for the bank to charge a processing fee on the same basis as if a loan had been sanctioned, it was equally fair for the bank to be compensated for its work on the loan application. It was not contested that the bank dedicated resources to assess the documentation in relation to the loan application.

On that basis, the Arbiter ordered the bank to refund the complainant €1,500 and keep €1,000 as compensation for the work carried out on the loan application.

The decision was not appealed.

Unfair blocking of a bank account (ASF 138/2020)

COMPLAINT UPHELD

Closure of a bank account; due diligence requirements as applicable when a bank account is closed; legal and contractual obligations as applicable to a bank when closing an account.

The complaint relates to the closure of the complainant's account by the bank without providing an explanation. The complainant claimed that:

a) Prior to closing the account, the bank had frozen the same account for more than three months without any explanation. This caused him to incur losses in potential earnings from the stock market, apart from inconvenience and aggravation.

b) The closure of his account in May 2020, on the basis that he posed a risk beyond the bank's threshold, was not adequately explained.

c) The bank had refused to address his basic questions and had shown little interest in requesting specific information from him which might have cleared up any issues it might have had.

d) The bank was requesting him to sign his consent to have his account closed, which he refuses to do judging by his experience operating the account with the bank over the previous decade.

e) He requested the bank to unlock the account and allow him access to the balance which stood at more than $50,000.

In its reply, the bank claimed that:

a) The complainant failed to submit documentation it legitimately requested in terms of its regulatory obligations. Had the complainant filed the requested documentation, it would have released the funds in question and proceeded with closing the accounts held by the complainant with the bank.

b) It did not cause any losses or damages to the complainant. Any damages purportedly suffered by the complainant were due to his failure to provide the documentation requested.

In his deliberations, the Arbiter observed the following aspects:

1) It was evident that the bank had blocked the complainant's account before it requested him to provide certain documentation. It had also frozen a transaction to be affected from his account.

2) Normally, a bank would be considered to have acted legally, fairly, and reasonably if it freezes an account for the following non-exhaustive reasons:

i. There is a court order either resulting from a precautionary or executive warrant or because of an order by a criminal court;

ii. The bank has reasonable suspicion that the actions of the account holder are fraudulent;

iii. When banks are complying with laws and regulations for the combating of money laundering and the financing of terrorism; or

iv. When the account holder passes away and an heir or an administrator to the deceased's estate has yet to be named.

3) On the basis of the above-mentioned principles and by reference to a Maltese Court judgement, a bank cannot unilaterally block and freeze the assets in a client's account unless sanctioned by law or contract. The bank did not indicate on what legal or contractual basis it blocked the complainant's account.

4) The bank failed to provide terms and conditions relating to the account and, consequently, did not prove that the blocking of the account resulted from any contractual agreement entered into between the parties.

5) Neither did the bank prove that it had a court order sanctioning the freezing of the account or that it had reasonable suspicion of money laundering or the financing of terrorism.

6) While financial institutions have to comply with certain requirements in relation to anti-money laundering and countering the financing of terrorism, it was equally highly important that these measures are applied in a fair and reasonable manner, and do not go beyond the limits of those requirements.

7) From the facts of the case, it resulted that the complainant had been carrying on the same activity for a number of years. The transaction which the bank blocked was similar to other previous transactions carried out by the complainant which were acceptable to the bank. No evidence was put forward that the complainant was acting illegally.

8) Moreover, the bank itself gave evidence that the complainant had supplied detailed information as to his source of wealth. The bank did not provide any valid reason to block incoming funds into the complainant's account. Thus, the blocking of the transaction was unreasonable.

9) Although the complainant provided electronic copies of documentation for regulatory purposes, he was still asked for such documentation to be provided in original. The complainant promised to send the requested documentation once the complaint process was finalised. In his decision, the Arbiter ordered the bank to process the frozen transaction and credit the complainant with the amount indicated in the same transaction. It also ordered the transfer of the complainant's funds to another account as indicated by the complainant following receipt from the complainant of the original regulatory documents that were already submitted electronically.

No monetary compensation was awarded to the complainant as he did not submit evidence that he had suffered any actual loss.

The decision was not appealed.

Termination of all bank services without reason (ASF 071/2021)

COMPLAINT UPHELD

Closure of all banking services; ongoing due diligence processes and record-keeping obligations; respecting the rights and reputation of bank customers; impact of a wider socio-economic perspective.

The complainant held an account and availed himself of a card from a local bank. In his complaint, he explained that he was trying to establish a business importing electronic goods from the EU, which activity he had declared to the necessary tax authorities. The seed capital was from inheritance. One day, he found out he was unable to continue using the bank's services and asked the bank to provide a reason for its decision. The bank requested the complainant to provide documentation in support of the various transactions he had done.

Although the complainant provided all the documentation and information requested, the bank still proceeded with the termination of all its banking services to him. He claimed that the bank's actions were unfair as it failed to provide him with a justification for its decision. He requested the bank to withdraw its decision and to provide guidelines to enable him to operate his account in accordance with its expectations.

In its reply, the bank claimed that it was obliged to adhere to ongoing due diligence and record keeping obligations as they arise from law. It claimed that, as the complainant had failed to provide the bank with the documentation it requested, it was left with no other option but to terminate its banking relationship.

In his decision, the Arbiter made several observations:

1) The complainant had explained that, other than his student account, he also held another account in which he had deposited his inheritance following the passing of his father. In parallel to his studies, he tried to set up a small business importing mobile phones for local resale. Business was better than he had originally anticipated and as initially declared to the bank. When asked to provide supporting documentation, he had provided the bank with all the documentation he could reasonably provide for the bank to carry out its due diligence.

2) An official of the bank explained that a periodic review of the complainant's account revealed that information he had initially declared to the bank concerning the projected turnover on his account was inconsistent with the actual value of the transactions that passed through the accounts. The bank had asked for a range of documents, but it was still unsatisfied with what was submitted. Although there were no other documents that the bank could possibly ask for, it still gave the complainant two months' notice to close his accounts. The official invoked provisions of Chapter 373 of the Laws of Malta (Prevention of Money Laundering Act) and refused to provide a reason for closing the accounts.

3) The law that sets up the Arbiter for Financial Services requires that complaints that fall under his competence shall be determined and adjudged by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances of the case.

4) By allowing the Arbiter to apply equity in his decisions, the law was effectively widening the scope by which justice could be attained, and this where the law was silent or that its strict application could lead to injustice. The law allowed discretion to the Arbiter within reasonable parameters and in accordance with the substantive merits of the case.

5) The bank was right and surely obliged to abide by law when conducting its due diligence obligations. However, the bank was also obliged to conduct such due diligence transparently and, at the same time, respect the rights and reputation of its customers.

6) It was not the customer that failed to provide documents to the bank; rather it was the bank that did not require further documents. Even if the bank was presented with all the documents requested, it failed to say which of the documents it found not sufficiently convincing, invoking anti-money laundering legislation without providing any evidence of this sort in the complainant's regard.

7) Although the bank has a right to exercise discretion, the Arbiter – as a tribunal set up to administer the law – is unable to adjudge based on assertions that are not supported by evidence. It was therefore unacceptable that the bank's witness statements in regard to one of its clients were unsupported by evidence, whilst invoking anti-money laundering legislation to justify its silence. Neither did the bank provide evidence that the invoices supplied by the complainant were fraudulent or that the complainant's statements were untrue. In addition, the value of the transactions were compatible with the type of business the complainant was pursuing.

8) The bank was also insensitive to the fact that the complainant was a start-up with limited experience, and this apart from personal circumstances that required particular attention. It was thus only reasonable to expect the bank to engage with the complainant and assist him as necessary.

9) The closure of accounts should also be seen from a wider socio-economic perspective. The impact of a bank's decision in this regard may cause problems for a consumer to open an account with a different bank, especially if the allegations of the type made by the bank would have impacted the reputation of the complainant. Excessive intrusive scrutiny of small clients is counter-productive and a waste of resources, when it would have otherwise been directed to other businesses that truly required such scrutiny.

The Arbiter ordered the bank to reinstate the complainant's accounts and to provide him with a credit card with the same conditions that applied prior to termination within seven days of the decision.

The bank was also ordered to pay the complainant €500 for moral damages.

The decision was not appealed.


HOUSE
BUSINESS
LIFE
INSURANCE
HEALTH
CAR
TRAVEL

Insurance cases

Travel insurance – Refund of costs following cancelled travel due to COVID-19 (ASF 103/2020)

COMPLAINTS UPHELD

Unavoidable cancellation of travel arrangements; recoverable and unrecoverable travel-related expenses; package travel arrangements and liability to pay refund; subrogation rights under the policy.

The complainants stated that, in December 2019 (when there had not been any hint of the pandemic which ensued subsequently), they had booked the flights and accommodation for their honeymoon, scheduled in July 2020. Their insurance policy had been purchased on 1 March 2020.

The provider had confirmed in writing that any local government restriction on overseas travel would entitle the complainants to compensation for the irrecoverable costs incurred, provided the policy had been purchased before such restriction came into force. The restrictions became effective on 21 March 2020.

The travel agent had made it clear from the outset that the accommodation expenses were unrecoverable. This was indeed confirmed in writing and had been copied to the provider.

The service provider had initially confirmed in writing that the respective cost was recoverable under the travel policy. However, it had subsequently changed its tune, insisting that the reimbursement of such cost had to be made by the travel agent concerned.

The complainants contended that they should be compensated by the provider which would, in turn, subrogate its outlay against the travel agent. They therefore requested the Arbiter to award them the amount of €1,050 (representing the accommodation cost).

On its part, the provider contended that:

a) Its travel policy compensated for irrecoverable unused travel and accommodation costs.

b) Local Subsidiary Legislation 409/2019, relating to the regulations governing package travel arrangements, puts the onus on the travel agent concerned to refund the costs incurred by its customers in the eventuality that a trip is cancelled.

c) This appeared to be backed up by the travel agent's own service terms and conditions, which were accessible on its website.

d) The public statements, issued by the Malta Competition and Consumer Affairs Authority, similarly identified the travel agent as the entity that was required to pay reimbursement of the cost claimed under its policy.

The Arbiter held that:

1) The provider had indeed changed its position on the case. After initially confirming that its policy would provide compensation, it had subsequently referred the complainants to the travel agent for the reimbursement they were due.

2) The travel agent had actually secured the refund of the air tickets. However, it had stated from the very outset that the accommodation costs were non-refundable.

3) The complainants contended that they had purchased the travel policy precisely in case their trip had to be unavoidably cancelled for reasons beyond their control. They insisted that they had done their utmost to obtain reimbursement, but their efforts were fruitless. They insisted that the provider should therefore step into their shoes and compensate them.

4) The complainants and the provider agreed that the policy should compensate irrecoverable travel costs. However, they differed on the interpretation of such wording, with the latter insisting that such reimbursement was the responsibility of the travel agent.

5) The policy in question had been purchased online on 1 March 2020, that is, after the public statement issued by the government on 25 February 2020 that non-essential travel to a number of specified destinations should be cancelled.

6) The policy itself did not contain a definition of the term 'irrecoverable', as it did for other terms used in its wording. It was therefore to be interpreted according to its ordinary meaning. Any possible ambiguity in its interpretation resulting from such omission was to be assigned in favour of the insured in accordance with case law and consumer legislation.

7) The complainants had done their utmost to recover their outlay from the travel agent concerned. Although they recovered the cost of their air tickets, the accommodation cost had been declared as irrecoverable by the said travel agent from the very outset.

8) The complainants had every right to claim compensation from the provider. They had purchased insurance against a specific risk which had subsequently materialised, causing them financial loss.

9) The provider's reasoning that the complainants should recover their outlay from the travel agent was not acceptable. Universal insurance practice required the provider to compensate a claimant, for a legitimate claim, and then be subrogated in the latter's rights.

10) The wording of the travel policy in question evidenced the fact that the provider had already reserved such subrogation right in its favour and it could therefore exercise it accordingly.

In the light of the foregoing, the Arbiter upheld the complaint and ordered the provider to reimburse the amount of €1,050 to the complainants.

The decision was not appealed.

Home insurance – Damage sustained to an expensive watch (ASF 113/2021)

COMPLAINT UPHELD

Accidental damage; extent of cover provided by the policy; watch repair and routine servicing; submission of quotation; utmost good faith, mutual obligation and responsibilities in an insurance contract; direction given to the complainant prior to repair works covered by the policy; direction given to the insurer to honour the claim in terms of the policy.

The complainant lamented the rejection of his claim for compensation in respect of damage sustained to his expensive watch, which had been accidentally scratched.

He contended that he had been specifically advised by the watch's manufacturer to use only a certified supplier which would necessarily need to carry out a diagnostic service on the watch so as to determine the extent of damage sustained, prior to replacing the scratched watch face. This was required so as to ensure the professional level of the repair as well as the continued high standard and quality of the product.

The complainant insisted that this procedure had been confirmed by each official supplier that he had visited in the City of London area.
Having sourced a quotation for this service, the complainant stated that this had been declined by the insurer concerned since it was inclusive of the diagnostic service. The said insurer deemed such diagnostic service as routine servicing of the watch, which was not covered by the home policy.

Prior to the further processing of his claim, the insurer insisted on the submission of a quotation for the replacement of the watch face only, which it was prepared to consider. However, this could not be provided in isolation since it contravened the official repair procedure of the manufacturer, the complainant contended.

The complainant further pointed out that such distinction, between watch repair and servicing, was not stated on the policy.

On its part, the insurer contended that:

a) In support of his claim, its policyholder had submitted a quotation for the damaged watch's servicing, which included the repair to be carried out. This was unacceptable since maintenance was not covered under the home policy.

b) Contrary to the complainant's contention that it was not possible for the manufacturer to provide a breakdown of the overall cost which distinguished between the watch's diagnostic procedure and the repair cost, it had actually received such breakdowns from other policyholders who had claimed for the repair of their damaged watches from the same manufacturer.

In his deliberations, the Arbiter considered that:

1) The insurer admitted that the accidental damage sustained by the watch was covered under its policy. However, it was declining to compensate the cost of the diagnostic procedure since it considered this to be

a routine servicing which was entirely unrelated to the accident concerned.

2) The contract of insurance is based on the utmost good faith of the parties concerned. Both the insurer and the insured must honour their respective obligations. The insurer was required to compensate a claim in an honest, fair, and fast manner. It should primarily look for reasons to pay a claim and not for reasons to decline it. It should reinstate a claimant to the same position enjoyed before an accident. If necessary, it should give such claimant the benefit of the doubt. The insured was required not to inflate a claim so as to make a profit from his loss to the detriment of an insurer.

3) The insured and the insurer were honest partners to the same contract. The foregoing ensured a mutually balanced and fair relationship.

4) Neither of the two parties had submitted tangible proof of their separate contentions; namely (i) the complainant's contention that a repairer would still need to carry out a diagnostic service on a watch simply because it had sustained a scratch on its glass; and (ii) the insurer's contention that it had routinely received a breakdown of the costings from policyholders claiming the repair cost of their damaged watches.

5) It would not be fair, equitable and reasonable to exclude the possibility that, apart from the scratch on its glass, the watch could have sustained other collateral damage. This could be definitely excluded only if a diagnostic procedure was carried out. Similarly, it would be equally incorrect to exclude the possibility that suppliers would not repair a damaged watch unless they service it in order to determine the extent and nature of the said damage.

6) The policy should compensate only the repair cost of the damage sustained by the watch as a direct consequence of the insured accident.

In the light of the foregoing, the Arbiter decided that the complainant should proceed with the repair of his watch but directed him to obtain a declaration from the repairer that the watch's servicing was necessary in order to establish the damage sustained during the accident. In this case, the insurer must then compensate the overall cost, subject to any policy limit(s).

However, if the repairer declared that only the scratched glass was related to the accident, then the insurer must compensate only its repair cost (similarly subject to any policy capping), inclusive of any labour cost. This to ensure that the watch is restored to its pre-accident condition.

The decision was not appealed.

Home insurance – Damage sustained to bathroom (ASF 004/2020)

COMPLAINT UPHELD

Compensation claim for detached tiles and cracked sanitary ware; damage not caused by negligence or wear and tear; accidental damage.

The complainant lamented the service provider's rejection of his claim for compensation in respect of the damage sustained in his bathroom. This consisted in the detachment of several tiles as well as a cracked sink.

After appointing an architect to assess and report on the matter, he had proceeded to replace all the affected tiles so as to avert the onset of further damage.

The complainant further contended that the said damage was neither the result of any negligence on his part nor was it due to wear and tear.

He therefore requested the Arbiter to order the provider to return him to the same position he was in before the loss, and this through the payment of €1,300.

On its part, the service provider contended that:

a) For any claim to be compensated, one had to determine whether the cause of the damage was actually one of the perils covered by the policy as no policy provided absolute protection. It claimed that the policy excluded cover for loss or damage caused by movement, settlement, the lack of or faulty maintenance, atmospheric or climatic conditions.

b) The technical expert it had appointed to investigate the case had explicitly stated that due to differential thermal changes in the building structure between the colder and hotter months, stresses build across the walls causing building movement that cause detachment of the wall tiles from the backing wall, with the result that tiles arch outwards.

c) The report of the technical expert appointed by the complainant stated that the latter had been aware of the damage since the summer of 2018.

d) In the meantime, the complainant had not taken any preventive measures, nor had he informed the provider about the situation. It was only in September 2019 – that is, after more than a year since he had become aware of the damage – that he had submitted his claim for compensation. During such prolonged period, the damage had continued to increase and to spread extensively.

e) The report of the technical expert appointed by the complainant had not denied that climatic conditions had caused the damage in question. On the other hand, the technical expert appointed by the provider had identified such conditions as the probable cause of the damage. The effect of such conditions was expressly excluded in the policy wording.

f) The damage sustained by the complainant had occurred progressively over a period of time and was therefore the result of a gradually operating cause, which was also not covered by the policy.
In his deliberations, the Arbiter considered that:

1) The complainant contended that no one – neither his appointed technical expert nor the repairer – had identified the cause of the damage. However, they had excluded bad workmanship and the ingress of water. Concerning the delay in submitting his claim, he explained that the initial onset of the damage did not imply its subsequent extent and he would not have claimed in respect of minor damage. He had then claimed once the considerable extent of the damage was manifest and when he was in possession of his technical expert's report as well as the fiscal receipts for the repairs carried out.

2) In his testimony, the technical expert appointed by the provider admitted that, in compiling his report, he had not surveyed the complainant's residence but that he had based himself on the report and the photos taken by the complainant's expert. In his view, the most plausible cause of the damage was the movement and settling of the building. This was a complex matter over which there was no control, and which could still happen many years after a building was completed.

3) The complainant had proven the sustaining of the damage as well as its extent and this in terms of the detached tiles and the cracked sink. The provider was not disputing this, but it was contending that the cause of such damage was excluded in the policy wording.

4) Neither one of the two architects appointed by the parties (that is, the provider and the complainant) had actually identified a specific and tangible cause for the damage sustained by the latter. The two aspects of this damage – that is, the dislodged tiles and the cracked sink – were unconnected. It was therefore probable that a common accidental cause had triggered the damage.

5) The fact that such damage had subsequently spread did not necessarily signify that its cause was a gradually operating one. Furthermore, the proximate cause of any damage did not automatically imply an immediate consequence. Rather, it could require some time to manifest itself.

6) The testimony given by the complainant had not been contradicted by the provider. This showed that the overall damage sustained was of an accidental nature and was beyond the complainant's control. It had taken place suddenly and unexpectedly at a particular moment, before subsequently spreading.

7) The provider had not submitted any proof that the damage had been caused deliberately by the complainant. The complainant had limited his claim to the damaged property and had refrained from claiming compensation for the undamaged tiles. He had not attempted to obtain a new bathroom at the provider's expense but had sought compensation only for the damage actually sustained.

In the light of the foregoing, the Arbiter upheld the complaint and ordered the provider to pay the sum of €1,300 to the complainant.

However, the decision was overturned on appeal.

Travel insurance – Claim for travel cancellation costs incurred due to the pandemic (ASF 107/2020)

COMPLAINT UPHELD

Compensation for unrecoverable costs; failure to travel; treating policyholders suitably and justly during a claim process.

The complainants objected to the service provider's decision to reject their claim for compensation in respect of unrecoverable costs incurred because of the unavoidable cancellation of their trip to Maastricht (to attend a concert), due to the COVID-19 pandemic.
They further contested the provider's denial that they had specifically purchased additional protection under their policy when they were in possession of the respective payment receipt.

The complainants requested the Arbiter to order the service provider to reimburse them with €998; that is, €665 for hotel accommodation and €333 for the concert tickets.

On its part, the service provider contended that:

a) The policy specifically provided cover in cases where a policyholder was prevented from travelling due to a Maltese government restriction arising from an epidemic or a pandemic. In this case, the government had removed the travel restriction relating to the Netherlands on 15 July 2020 whereas the complainants' flight was scheduled on 17 July. Hence, there was no policy cover in force.

b) Its statement contending that the complainants had not purchased additional protection was mistaken and it had in fact already apologised for this error. However, it had also drawn their attention to the fact that, even in terms of this additional protection which was in force, the claim submitted by them was still not covered.

c) It was relevant to point out that the cover extension provided under the said additional protection applied solely in case a flight was cancelled as a result of adverse weather conditions or other natural disasters. The case under review did not fall within such parameters.

In his deliberations, the Arbiter concluded that:

1) Although the complainants and the provider were essentially in agreement about the facts of the case, they were disagreeing on the interpretation of the policy.

2) The complainants were contending that, regardless of the withdrawal of the government's travel restriction, they could still not travel to the Netherlands since, due to the pandemic, their flight had been cancelled by the airline, their hotel had closed down and the concert had also been cancelled by the organisers.

3) Any insurer, when presented with a claim, should ensure that the claimant be treated suitably and justly in its processing; and this by:

i. Treating the claimant's interests as if they were its own while giving him/her the benefit of the doubt;

ii. Endeavouring to identify the reason(s) for settling a claim and not for declining it;

iii. Considering the claim-processing procedure as resulting from a contract based on the highest good faith between its parties rather than on an insurer vs insured situation

iv. Processing a claim and settling it within a reasonably short time; and

v. Providing a clear explanation in case of a claim declinature.

4) The two-day period between the lifting of the government restriction and the scheduled departure date was too short for the complainants to make alternative travel arrangements. Moreover, this would still have not been practically possible due to the unavailability of another flight to the same destination, the closure of the hotel and the cancellation of the concert.

5) This was a classic case where the complainants/claimants should have been accorded the benefit of the doubt by the provider, and this so as to ensure the equitable treatment of their case. Their failure to travel was not due to a capricious reason but rather to reasons entirely beyond their control, that is, the unavailability of certain essential services such as the flight, the accommodation, and the concert. Such unavailability was solely due to the COVID-19 pandemic, for which cover was available under the travel policy concerned.

6) No insurer should decline a claim in respect of a loss sustained by any policyholder whose cause was beyond his/her control and this all the more so when the claimant had acted in good faith, as evidenced by the successful attempt to recover the flight cost.

In the light of the foregoing, the Arbiter upheld the complaint and ordered the provider to pay the claimed amount in full.

The decision was not appealed.

Travel insurance – Declined claim for additional accommodation costs (ASF 120/2020)

COMPLAINT REJECTED

Open travel cover insurance policy; application of 'missed departure' cover; extent of insurer's responsibility for poor service given by an airline following overbooking.

As the holder of a premium credit card, the complainant

was insured under an open travel policy provided by the issuing bank to its card holders. He objected to the declinature of his claim for accommodation costs incurred following the airline's failure to onboard him on a connecting flight due to overbooking. The complainant had to travel from Doha to Tunis, via Istanbul. The airline failed to onboard him in Istanbul, on two consecutive days, for the final leg of his trip. As a result, he incurred €290 in hotel accommodation costs.

The provider argued that it had declined the complainant's claim in accordance with its policy terms and conditions. It claimed that the complainant's case did not fall within the cover provided under 'missed departure'. In addition, overbooking was not covered under the policy.

In his deliberations, the Arbiter noted that:

1) The complainant was contending that compensation was due to him under the missed departure and cancellation/abandonment sections of the policy.

2) The overbooking made by the airline, which caused the complainant to needlessly incur accommodation costs for which he was seeking compensation, was not covered by the policy. The relevant section was intended for internal means of transport which fail to deliver a passenger to the airport in time to catch a flight.

3) Compensation would have been due had the cancellation of the complainant's trip been caused by a delay (of at least 24 hours) of the departure of his trip from Doha. This was not the case since the (overbooked) flight in question was from Istanbul to Tunis.

4) The circumstances of the case show that the complainant was the victim of poor service by the airline concerned in overbooking its flights.

In the light of the foregoing, the Arbiter held the view that the complainant's case was not covered by his travel policy and that no compensation was due to him by the provider.

Consequently, the complaint was rejected.

The decision was not appealed.

Motor insurance – Refusal to incept cover (ASF 029/2020)

COMPLAINT REJECTED

Declinature to incept/renew cover; vehicle used for business purposes; loss of earnings; underwriting decision; claims record.

The complainant stated that, in January 2019, he had invested in a new car which he operated as a taxi. He had insured it on a comprehensive basis and, though he worked a 60-hour week and had driven 81,000 kilometres in a year, he had a claims-free record.

The complainant further stated that, when attempting to renew the insurance policy on his car in January 2020, the provider had declined his renewal request citing the fact that he had submitted a claim in 2018 in respect of an accident involving his private car.

The complainant contended that the provider's refusal had prevented him from continuing with his work. He insisted that the provider had even declined his offer to reduce the policy cover to third party only or to third party fire & theft while increasing the policy excess to €5,000.

The complainant claimed that his efforts to identify an alternative insurer had met with similar refusals as they were already aware of his case.

The complainant therefore requested the Arbiter to order the provider to insure his car whilst compensating him for his lost earnings at a daily rate of €250.

On its part, the provider contended that:

a) The vehicle concerned belonged to an unrelated firm and had been insured by the complainant in the latter's name. The said firm then set up a contractual relationship with a number of persons as self-employed whose services it used as drivers for its vehicles; the complainant was one such person.

b) After requesting the firm for a list of its drivers, the provider had become aware of the complainant whom it had decided not to insure due to operational and underwriting reasons.

c) Although the law obliges a motorist to have an insurance policy that would compensate the damage(s) sustained by third parties as a result of the vehicle being driven on a road, it did not however accord rights to a motorist to be insured at all costs. Nor did it oblige an insurer to issue or renew a policy on demand.

d) The decision not to continue insuring the complainant was a pure business decision based on his claims record with another insurance company in the recent past. Taking into consideration the fact that the policy would have also covered his taxi passengers, the overall risk was deemed to be too big for the provider to carry. Such decision was not illegal and was within the right of the provider to choose the party with which to conduct its business.

In his deliberations, the Arbiter observed that:

1) The complainant had testified that the reason given verbally by the provider when declining to insure him was the claims record that he had with an alternative insurer on his personal car. These were bumper to bumper accidents in which no one was injured. However, the value of such claims was on the high side since the vehicles involved were expensive models. He had insisted that, during his time with the provider, he had never had any road accident nor had any complaints been made against him by his passengers or by the firm. He reiterated that he was presently out of work due to the provider's refusal to insure him.

2) The provider's representative had testified that the market boom in the number of taxis had resulted in a consequent increase in the number of claims submitted. In order to mitigate its risk, the provider had therefore decided to start vetting the drivers concerned in terms of the frequency and severity of their personal claims record. In the complainant's case, the provider had established that he had submitted two large claims in a rather short period while his personal car was insured with another insurer, which had subsequently refused to renew his policy. The provider was also concerned at the fact that the complainant would be spending a comparatively longer time on the road driving his taxi than driving his personal car. This heightened the possibility of being involved in road accidents. All this had therefore triggered its decision not to renew the policy covering the complainant.

3) Although the law obliges each motorist to insure their vehicle for third party risks, it did not oblige an insurer to accept all the insurance proposals that it received. It was the insurer's prerogative to decide which proposal(s) to accept and at what terms.

4) The renewal of a policy, at the end of its insurance period, was a new contract in respect of which the insurer concerned was entitled to decide its way forward.

5) No evidence had been provided that the policy covering the complainant included a condition requiring its automatic renewal. Neither could the Arbiter impose on the provider which person(s) to insure.

In the light of the foregoing, the Arbiter rejected the complaint.

The decision was not appealed.

Motor insurance - Declined compensation for damaged car tyres (ASF 036/2020)

COMPLAINT REJECTED

Specialised cover for tyre damage; breach of specific policy conditions; unroadworthy tyres; contributory damage.

The complainant contended that he had purchased a policy to cover tyre damage because he was seeking peace of mind since he travelled a lot on the motorway. He stated that he had immediately had the tyres inspected at a garage as soon as he realised that something was wrong with them. However, his claim for compensation (£180) had been declined by the insurer, citing the wear and tear of the tyres.

While insisting that this was not the case, the complainant submitted a form compiled by the garage stating that the tyres concerned had been 'illegally repaired' before being installed on his car. However, this form had not been taken into consideration by the insurer in its decision.

He therefore requested the Arbiter to award him £180 in compensation.

On its part, the provider contended that:

a) The tyres were damaged because they were under-inflated and driven whilst punctured. Furthermore, their tread depth was below the legal minimum, and this in breach of a specific policy condition.

b) Available photos showed scratches and slashes on both front and rear nearside tyres. The offside front tyre showed patching. The nearside rear tyre had been driven whilst damaged.

c) The tyre report was compiled by the complainant's own chosen repairer. Furthermore, this stated that three thousand miles had been driven by the complainant since

purchasing the car from a dealer. This fact cast further doubt on the validity of the complainant's claim.

In his deliberations, the Arbiter noted that:

1) In his testimony, the complainant stated that, after purchasing the vehicle, he had felt a vibration while driving it. He had found that one of the tyres was perished. Additionally, two other tyres had issues as well. He had therefore sought compensation from the insurer.

2) On the other hand, the provider's representative had testified that the policy compensated damage sustained as a result of unforeseen incidents, such as damage done accidentally or maliciously. From the information available, it transpired that the tyres were not damaged in an incident; rather, they had to be replaced because they were not roadworthy.

3) The representative further stated that photographic evidence showed that one of the tyres was so worn that its internal wire was showing through. He explained that this could not have been caused by an incident but by the wear and tear accumulated during its prolonged use.

4) The insurer is required to honour a claim only if its subject matter falls within the terms and conditions of the policy. The complainant had not indicated that he had been involved in an accident or that his tyres were maliciously damaged.

5) The policy wording stated clearly that cover would apply only in the event of an accident or malicious damage. It further stated that cover would not apply where the tyre damage accumulated over an extended period of time.

6) The photographic evidence available unequivocally showed that the damage sustained by the tyres was obviously caused by wear and tear.

7) The complainant had contended that the tyres were 'illegally' fitted on his car. Therefore, the insurer could not be held responsible for the illicit acts of others.

8) The complainant had also admitted that he had driven the car whilst the tyres were damaged, thereby contributing to such damage himself.
In the light of the foregoing, the Arbiter rejected the complaint.

The decision was not appealed.

Motor insurance – Claim refusal following hit-and-run accident (ASF 114/2020)

PARTIALLY UPHELD

Replacement car; unavailability of replacement parts; damages sustained to engine; wear and tear; additional repair costs for mechanical repairs.

The complaint related to the manner a claim for compensation had been handled by the insurer under a comprehensive motor policy following damage sustained in a hit and run accident.

The complainant contended that the insurer had admitted in writing that it had failed to carry out a full and thorough initial inspection of his damaged vehicle. This resulted in a prolongation of the repair procedure since, once it was carried out, it was established that more parts were required than had been initially determined.

The complainant further stated that he had been compensated for only two weeks of car hire, even though the repair of his vehicle required three months to be completed.

Moreover, the garage which carried out the said repair was not his personal choice but had to be chosen from a list of approved garages provided by the insurer.

The complainant was therefore requesting the reimbursement of the extensive car hire cost as well as of certain mechanical repairs (€170).

On its part, the insurer contended that:

a) The vehicle was initially surveyed three days after the occurrence of the accident.

b) During such inspection, it was not possible to determine the full extent of the damage sustained since the car could not be jacked. Hence, the surveyor could report only on the visible damage and had to await the repairer's feedback once the car could be lifted for a better inspection.

c) Once such feedback was received, the insurer placed an urgent order (valued at €1,501) for the required parts with the local vehicle concessionaire. However, these parts were unavailable locally and had to be brought from abroad, thereby delaying the repair procedure.

d) Once the car had been dismantled for repair, further damage was discovered in its steering rack. This could not have been identified at the inspection stage. An order was placed for the required parts. However, these were not immediately available since the Italian supplier was closed for summer holidays.

e) To offset the delay which had inevitably accumulated in the repair procedure, the insurer exceptionally opted to import such parts by airfreight. This was comparatively more expensive than using the normal channels.

f) The insurer had declined to compensate the cost of certain defective mechanical parts since their damage was unrelated to the accident but attributable solely to normal wear and tear, especially considering the mileage of the vehicle.

g) The amount paid to the complainant (€250) for the hire of a substitute vehicle was in accordance with the policy limit.

h) Despite the advice of the insurer, the complainant had opted to hire such vehicle from a comparatively more expensive garage (when compared to the going market rates). This shortened the hire period which was to be compensated by the insurer.

In his deliberations, the Arbiter noted that:

1) The three-day period which elapsed between the accident date and the vehicle's initial inspection date was a reasonable one.

2) Despite placing the order for the required parts on time, the reason for their delayed arrival from abroad was entirely beyond the control of the insurer. Moreover, when additional parts were required, these were brought over by airfreight to expedite the overall repair procedure.

3) The insurer therefore had done all it could to expedite the repairs and was not responsible for the time taken to carry them out.

4) It was clear that the compensation for loss of use was capped at €250 in the policy, which had been paid in full by the insurer and had been accepted unreservedly by the complainant. It was therefore not possible to award any higher amount.

5) Concerning the insurer's declinature to compensate the cost of the mechanical repairs, the testimony of its representative was contradictory. On the one hand, he had contended that the damage was unrelated to the accident. However, he had subsequently admitted that the insurer had compensated the cost of the car's engine cover since a hairline crack had been identified in it.

6) The insurer was insisting that the declined cost of the mechanical repairs carried out related to the vehicle's catalytic converter. Such declinature was justified since the damage was caused by wear and tear. However, this contention was not substantiated by any solid evidence – for example, by a mechanic's report – that disproved any connection with the accident as well as the occurrence of wear and tear.

7) The complainant had contended that the vehicle was running fine before the accident and that it was only after the occurrence of the latter that the mechanical problems (with its catalytic converter) emerged.

8) On a balance of probability, the complainant's insistence was more credible. The replacement of the engine cover by the insurer concerned undermined its contention that no engine damage had been caused by the accident. Therefore, one could not definitely exclude that the mechanical repairs (amounting to €170) were not the result of the accident.

In the light of the foregoing, the Arbiter rejected the part of the complaint regarding loss of use but upheld that relating to mechanical repairs (€170).

The decision was not appealed.

Health insurance – Claim for surgical procedure (ASF 048/2019)

COMPLAINT UPHELD

Consecutive health cover provided by separate and different insurers over an extended period of time; extent of cover offered for sports-related injuries.

The complainant (acting on the authorisation of a family member) contended that, for over 30 years, his firm had been insured under separate but consecutive health policies placed with different insurers. These policies covered a limited number of employees and family members.

During the said period and in accordance with the advice received from its brokers, the firm changed insurers

several times. In each case, the insurance cover in force would always be on a continuous like-for-like basis, subject to full disclosure of medical conditions.

A family member (hereinafter the 'claimant') had undergone a surgical procedure in 2016 intended to improve his shoulder strength and enable him to continue with his sporting activities, including the playing of rugby. The insurer concerned at the time had actually paid for part of the cost. However, there had been a subsequent recurrence of the ailment which similarly required surgery. The current insurer had declined to consider the respective claim.

The complainant was therefore requesting the Arbiter to order the insurer concerned to compensate the cost (which was not specified) of the required surgical procedure as well as the cost of consultation and transport.

On its part, the service provider contended that:

a) Differing cover terms and conditions were provided by the separate insurers with which the complainant's firm had been insured over the years.

b) Though the claimant had been insured throughout the said period without any interruption in cover, his injury was sustained while playing rugby. This was backed up by medical reports.

c) The provider's policy clearly excluded injuries arising from rugby activity. Consequently, the claim for compensation had to be declined.

In his deliberations, the Arbiter noted that:

1) The complainant denied that the claimant had sustained a new injury whilst playing rugby in 2018, as was being contended by the provider. Rather, he was insisting that the procedure undertaken in 2016 had been insufficiently effective and that the claimant required further surgery if he was to continue playing.

2) The complainant contended that the claimant was covered by the provider's policy since the latter should have been identical to preceding policies which covered the playing of rugby.

3) The complainant had not disputed the provider's contention that the claimant's medical history showed that he had been recovering well after the initial surgery undertaken, only to be aggravated again as a result of being injured in a severe rugby tackle.

4) From the testimony given by the parties, it was clear that the claimant had never fully recovered from his initial injury. This fact was supported by medical reports which stated that his condition was then aggravated by the aforementioned rugby tackle.

5) Following his initial injury, the claimant had continued to play rugby. Such participation triggered again the medical condition concerning his shoulder.

6) A thorough review of the provider's policy document established that rugby was indeed excluded from the cover. Nevertheless, the policy wording also provided the option that persons transferring their cover to the provider (on its renewal date, without any interruption) would continue to be insured by the provider on identical underwriting terms as had been provided by the preceding insurer.

7) The foregoing had neither been contested by the provider nor did it prove that the claimant had not been covered for rugby by the preceding insurer.

8) Moreover, the foregoing supported the complainant's contention that the group health cover had been transferred to the provider on a like-for-like basis.

In concluding his consideration, the Arbiter upheld the complaint. He ordered the provider to compensate for both the consultation and transport costs in full, as well as the cost of the required surgical procedure subject to any applicable policy limit(s).

The decision was not appealed.

Health insurance – Pre-existing medical condition as basis for claim rejection (ASF 078/2020)

COMPLAINT REJECTED

Pre-existing medical condition; utmost good faith, answering correctly and truthfully to questions in a proposal form.

The complainant stated that he had suffered from a number of medical issues over a six-week period, one of which was diarrhoea. Following inconclusive blood tests, he had been medically advised to undertake a colonoscopy and claimed compensation for the respective cost.

The service provider declined his claim contending that there was a pre-existing medical condition prior to the inception of the policy.

On his part, the complainant insisted that diarrhoea was a symptom of several diseases. Furthermore, undertaking a colonoscopy to determine its cause did not signify that it was a pre-existing condition.

He therefore requested the Arbiter to order the provider to settle his claim (amounting to €935).

On its part, the service provider contended that:

a) The complainant's claim had been refuted since it related to a condition that was already present when the complainant purchased his policy. A clear definition of what constituted a pre-existing medical condition was available on its website.

b) Despite being bound to disclose such condition on the principle of utmost good faith, the complainant had instead chosen to negatively answer a number of direct questions on the proposal form intended to establish the existence of such a condition.

c) The fact that the complainant had consciously opted to give false replies entitled the provider to void his policy from its outset, an option that the provider had not pursued.

d) A quotation for the cost of a colonoscopy was received by the complainant on the day before he purchased his policy.

In his deliberations, the Arbiter noted that:

1) From the documentation provided by the service provider, and particularly the statements made by the complainant in the two separate claim forms submitted, it was clear that the latter had already visited a doctor, blood tests had been carried out and a quotation for a colonoscopy had been sourced. All this was before an insurance proposal form had been completed and the relative policy had been incepted.

2) It was equally clear that the complainant was already suffering from the medical condition complained of, though this had not been definitely diagnosed pending the outcome of the colonoscopy and prior to purchasing the policy concerned.

3) Despite the duty to disclose in the proposal form all material facts relating to any medical condition, the complainant had answered negatively to two direct questions related to specialist consultation carried out during the preceding five years (concerning an actual or suspected medical condition) as well as to any known or foreseeable need to consult a doctor or any other health professional. Indeed, such consultation was already ongoing whilst blood tests had already been carried out and a colonoscopy was expected to be carried out.

4) Such omission could not be ascribed to forgetfulness on the complainant's part.

5) The policy wording specifically excluded any pre-existing medical condition, defined as a condition for which the policyholder has received medication, advice, diagnostic tests or treatment or in respect of which he had experienced symptoms.

6) Although the provider did not void the policy, which it could rightfully do under its terms and conditions, the complainant had still failed to disclose material facts.

In light of the foregoing, the Arbiter rejected the complaint.

The decision was not appealed.

Involuntary unemployment and redundancy policy – Rejection of claim benefit following redundancy (ASF 039/2021)

COMPLAINT UPHELD

Involuntary redundancy; provision of 'necessary' supporting documentation during claims' processing stage; utmost good faith between the insurer and the policyholder.

The complainant contended that the provider had unjustly declined his claim for compensation in respect of his period of involuntary redundancy, citing his alleged failure to provide all the necessary information required for the processing of the said claim.

Whilst pointing out that the term 'necessary information' was not defined in the policy, he insisted that he had provided more than sufficient information to prove that his claim was a genuine and legitimate one.

He further contended that the provider's request for sight of his bank statements was unnecessary and unwarranted since it breached his privacy.

The complainant therefore requested the Arbiter to order the provider to pay him £19,400 plus an additional £1,940 as interest.

On its part, the provider contended that:

a) The complainant's redundancy and consequent unemployment was due to him and his employer signing a settlement agreement, through which the parties agreed to terminate the employment contract. This was to be distinguished from redundancy *per se* where it is the employer who terminates the contract of employment.

b) The documentation requested from the complainant was the standard information that is customarily required to substantiate an unemployment claim; namely,

i. A copy of any risk letter(s), consultation(s) and termination letter(s) received by the claimant: this was necessary to prove that no other reason(s), other than involuntary redundancy, had led to the complainant's job loss.

ii. A copy of the bank statement(s), starting from the date of the redundancy: this was required to evidence that the complainant did not have any income from any alternative employment while he was redundant.

c) It was up to the provider to determine the extent of information required to ensure that a claim is valid and satisfied the policy terms.

d) It was made clear to the complainant that his failure to provide all the information required by the provider would invalidate his claim.

e) The monthly income benefit claimable under the policy was £2,000. Since the complainant had not notified the provider of any return to employment, this benefit would be payable from the termination date of the employment to the policy's end date. Taking into consideration the payment in lieu of notice period and the 61-day excess period (both of which would be deducted), the compensation payable to the complainant would amount to £17,533 in all.

In his deliberations, the Arbiter noted that:

1) The bone of contention between the parties was the extent of information that had to be submitted to substantiate the claim in question. The complainant was contending that he had provided all the necessary information whereas the provider was insisting that this was insufficient.

2) Maltese case law had repeatedly stated that the insurance contract was based on the utmost good faith between the parties. This implied that the said parties should interact by honouring their respective obligations towards each other. On the provider's part this signified, among others, that it should primarily look for reasons to pay a claim and not for reasons to decline it. It should thus give its claimant the benefit of the doubt.

3) Among the supporting documentation submitted by the complainant, there was the claim for jobseekers' allowance. This proved conclusively that the complainant had been made redundant by his employer. This was also specifically attested by the latter in a specific section of the claim form.

4) The settlement agreement between the complainant and his employer had not been triggered by the former. It was essentially an arrangement through which the employer was settling what was due to his employee, including notice money.

5) Even if the complainant had declined the payments made by his employer, he would still have been made redundant since the company wanted to streamline its workforce. Therefore, the complainant actually had no choice but to accept what was offered to him.

6) The settlement agreement also served to provide the employer with a guarantee that the complainant would not institute any legal proceedings against him.

7) The information supplied by the complainant was sufficient to prove the genuine nature of the claim. Once redundancy had been conclusively proven, the provider's additional request for bank statements did not seem to be reasonable and fair.

8) The specific policy condition stating that a claim would be declined if the claimant did not supply all the necessary information should not be interpreted by the provider as a *carte blanche* empowering it to demand any information it might imagine. The term 'necessary' actually limits the extent of information that the provider was entitled to elicit from the complainant.

9) Once the complainant's redundancy had been proven beyond any reasonable doubt, the provider's request for additional information would not have added any more comfort to the provider about the genuine nature of the claim.

10) When considering the entire documentation furnished by the complainant to the provider, it was evident that the former had indeed provided the latter

In the light of the foregoing, the Arbiter upheld the complaint and ordered the provider to pay the complainant £17,533.33. In addition, since the amount should have been paid on a monthly basis and was effectively due by 16 August 2020, the Arbiter further ordered the provider to pay interest at an annual rate of 8% from the said date up to the date of effective payment.

The decision was not appealed.

Sickness and Involuntary Redundancy Policy – Non-renewal of policy following withdrawal of insurer from the market (ASF 071/2020)

COMPLAINT REJECTED

Commercial decision taken by insurer to discontinue class of business; one-year insurance policy period; insurer not obliged to renew cover; request for premium refund turned down.

The complainant objected to the decision by the service provider to pull out of the insurance market, ostensibly because of the adverse effects of the pandemic.

He contended that he had purchased his policy, which would have been in force until his retirement, in order to safeguard himself in the eventuality that anything unfortunate were to happen to him during its currency.

The provider's unilateral decision to withdraw from the market had deprived him of such vital protection were he to lose his employment or fall seriously sick. Furthermore, he had not succeeded to find an alternative policy from another provider.

He further contended that, through its withdrawal, the provider had failed to meet the service expected by its policyholders, and this at the time when they needed it most.

He therefore requested the Arbiter to order the provider to refund him all the premiums paid from the policy's inception to its termination. This amounted to £4,133.
On its part, the provider contended that:

a) It had indeed decided to discontinue underwriting this class of business for all its clients and had duly notified the financial regulator about such decision, which was based on commercial grounds.

b) The policy type was not long-term. The aforementioned decision signified that it would no longer offer to renew the existing policies on their termination at the end of the respective policy year.

c) Had the policyholder submitted a valid claim while the policy was in force, then this would have been paid.

d) Since insurance cover had been in full force and effect, it was therefore unable to provide a premium refund.

In his deliberations, the Arbiter noted that:

1) The complainant was essentially requesting the renewal (and the continued maintenance in force) of his policy.

2) From a practical point-of-view, one had to distinguish clearly between the non-renewal of a policy and its cancellation. The former takes place before a policy's expiration date while the latter occurs when the insurer allows a policy to lapse and opts not to offer a new policy.

3) The policy period was of one year. At the end of such period, the insurer concerned was not obliged to renew the policy nor to find alternative cover for its (former) policyholders.

4) In accordance with the terms and conditions of the policy, neither party to the insurance contract could oblige the other party to renew it.

5) The Arbiter's Office did not have any authority or jurisdiction over the provider's decision to cease its underwriting of this class of business for all its policyholders. Rather, such authority fell under the exclusive jurisdiction of the provider's regulatory authority.

6) The complainant was not entitled to the reimbursement of the annual premiums paid over the years. He had been duly covered for the risk and, if the need arose, he could have submitted a claim for compensation. His risk had effectively been transferred to the provider which was therefore entitled to receive and retain the respective premiums.

In the light of the foregoing, the Arbiter rejected the complaint.

The decision was not appealed.

Involuntary unemployment and redundancy policy – Claim rejected for not producing an employment contract (ASF 057/2021)

COMPLAINT UPHELD

Compensation payable for unemployment; provision of supporting documentation during claims' processing stage.

The complainant contended that she had purchased the insurance cover in question from the provider in order to have peace of mind in case of unemployment, redundancy, illness, or accident. She claimed that she had paid over £10,000 in premiums since April 2015 and had never claimed before.

The complainant insisted that she was being penalised by the provider for not having an employment contract, which had not been offered to her by her employer.

She further contended that the provider had breached its duty of care by prolonging the claim-settling procedure unnecessarily and that this had affected her health and mental wellbeing.

The complainant was therefore seeking compensation through the Arbiter for her unemployment, for which she was not at fault. However, the specific amount claimed was unclear.

On its part, the provider contended that:

a) The complainant held two separate policies, incepted in August 2019 and June 2020 respectively.

b) The documentation (policy terms and schedules) submitted by the complainant in support of this case related to other insurers.

c) The complainant's claim for compensation had been declined in accordance with the policy terms and conditions which specified that the insurer would not pay claims where the claimant was unwilling or unable to provide all necessary information required to substantiate the claim. In this regard, the complainant had failed to produce her employment contract.

d) The said policy terms and conditions further specified that a claim would be declined in cases where there was insufficient evidence of unemployment. In this regard, the complainant had answered negatively the specific question on the claim form as to whether she was undertaking any paid or unpaid work while she was unemployed. However, there was evidence that the complainant was actually working with an alternative employer during the alleged unemployment period.

e) Though the complainant did submit some supporting documentation to substantiate her claim, it was up to the provider to determine whether additional information would still be required to ensure that a claim satisfied the Policy terms and conditions.

f) The complainant stated that her unemployment commenced on 1 July 2020 and that she had started working again on 5 October 2020. She further stated that she had a three-month notice period. The latter period would therefore end on 30 September 2020. The policy terms and conditions required a 30-day waiting period after this date. Since the complainant had started to work again during such waiting period, there would not be any claim settlement due.

g) In the eventuality that the three-month notice period would not apply, then the amount claimable by the complainant would total £7,916.

In his deliberations, the Arbiter noted that:

1) Though the submission of an employment contract would assist the provider in determining such features as the notice period, salary etc., this did not necessarily prove that the person concerned was actually unemployed. Rather, a letter declaring redundancy by the employer as well as the acceptance of unemployment by the appropriate government entity would be more reliable evidence.

2) The complainant was unable to produce an employment contract because this had not been provided to her since she had been engaged verbally. In view of the fact that the policy wording specifies the submission of necessary information to substantiate a claim, the most important and necessary information required by the provider would be solid and undisputable evidence of unemployment.

3) The complainant had indeed submitted sufficient information to prove her unemployment beyond any reasonable doubt. This was done by means of the letter issued by her previous employer confirming that her employment had ended on 30 June 2020 due to

redundancy and that the three-month notice period had been waived; and also her being granted a jobseeker's allowance, thereby proving that her unemployment had been accepted by an official source.

4) The foregoing showed that the complainant had proved her unemployment and that she had provided all the necessary information for the processing of her claim for compensation. The provider's declinature of the claim was therefore unreasonable and unequitable.

In the light of the foregoing, the Arbiter upheld the complaint.

When calculating the compensation due to the complainant, the Arbiter noted that the complainant's two policies jointly provided a benefit of £2,500 per 30-day period. Given that the unemployment period lasted 95 days, the complainant was therefore due £7,916 as compensation under the said policies. No deduction was to be made from this amount since the complainant had worked her notice period and had been remunerated accordingly by her previous employer.

The decision was not appealed.

Life insurance - Shortfall in policy maturity value (diverse cases)

COMPLAINT PARTIALLY UPHELD (ASF 001/2020)

Complainant's reasonable and legitimate expectations; use and meaning of the terms 'estimate' and 'approximate'.

The complainant stated that, a few days before the maturity date of his life insurance profits policy, he had been informed by the provider that its maturity value amounted to €24,305. This contrasted starkly with the superior amount which had been quoted to him initially when he was considering the purchase of the policy.

He further contended that the protracted correspondence exchanged with the provider had failed to offer a satisfactory explanation by the latter of the shortfall in the policy's maturity value.

The complainant therefore requested the Arbiter to condemn the provider to award him the maturity value quoted at the purchase stage.

On its part, the provider contended that:

a) The complainant had not specified the amount which he was requesting the Arbiter to award him but merely referred generically to the maturity value indicated to him at the purchase stage. However, two alternative amounts had been indicated by its sales representative. Though it was logical to assume that the amount required by the complainant was the higher of the two (that is €51,549), such ambiguity had prejudiced its right to put up a proper defence against the complainant's allegations.

b) The complainant was not due any additional financial benefit other than that notified to him (€24,305); and this for the following reasons:

i. Its sales representative had quoted two alternative estimates of the policy's maturity value because it had based itself on the bonus rate provided by the underwriter in two separate years. This envisaged that such bonus rate would remain unchanged for the duration of the policy.

ii. The difference in the two maturity values quoted shows that such bonus rates were not constant but fluctuated from one year to the next. Furthermore, the inclusion or otherwise of a terminal bonus in the ultimate maturity value was at the entire discretion of the insurer. These variables showed that the maturity value could not be guaranteed.

iii. The separate amounts quoted to the complainant had been qualified by the term 'estimated' as neither one of them was actually guaranteed.

iv. The term 'estimated' was to be understood according to its normal interpretation; otherwise, it would be implied that the alternative maturity values quoted were actually guaranteed. This could not be the case since the realisation of the said values depended entirely on the performance of the underlying investments. Such performance had deteriorated over the years that the policy in question had been in force.

v. The investment element in the policy had performed well over the years since it had provided an annual return of 3% over the policy term.

vi. Despite the reduction in the projected maturity value, the policy in question had still been a worthwhile investment for the complainant since it had simultaneously provided him with life Insurance cover with a guaranteed sum insured payable in case of his demise before the maturity date. Such added benefit was not normally available in savings products.

In his deliberations, the Arbiter noted that:

1) The complainant had stated under oath that he had decided to purchase the policy in question after an unsolicited visit to his residence by the provider's representative. He had been particularly attracted by the promised maturity value of €51,549 that would be available on his retirement. The said amount was stated in writing on a document signed by the representative.

2) The complainant further stated that the representative had spoken only about the attractive maturity value of the policy and had never mentioned any investment (or other) inherent risks that could materialise over the years that the policy would be in force. Due to his (and his wife's) lack of knowledge about such matters, he had trusted the representative completely; and this to the extent of disregarding the annual bonus statements received from the provider since he was confident that the maturity value quoted by the representative would materialise in the end.

3) The manner in which the policy had been sold to the complainant, and the information provided during such sale, were of crucial importance. In this regard, only the complainant's version was available.

4) Despite the provider's contention that the complainant had not specified which of the two separate maturity values (provided to him by the representative) he was pursuing in these proceedings, the supporting documentation submitted by him clearly showed that the sale of the policy was indeed based on an estimated maturity value of €51,549.

5) Despite the use of such terms as 'estimated' and 'approximately', the documentation offered by the provider's representative to the complainant appeared to emphasise the fact that the policy's eventual maturity value would be more or less €51,549. This inevitably gave rise to an expectation on the complainant's part that he would have actually collected that sum once his policy matured; such expectation had to be respected.

6) The term 'approximately', in its ordinary everyday meaning, signified that the maturity value it qualified would not differ greatly from that actually offered to the policyholder. Consequently, the compensation to be awarded to the complainant should not vary significantly from the maturity value quoted to him at the outset.

In the light of the foregoing, the Arbiter upheld the complaint and ordered the provider to pay the amount of €43,816 to the complainant.

The decision was not appealed.

COMPLAINT REJECTED (ASF 130/2020)

Credibility of testimony given by the complainant and the seller of the policy; choice of policy that benefitted the insured.

The complainant stated that he had purchased the policy in question on the advice of a bank employee. Though he was initially sceptic about the said policy, the employee's persistence had finally persuaded him that it would be beneficial for him to purchase it.

He had therefore opted for a 25-year endowment with profits policy that would provide a maturity value of €209,901. The employee had explained to him that this amount would be very handy on his retirement and could serve as collateral were he to require an overdraft with the bank in connection with his business.

The complainant insisted that the maturity value quoted to him had never been qualified in any way. Nor had he ever been notified by the provider that the said maturity value would not be attained. Throughout the currency of the policy, he had remained steadfast in his expectation that he would be receiving the amount quoted to him at the outset.

However, at the policy's maturity, he had been formally notified by the provider that he would be receiving only €94,349 inclusive of the applicable terminal bonus. This represented only 45% of the amount that had been promised to him at the outset.

The complainant acknowledged that the maturity value indicated to him may have been an estimation, however not by a variance of 45%.

The complainant therefore requested the Arbiter to order the provider to abide by its obligations and pay him the amount of €209,901.

On its part, the provider contended that:

a) The amount being claimed as compensation by the complainant was based on a mere estimate (illustration) issued at the pre-purchase stage and not on any written guarantee. The terms used at the time had to be interpreted and understood according to their normal everyday meaning. Otherwise, the said amount might misleadingly appear to have been guaranteed.

b) The discrepancy between the quoted maturity value and that provided was due to the policy's actual investment value on its maturity date; it was not due to any unilateral decision on the provider's part. Since the said value was in accordance with the policy's terms and conditions, the provider was willing to pay it.

c) There was no acceptable or reasonable percentage variation that could bridge the gap between the initial quotation (estimate) and the actual maturity value. Nor had any agreement in this regard ever been made between the parties.

In his deliberations, the Arbiter noted that:

1) In his testimony, the complainant had insisted that he had trusted the separate maturity values provided to him by the bank's representative; namely, €152,653 and €209,897 (which amount was inclusive of the terminal bonus). He had been assured that the former amount was certain while the latter was equally attainable provided he kept his policy in force till its end. The said representative had never informed him that the aforementioned figures could decrease in any way. All this had finally persuaded him to overcome his initial reluctance to purchase the policy in question.

2) The provider summoned the bank's representative to testify, and this in his role as the seller of the policy to the complainant. He had stated that he had explained to the latter the policy's workings and its dual role. He had also underlined the utility of the latter aspect as collateral for the loan facility that the complainant was taking at the bank.

3) The bank's representative had further stated that the quotation provided to the complainant was calculated by the bank's computer system. He contended that he had never guaranteed the resulting amounts, which were clearly qualified by the term 'estimated'.

4) The Arbiter noted the marked contrast between the testimony of the complainant and that of the bank representative. The former had insisted that he had been repeatedly invited to purchase the policy, even if he was manifestly reluctant to do so. On the other hand, the bank's representative stated that he had no personal incentive to pressure the complainant since no incentives were offered by his employer to maximise the sale of policies. The complainant had also wanted the policy as collateral for his bank loan, which he pledged from the outset to the bank.

5) The testimony given by the bank's representative was quite convincing and credible, providing a clear explanation of the policy's workings to the complainant and of the method in which it had been sold to him. Moreover, it was to be noted that the said representative had no particular motive in selling the policy to the complainant.

6) The bank's representative could have provided the complainant with a simple term policy which would have met the bank's requirements. However, he had actually gone beyond the call of duty and advised the complainant to opt for an endowment policy which also provided a financial benefit to the complainant at its maturity. Being a businessman, the complainant had surely noted the inherent financial advantage of an endowment policy over a term policy.

7) The detailed explanation of the policy's workings given to the complainant by the bank's representative had not created any particular expectation in the former that had not been satisfied. Nor had the former been misguided or deceived in any way.

8) The complainant had actually made a profit of €35,329 from his endowment policy. This showed the value of the advice he had been given by the bank's representative.

In the light of the foregoing, the Arbiter rejected the complaint.

The decision was not appealed.

COMPLAINT REJECTED (ASF 015/2021)

The complainant contended that, for the last 16 years, she had held a savings policy for which she paid about €600 in annual premium. The policy was due to mature in 2024)

The provider's representative had contacted her and advised her to replace her current policy with an alternative investment product as the latter would provide a comparatively better return.

The surrender of her aforementioned policy resulted in a financial benefit of €10,480 which she accepted only reluctantly since she was not satisfied with this sum.

When she requested the said representative to specify profit she would make under her surrendered policy, the complainant was disappointed to learn that this amounted to a mere €800. She thought that the amount was too low, considering the 16-year period during which her policy

had been in force as well as her respective premium payments during this period.

She requested the Arbiter to require the provider to review and revise the surrender value of the policy to €8,000.

On its part, the service provider contended that:

a) The complainant could not ask for compensation which exceeded the value of her policy which she herself had decided to surrender prior to its maturity date and whose return she had accepted by cashing the provider's cheque for the aforementioned amount.

b) The complainant had never been promised any definite sum at the end of her policy. This was evidenced by the documents which she had signed and by the policy itself as well as by the annual statements which had been provided to her and which she had never contested during the 16-year period that her policy had been in force.

In his deliberations, the Arbiter noted that:

1) The complainant stated that she was a postal employee with a limited knowledge of insurance matters. She had testified that, when initially purchasing the policy, her intention was to see it through to its end. However, she had subsequently opted to surrender it because she had trusted the advice of the provider's representative. She alleged that the latter had put psychological pressure on her to surrender her policy and opt for an alternative one.

2) The provider's two representatives had testified that it was the complainant who had asked to liquidate her policy. Detailed explanations, about the implications of surrendering the existing policy and the workings of the alternative one, were repeatedly provided to the complainant during separate meetings. The complainant had understood such explanations. The complainant accepted the cheque for the surrender value unreservedly and without making any reservations as to the amount.

3) Despite the complainant's contention that she had been misguided by the provider's representative to surrender her policy before its maturity date, the facts of the case showed that the complainant had initially agreed to such surrender so as to replace the policy with another one that was more consonant to her financial requirements.

4) The complainant had admitted that she was aware that her acceptance of the provider's cheque (for the policy's surrender value) signified her agreement to terminate such policy. There was serious doubt about the complainant's contention that she had accepted the cheque for the surrender value unwillingly, and this because there was nothing to prevent her from continuing to maintain the existing policy in force.

5) No evidence had been provided of the financial amount actually lost by the complainant due to the early surrender of her policy. However, it was undisputed that such surrender had resulted in an €800 profit for her.

6) The complainant's request to be accorded a compensation of €8,000 was not supported by evidence that this amount was really the complainant's loss when she surrendered the policy. The said amount therefore appeared to be a fictitious one.

7) There was no evidence that the provider had put psychological pressure on the complainant to surrender her policy.

In the light of the foregoing, the Arbiter rejected the complaint.

The decision was not appealed.

Investments cases

Alleged losses suffered on non-investment grade bonds (ASF 007/2020)

PARTIALLY UPHELD

Investment advice; suitability of investments; composition of a portfolio; provider's responsibility to maintain proper documentation

The complainant submitted that he was given investment advice by the provider. He claimed that the provider:

a) Had mis-sold him investments that were unsuitable to his personal circumstances and incompatible with his liquidity requirements.

b) Failed to take account of his lack of financial knowledge and experience in bonds and that he had never invested in bonds. He was thus not in a position to assess the risks for such investments.

c) Had recommended a portfolio of bonds which did not reflect the complainant's short-time investment horizon (six to 18 months), his need for income and minimal capital loss and where the ease of sale and liquidity of the investments at short notice had to be assured.

d) Applied an aggressive and high-risk investment strategy which transformed his portfolio into a highly speculative and risky one with material positions (in excess of €100,000 each) placed into non-investment grade bonds which went contrary to the provider's own asset allocation model for moderate risk and income-oriented investors. As much as 82.92% of his portfolio was invested in non-investment grade bonds when the provider's model allowed a maximum of 30%.

e) Had been negligent to the extent that he had suffered an overall loss of 19% over an 18-month period up to 31 October 2019, with the massive losses resulting from three speculative investments.

The complainant claimed compensation by way of reinstatement of losses from the said three investments and requested the Arbiter to determine that the provider failed to act with due skill, care, and diligence and to abide by the applicable regulatory regime.

The financial provider rejected the complaint's statement and refuted responsibility for the claimed losses. It contended that:

a) It had followed the conduct of business rules and always kept the complainant informed and updated. Its investment recommendations were given in accordance with the suitability requirements, and the necessary warnings/information were fully disclosed to the complainant to enable him to make an informed decision.

b) The complainant's objective was not to achieve minimal income but to reach a higher income compared to the four to seven per cent level he had been accustomed to.

c) The complainant kept changing the circumstances relating to his financial situation and liquidity requirements, and also gave conflicting and inconsistent information on the latter.

d) That the unfortunate events involving the complainant's portfolio were the result of credit and market risk which could be understood well by a bond/property investor such as the complainant.

In his deliberations, the Arbiter noted the following:

1) The complainant's investment account was opened in 2018. The documentation indicated that he was not familiar with bonds and funds, but rather with shares. He held no liabilities and owned a substantial property investment apart from his home. The investment objectives of the complainant were indicated as being 'Income' (compared to 'Capital Growth'/'Balanced Approach'), with a 'Moderate' Risk Profile and a 'Short (up to 5 years)' investment timeframe.

2) The investment proposal showed that the complainant held around €450,000 with a local bank which was earmarked for the renovation of property in Malta in around 18 months' time. The complainant had expressed the wish to employ the funds in a way that would have earned him a better return compared to the negligible bank interest rate.

3) The portfolio in which the funds were invested comprised a number of bonds which included three

debt securities. All lead to major losses according to the complainant.

4) Nearly 60% of the investment portfolio comprised just two bonds at the time of commencement of the portfolio and during the initial months. Hence, individual exposure to the said investments was indeed quite considerable. Additionally, a high percentage of the portfolio was invested into non-investment grade instruments.

5) The basis for such high exposure, both individually and collectively within the whole portfolio, was however not clearly and thoroughly documented by the provider while providing advice to the complainant.

6) The complainant's objective was not a low risk/ low return strategy but rather one of moderate risk. He was willing to accept capital fluctuations of around 15% as disclosed in the investment report.

7) One of the three bonds in which the complainant held a substantial investment experienced a near 30% drop in value within less than a year and kept deteriorating to around 50% of its original value in subsequent months. Given the high individual exposure to this bond and the other disputed investments and the drop in value of each of the three investments, it was evident that the fluctuations of capital experienced by the complainant went beyond the 15% threshold he was willing to take.

8) The service provider never contested the claim that was made by the complainant that the non-investment grade instruments were unsecured and had a very low credit quality at the time of purchase of between four to six notches below the best credit rating in the speculative/ non-investment grade credit ratings. Such ratings would have indicated a prevalence of high risk attached to the said investments.

9) The risk to which the complainant was exposed was ultimately higher in view of the high exposure to non-investment grade instruments, both individually and collectively, within the portfolio. If the complainant was willing to sustain a greater capital risk for higher returns as alleged by the service provider, then this should have been adequately and clearly documented as required by the relevant regulatory norms. Adequate and clear documentation justifying the higher risk taken in the recommended portfolio was, however, not evident.

10) The investment advice documentation was also incorrect when it claimed that the complainant had previously invested in assets that were similar to the proposed investments. Indeed, the complainant insisted that he had never invested in bonds.

11) Furthermore, the service provider had not clearly and adequately documented why it had materially departed from its own typical asset allocation model for moderate risk investors whose financial objective was income.

12) No evidence was presented to show that the complainant had been provided with sufficient information that would have enabled him to properly understand the characteristics and risk elements of the non-investment grade instruments in which he had been advised to invest.

13) The service provider did not meet the relevant regulatory obligations that required it to properly assess the risk a client was willing to take and similarly document his investment objectives. A provider had to clearly and unequivocally demonstrate that such obligations had been undertaken; it transpires it did not.

Thus, the recommended portfolio did not meet and reflect the complainant's objectives and risk tolerance.

However, the complaint could only be upheld partially as two of the three disputed investments had ultimately not resulted in a net loss when taking into consideration the respective dividend payments earned. In regard to the third bond investment, compensation was awarded for the losses sustained throughout its holding period as well as for the amount of any net profit (inclusive of dividends and any realised currency gains/ losses) resulting on the overall portfolio of remaining investments that were made on an advisory basis.

The decision was appealed.

Competence of the Arbiter to look into a complaint (ASF 016/2021)

COMPLAINT UPHELD

Investment portfolio composition; limited evidence submitted by the financial services provider; gradual decline in value of the portfolio; suitability of advice, assessment of risk.

The complaint related to losses suffered by the complainant on an investment portfolio following the default of two out of four securities comprised in it. The portfolio was acquired in 2012 at a cost of €15,000. The complainant claimed that he had not been made aware of the high-risk nature of the investment. In summary, the complainant claimed that:

a) The value of the portfolio started to decline at the end of 2014 when consulting with his adviser, he had been advised to take a wait-and-see approach. In June 2016, one of the bonds was isolated from the rest of the portfolio. The same occurred a year after in 2017 in regard to a second bond.

b) The fall in value continued in 2018 and, from then onwards, the investment adviser avoided taking or responding to his phone calls and emails. Around Christmas in 2018, the adviser informed him that he was able to recover €7,500 out of his portfolio. The remaining value dwindled to just over €150. He requested to have the recovered value transferred to his bank account but the provider took an inordinate amount of time to do so, attributing such delay to the provider's negligence.

c) In May 2019, he was told that the two isolated bonds were to be re-invested for four years until 2022 for the purpose of recovering the capital losses. He was told that there were no other alternatives if he wished to recuperate such losses. On 1 January 2021, his remaining portfolio of the two isolated bonds was valued at €58.

d) He claimed that the bond portfolio had been mis-sold to him and requested compensation for the capital losses suffered.

In its reply, the provider claimed that the Arbiter did not have the competence to look into the case as the complainant took more than two years to lodge a complaint with it, and this as required by law. It further claimed that the complainant was aware of issues relating to the bond portfolio much earlier than when he had submitted a complaint to it. In its submissions, it explained that:

a) In 2016, it had sent a letter to the complainant explaining that one of the bonds had deferred payment of interest and that the issuer had support for the repayment of 80% of its capital. Given such circumstances, the bond was isolated from the portfolio.

b) A year after, the provider sent a circular in regard to the default of another bond in the portfolio. That bond was also isolated from the portfolio.

c) In 2018, the aggregate value of these two bonds was around €156. Valuation statements were sent annually to the complainant.

In his deliberations, the Arbiter first focused on whether he had the competence to look into the complaint following the provider's claim that the complaint was lodged with the financial services provider beyond the two years, prescribed by law, from the complainant first becoming aware of the conduct being complained of.

The Arbiter further observed that:

1) As to the first bond that was isolated from the portfolio, the letter sent to the complainant was somewhat ambiguous as it not only refrained from directing the investor to sell his holding but that it hinted at the fact that the deferment of the interest payment would have eventually led to a positive outcome.

2) The wording of the letter was rather subdued so as not to raise any alarm for retail investors, although those conversant with financial investments (such as the provider) would have interpreted its contents differently. In this sense, the investor was not adequately informed as to the severity of the matter, in which case it would surely have led him to file a complaint with the provider.

3) The same applied to the second letter. The provider itself stated in the letter that the investor was not required to do anything at that stage and that the firm would continue to provide information as to the bond issuer's restructuring. Indeed, when the complainant asked his adviser for further information, he was told to take a 'wait-and-see' stance.

4) What was certain was however the contents of an email which the provider sent to the complainant on 30 December 2019. In that email, the provider informed the complainant that one of the bonds would mature in December 2022 and that nothing was certain about the other bond. After that email, the complainant received no further information from the provider.

5) Given the contents of that last communication from the provider, the complainant had until the end of December 2021 to lodge a complaint with the provider, which he in fact did in January 2021. Thus, there was no issue with regards to the Arbiter's competence as the complaint was lodged within the time frame required by law.

As to the case merits, the provider did not provide any solid evidence in its defence. The Arbiter had only the complainant's version on which to assess the case. He observed that:

6) The bond portfolio was composed of four bonds which were non-investment grade and of a speculative nature.

7) The complainant claimed all along that he did not wish to invest in high risk assets. The complainant's risk profile was that of a medium risk investor. The provider should not have classified him as high risk and offered him a bond portfolio made up of non-investment grade bonds some of which with an interest rate as high as 9.5%.

8) Clearly, the provider failed to act in the best interest of the client. The provider did not observe the MIFID criteria regarding the suitability of the investment. Had the suitability assessment been conducted in a proper and professional manner, the provider would not have offered to the complainant such high risk investments.

The complaint was upheld, and the provider was ordered to pay compensation to the complainant, after considering the amount of capital recovered and the interest that may have been paid.

The decision was not appealed.

Deposit limits imposed on a trading account (ASF 064/2020)

COMPLAINT REJECTED

Funding of an online trading account; limits set for payment by card; alternative payment options; presumption of trading profits.

The complaint relates to the limits on deposits allegedly imposed by the service provider to the complainant's trading account. The complainant explained that during February 2020 (up to the first week of March 2020), he had noted volatility in financial markets from which he could have made substantial profits. However, the service provider limited the funds that he was able to deposit into his online trading account thus preventing him from taking advantage of the said opportunities. He claimed that he had previously been allowed to successfully deposit higher amounts in his account via his debit card and that alternative payment methods proposed by the provider were not feasible.

On the basis of his calculation, the complainant sought £14,769.55 from the service provider as compensation for the losses he claimed to have incurred as a result of the provider's restrictions.

In its reply, the service provider submitted the following:

a) The complainant made deposits into his trading account via a third-party payment provider who set a £500 daily deposit limit. The complainant was aware of such limit as he had provided evidence to that effect. He was advised, both verbally and in writing, about the possibility of depositing via bank transfer and this around two to three weeks before the issues that the complainant was lamenting about. It was the complainant's choice not to heed the provider's suggestion to use such alternative payment methods.

b) The complainant had been incurring trading losses in February 2020, a situation that had also prevailed in the previous month. In this regard, the claim for compensation of £14,769 that the complainant was asking as remedy was unsustainable and claims of trading profits by means of higher deposits were not guaranteed.

The Arbiter, in his deliberations, observed the following:

1) Evidence made available by the payment provider clearly indicated that the complainant's payment processor had established a £500 daily deposit limit. This limit, which prevailed at least for the month of February, was raised to £5000 in March. Higher amounts above such limit would have had to be sent via a bank transfer.

2) The trading history report for the complainant showed that his margin level fell below the 100% benchmark as far back as January 2020 (when the free margin turned negative) and consistently remained below the said benchmark in the ensuing days including, and up to, February 2020.

3) Despite the complainant being consistently below the 100% margin level until the end of January and during the whole month of February 2020, and seemingly aware of certain problems with his usual deposit method as early as February 2020, he still failed to do any additional deposits to improve his margin. It was only when his margin level fell again to around 50% in late February 2020 that he affected a further deposit using his chosen payment method.

4) The complainant ultimately had other payment options at his disposal including bank account payments as indicated by the service provider. Such payments arrived

promptly and certainly not up to five business days as the complainant was claiming. Ultimately, it was his choice not to pursue bank transfers, as was suggested to him.

The Arbiter was not in a position to award compensation based on the complainant's presumption that additional deposits would have improved his trading position and/or that the complainant would have realised profits on new trading positions. These were all hypothetical situations, which could neither be verified nor deduced on the basis of historical trading performance.

The Arbiter thus rejected the complaint.

The decision was not appealed.

Unheeded request to withdraw funds from an investment account (ASF 072/2020)

COMPLAINT UPHELD

Provider's non-filing of a reply; contumacy; provider's obligations to respond to requests made by its clients; addressing identified misconduct.

The complaint was made by the director of a company (the complainant) in relation to an investment account it claimed it held with the financial services provider. The complainant alleged that:

a) Over a span of 12 months, it had made numerous requests to the financial services provider to withdraw funds it held in its investment account.

b) The financial services provider denied access to the funds and provided no reasons for its decision nor did it reply to withdrawal requests.

c) Two formal letters of complaint sent to the financial services provider were not even answered.

The complainant requested the retrieval of all the funds held in the account and the reimbursement of the non-activity charges applied to the said account.

The financial services provider did not file a reply to the complaint lodged with the Office of the Arbiter for Financial Services.

In his deliberations, the Arbiter made the following observations:

1) The complainant presented evidence that it held an investment trading account with the provider denominated in US Dollars. The account had a balance of $38,382 as at the end of April 2020. An inactivity fee of $30 for the first quarter of 2020 was also applied.

2) The financial services provider did not file a reply and was therefore contumacious. Although the service provider was given the opportunity to justify its contumacy, the service provider stated that 'the law' prevented it from filing a reply. However, the financial services provider did not elaborate on this and did not indicate as to which law it was referring to.

3) The financial services provider's attitude could only be considered as being tantamount to an admission of the complaint.

4) However, one would still need to assess whether the complainant had managed to prove its case, and this by reference to the facts as submitted by the said complainant.

5) The complainant provided evidence that the financial services provider had simply disregarded its requests to operate and withdraw the funds in its account. It was also charged a fee for 'non-activity' when it was not its fault that it could not operate the account.

6) A financial services provider was duly expected to communicate with the complainant promptly and in a comprehensive and clear manner. Failure to do so was highly unprofessional. It was reasonable for the complainant to explain its actions.

7) Any valid request made by a customer of a financial services provider, in respect of an account to which s/he is legally entitled to, should be promptly processed in line with the provisions and terms of the contract of service/product as applicable.

The Arbiter thus upheld the complaint and ordered the financial services provider to rectify the conduct complained of and its consequences. He also ordered the complainant's account to be closed and to transfer all proceeds, including a refund of any inactivity fees, to an account of the complainant's choice.

The decision was not appealed.

Private pensions cases

Responsibility of the trustee and retirement scheme administrator (ASF 009/2019)

COMPLAINT PARTIALLY UPHELD

Actual losses on a portfolio of structured notes; regulatory status of the investment adviser; applicable investment and diversification requirements; ensuring that portfolio invested actually reflected the beneficiary's investment strategy and risk profile.

The complaint related to a personal retirement scheme established in the form of a trust and administered by the service provider, who was also its trustee and retirement scheme administrator.

The complainant's case can be summarised as follows:

a) The service provider had allowed his (previous) investment adviser to deal in structured notes within his pension scheme, to the extent that his scheme ended up losing around 70% of its value.

b) The investment adviser did not hold the appropriate licence to conduct investment activities. The complainant questioned how the service provider was doing business with an unlicensed person.

c) Some of the investments in the retirement scheme were structured notes involving periods of only 18 months. Such structured notes were not appropriate for pension investments and should have never been allowed by the service provider. This was tantamount to gross mismanagement and gross negligence as well as total lack of care towards him as a client.

d) The complainant requested compensation for the amounts lost on the structured note investments, where he claimed total losses of £72,000.

In summary, the service provider submitted the following:

a) The retirement scheme in which the complainant had invested was created by a trust deed which allowed members to nominate an investment adviser and to indicate the preferred investment strategy for the member's plan. It did not and was not authorised to provide investment advice.

b) Other than investment restrictions set by the regulator in its rules, the service provider devised its own investment restrictions, including for structured notes. The notes in the complainant's portfolio were within these parameters.

c) The investment adviser named by the complainant did not have any direct or personal control over the scheme's investments. Dealings were made at the request of the company with which the adviser worked. All such dealings fell within the parameters of the scheme's investment restrictions and the complainant's own risk profile and tolerance to risk, as expressed in the complainant's application form.

d) The structured notes selected by the complainant and his investment adviser were scored in relation to the overall portfolio and every purchase was well within the complainant's stated risk appetite.

e) The claimed loss of €72,000 was incorrect.

In his deliberations on the complainant's investment portfolio, the Arbiter observed the following:

1) The complainant's investment objectives were to provide for the potential for growth over the medium to longer term. He was categorised as having a medium risk appetite.

2) His application form for membership of the scheme indicates two investment advisers within the same investment firm. One of the advisers confirmed that he was regulated by a central bank in a Middle East jurisdiction.

3) The investment portfolio forming part of the retirement scheme held a number of investments in one fund, but the remaining in structured notes. Some of the structured notes were redeemed before the surrender of the whole scheme, with a few yielding capital gains.

4) The complainant surrendered the investment portfolio in January 2018 for the amount of £57,184.82. The difference between the indicative initial amount

invested (£136,714) and the surrender value equates to £79,529. A total of £55,318.15 was paid to the complainant following the deduction of termination fees charged by the service provider.

5) Although the complainant alleged a loss of £72,000 in respect to four structured notes, the actual loss was lower than that based on statements furnished by the service provider. However, a net loss ultimately emerged not only with respect to the four structured notes indicated by the complainant, but also on all structured notes investments in his portfolio. Apart from that, a loss also clearly emerged even when considering the overall position within his whole investment portfolio. This was inclusive of the realised gain made on the collective investment fund. The loss did not exceed £29,640.60 and was indeed lower than the £72,000 loss claimed by the complainant in his complaint.

Having determined that the complainant has indeed suffered a loss on his retirement scheme overall, the Arbiter then considered the substance of the shortcomings of the service provider as alleged by the complainant:

6) The service provider did not comment on the regulatory status of the firm with which the investment advisers, who serviced the complainant, were employed. The service provider did not present any proof of the checks it claimed to have made on such entity. Nor did the service provider submit any evidence of the verification it made of the licence that such firm claimed to have.

7) As part of its duties, the service provider was required to ensure that investments undertaken within the retirement scheme satisfied the applicable investment and diversification parameters. It could not be ascertained that the structured notes allowed to form part of the complainant's portfolio were actually in line with the diversification requirements, namely the maximum exposure limit specified in the application form, or that they reflected the limits and standards referred to in the regulator's pension rules, such as the maximum limit in exposure to any one single issuer/product and/or the concept of investments being made in a prudent manner.

8) The portfolio consisted of substantial investments in structured notes, some of which were sold within just a few weeks or months from acquisition. Although no fact sheets of such notes were produced or could be sourced, it was nevertheless sufficiently clear that such structured notes included features which enabled substantial losses to be made, or even the possibility of the investment to be completely or almost completely lost.

9) In the circumstances, it could not be reasonably determined that the portfolio of investments was reflective of the complainant's preferred investment strategy and risk profile.

In his conclusion, the Arbiter determined as follows:

10) The failure to achieve the scheme's scope, that is to provide for retirement benefits, was indicative of the higher risks that had been taken within the investment portfolio overall.

11) Whilst the retirement scheme administrator was not responsible to provide investment advice to the complainant nor to select the underlying investments of the retirement scheme, the trustee and administrator still had a duty to check and ensure that the portfolio composition recommended by the investment adviser was a prudent one as reasonably expected from a retirement plan.

12) Given the service provider's failures, the complainant should be compensated for 70% of the losses he sustained on his overall investment portfolio.

The decision was confirmed in full on appeal.

Losses caused by over-exposure to a portfolio of structured notes (ASF 083/2019)

COMPLAINT PARTIALLY UPHELD AND CONFIRMED ON APPEAL

Dual role and responsibility of the retirement scheme administrator and trustee; bonus paterfamilias; financial advice; adhering to the word and spirit of the regulatory rules and own internal investment guidelines; portfolio diversification, structured notes; retail investor.

The complaint was made against the service provider relating to a personal retirement scheme established in the form of a trust and administered by the service provider in its dual role as trustee and retirement scheme administrator.

The complainant claimed that:

a) The service provider had failed to act in her best interests and to follow its own guidelines when her portfolio was invested in structured notes that were highly risky and aimed for professional investors only. As a result,

she suffered losses on her pension fund, leaving her with little, and quite possibly, no income for her retirement.

b) Her funds were placed in an investment bond that was expensive and had a lock-in period which meant she could not withdraw from it without incurring huge penalties.

c) The service provider accepted business from unqualified advisors.

d) She had only recently become aware of the extent of the problem and was devastated to find that money she was relying on for her retirement had been abused in that way.

e) According to a 2019 statement, her pension fund was worth £22,545, with a loss of £39,383, that excluded a withdrawal of £13,000.

She requested that her pension fund be restored to its original value, less the money withdrawn (£13,000). It was noted that the initial investment before costs amounted to £74,926.

In its reply, the provider submitted that:

a) It was not licensed to provide investment advice. It was the complainant who appointed the adviser. It was not aware of any attempt by the complainant to initiate proceedings against the adviser or its officials, who advised the complainant to invest in products which have led to the complainant's alleged losses. The adviser had ceased trading and was no longer operating. This was the only reason why the complainant has filed a claim against it, rather than the adviser.

b) The complainant had not brought any evidence to substantiate her generic allegation that she was a low-to-medium risk retail investor whose funds were invested in high-risk professional investor only structured notes. As to the claim that she had been placed in an expensive bond that had a lock-in period with high exit penalties for early withdrawal, it submitted that the complainant was informed of all associated fees and charges at inception stage and had never complained.

c) The complainant must show that it was the service provider's actions or omissions which caused the loss being alleged, failing which it could not be found responsible for the complainant's claims.

In his decision, the Arbiter made the following observations:

1) The complainant's occupation was indicated as a house worker and certainly not a professional investor. She had no prior experience and knowledge of investments in structured notes.

2) The case in question involves a member-directed personal retirement scheme where the member was allowed to appoint an investment adviser to advise her on the choice of investments. The assets held in the complainant's account with the retirement scheme were used to acquire a whole of life insurance policy for the complainant.

3) The amount originally invested was £74,926. Under the direction of the investment advisor and as accepted by the service provider, the funds were used to acquire a portfolio of investment instruments which comprised substantial holdings in structured notes.

4) Despite that the retirement scheme administrator was not the entity which provided the advice to invest in the contested financial instruments, the service provider had nevertheless certain obligations to undertake in its role of trustee and scheme administrator. The obligations of the trustee and retirement scheme administrator in relation to a retirement plan are important ones and could have a substantial bearing on the operations and activities of the scheme and affect directly, or indirectly, its performance.

5) No evidence was submitted by the service provider of the regulatory status of the investment adviser.

6) The appointment of an entity such as the investment advisor meant, in practice, that there was an inferior protection for the complainant, as compared to a structure where an adequately regulated advisor is appointed. The service provider, being a regulated entity itself, should have been duly and fully cognisant of this. It was in the best interests of the complainant for the service provider to ensure that the former had correct and adequate key information about the investment advisor.

7) Caution was reasonably expected to be exercised with respect to which investments were comprised in the portfolio, more so when taking into consideration the nature of the retirement scheme and its specific objective. The exposure to structured notes in the

complainant's portfolio was extensive, with the insurance policy underlying the scheme being, at times, solely or predominantly invested into such instruments. Such excessive exposure to structured products occurred over a long period of time.

8) Although no fact sheets in respect of the complainant's underlying investments were produced, as part of the investigatory powers granted under the Act, the Arbiter managed to source, from a general search over the internet, fact sheets in respect of various structured note investments that featured in the complainant's portfolio. Apart from the credit risk of the issuer and the liquidity risk, the fact sheets clearly showed that the investor could possibly receive less than the original amount invested, or potentially even losing all of the investment.

9) Not only were various investments not reflective of the service provider's own investment guidelines but, on multiple occasions, there were material departures from such guidelines where the maximum limits were materially exceeded.

10) The service provider's role as administrator and trustee, in ensuring that the scheme's investments were managed in accordance with relevant legislation and regulatory requirements and in accordance with its own documentation, had not been truly achieved in respect of the complainant's investment portfolio.

11) The extent of losses experienced on the capital of the complainant's portfolio was in itself indicative of the failure in adherence to the applicable conditions on diversification and avoidance of excessive exposures. Otherwise, material losses, which were reasonably not expected to occur in a pension product whose scope was to provide for retirement benefits, would not have occurred.

12) Although the retirement scheme administrator was not responsible to provide investment advice to the complainant, it had clear duties to check and ensure that the portfolio composition recommended by the investment advisor provided a suitable level of diversification and was *inter alia* in line with the applicable parameters, and this so that the aim of the retirement scheme would be achieved with the necessary prudence required in respect of a pension scheme.

In conclusion, there was evidently a clear lack of diligence by the service provider in the general administration of the complainant's scheme and in carrying out its duties as trustee, particularly, when it came to the scheme's oversight functions, portfolio structure and the acceptance of the advisor. There were also various instances which indicated non-compliance by the service provider with applicable requirements and obligations. The service provider did not meet the reasonable and legitimate expectations of the complainant who had placed her trust in the service provider and others, believing in their professionalism and their duty of care and diligence.

Being mindful of the key role of the service provider and in view of the deficiencies identified in the obligations emanating from such role, the Arbiter concluded that the complainant should be compensated by the service provider for part of the realised losses on her pension portfolio.

In the particular circumstances of this case, considering that the service provider had the last word on the investments and acted in its dual role of trustee and retirement scheme administrator, the Arbiter considered it fair, equitable and reasonable for the service provider to be held responsible for 70% of the net realised losses sustained by the complainant on her investment portfolio.

The service provider was required to provide a full and transparent breakdown of the compensation awarded to the complainant.

The decision was confirmed in full on appeal.

Provision of quarterly valuation statements (ASF 014/2019)

COMPLAINT PARTIALLY UPHELD

Provision of quarterly and annual valuation statements to members of a retirement scheme; acting in the best interest of members of the retirement scheme; regulated entity's requirement to promote transparency and trust.

The complaint relates to a retirement scheme established in the form of a trust and managed by the service provider as its trustee and retirement scheme administrator.

The complainant, who is a member of the scheme, claimed that the service provider had failed in its contractual obligations to provide him with quarterly statements.

In so doing, it denied him vital information which was required by the tax authorities in the country where he was residing. Such lack of reporting, the complainant claimed, made it impossible for him to monitor movements from/to his account and he was thus unable to monitor his investment. He further claimed that:

a) The control of his retirement scheme account was an important factor in his decision to invest with the service provider, which clearly knew about this requirement.

b) Although the service provider claimed that it only issued statements once yearly, not even such yearly statements were however received.

c) Fees were being deducted from his plan on a quarterly basis, a portion of which must relate to the provision of the regular statements which were missing in his case.

In view of the missing statements, the complainant requested a refund of fees incurred between March 2016 (when his scheme was set up) to 14 January 2019. This amounted to £825.

In its reply, the provider submitted that:

a) As trustee and administrator of the retirement scheme, it essentially was the policyholder of such scheme. In order to carry out this function, it receives statements from all investment product providers, including a life insurance company, on a quarterly basis in order to calculate the pension assets under its administration. The provider claimed that the complainant must have been referring to product documentation issued by the life insurance company that makes reference to the provision of quarterly valuation statements based on the latest price information available. However, the issue of such periodic statements was meant to be provided solely to the policyholder, that is, the service provider and not to the member of the policy (the complainant), who in any case receives annual valuation statements at no charge.

b) It was also noted that any *ad hoc* valuations which members might request from time to time were also provided free of charge.

c) The service provider offered the complainant €250 as an ex-gratia payment, without admission of liability on its part and in full and final settlement of the complaint. This would be payable to the complainant when he either withdraws all of his pension via flexible access or transfers his scheme to another provider.

In his deliberations, the Arbiter observed the following:

1) The service provider was indeed the policyholder in its capacity as trustee of the scheme. It was thus clear that the service provider was the recipient of the quarterly statements from the life insurance company in respect of the underlying investment policy of the retirement scheme.

2) The complainant had been requesting the receipt of quarterly statements since 2017.

3) The service provider did not explain whether it had any difficulties in providing the complainant the quarterly statements, which it should itself have been receiving on such a regular basis from the life insurance company.

4) Neither did the service provider explain or provide reasons why it did not issue the requested quarterly statements to the complainant, other than just mentioning its usual practice of sending statements on an annual basis.

5) It is therefore unclear why the service provider had refrained from providing the complainant with the requested quarterly statements.

6) The need for full transparency regarding fees and transactions undertaken within a retirement scheme, and the provision in this regard of timely, complete and clear information concerning the performance, transactions and charges effected within the retirement scheme and its underlying material investment, is ultimately a key basic function expected and required to be upheld at all times in the management of a retirement scheme by the trustee and scheme administrator.

7) Such actions would indeed be reflective of the duty and responsibility of the trustee and retirement scheme administrator to act in the best interests of the member of the retirement scheme and the prudence, diligence, and attention of a bonus paterfamilias.

8) Proper communication with clients and tangible efforts to promote transparency and the creation of trust are indeed basic functions reasonably expected from any professional regulated entity.

9) There was no reason for the scheme administrator not to uphold the complainant's request for the quarterly statements, nor to withhold or delay the provision of the requested additional statements.

Concerning the complainant's request for compensation, the Arbiter considered that there was no sufficient evidence that the complainant was being directly, or indirectly, charged the claimed amount of £75 in respect of the quarterly statements issued by the provider of the policy underlying the retirement scheme.

Nonetheless he directed the service provider to:

i. Ensure that the complainant receives the quarterly reports so requested by him in a timely manner.

ii. In addition, provide the annual statements that it was obliged to provide at no charge.

iii. Inform and assist the member in the event that online access to real time information was available in respect of the member's investments and transactions undertaken within the scheme and underlying policy.

iv. Assist in a timely and comprehensive manner the complainant in his requests for clarifications regarding entries featured in the said statements.

The decision was not appealed.

Collective case relating to a private retirement scheme

LIMITS OF THE ARBITER'S POWERS AND DUE DILIGENCE OBLIGATIONS PRIOR TO TRANSFER OUT OF A PRIVATE RETIREMENT SCHEME (ASF 107/2019)

Collective case involving 60 individually-filed complaints on similar merits, all against the same financial services provider. The complaint was rejected.

The complaint was made against a financial services provider, which was later substituted by another financial services provider, related to a private retirement scheme. The scheme was established in the form of a trust and administered by the service provider as its trustee and retirement scheme administrator.

The Arbiter deemed that 60 individually-filed complaints against the same financial services provider were intrinsically similar in nature and accordingly could be treated as a collective case in accordance with article 30 of the Act. This was also consonant with article 19(3)(d) of the Act that obliges the Arbiter to deal with complaints in an economical and expeditious manner.

The complainants were represented by an official of a claims management company incorporated in the UK, who subsequently became an official of another UK-incorporated community interest company.

Summary of the complaint

The complainants claimed that the service provider had:

a) Allowed, and failed to disclose, conflicts of interests involving the investments into a particular business set up.

b) Never discussed the investment strategy with the complainants and they had serious concerns that the investments in the business set up (consisting of a bond and property holding investments) would never mature or be realised.

c) With such business set up, the provider had a conflict of interest throughout the investment process.

d) Failed to ensure consideration of the complainants' circumstances, aims and investment objectives/strategy; and

e) Failed to ensure the appointment of an adequately qualified financial advisor in relation to the transfer of their UK pension and the investments into the business group.

Various complainants highlighted an additional aspect in their complaint, namely that the service provider was refusing to transfer their pension back to a UK company of their choice, despite their repeated requests to the trustee to undertake such transfer.

As a remedy, the complainants requested the trustee of the scheme to purchase any illiquid assets from their scheme and place the money into their pension fund. Some of the complainants also requested the entire sum of money received from the service provider, together with interest, to be placed into a UK pension provider of their choice.

In its reply, the service provider refuted all the claims made against it as being unfounded in fact and at law, claiming among other aspects that:

a) It did not have any conflict of interest and it acted in line with the regulatory requirements.

b) It was not satisfied with the outcome of its due diligence exercise carried out in relation to a UK Scheme into which the transfer was being requested.

c) It considered the representative of the complainants to have a conflict as he had common links and significant control on the claims management company, the transfer out Scheme and its trustee; and

d) The remedy requested for the trustee to purchase any illiquid assets and place the proceeds into the scheme went contrary to the Malta Pension Rules.

Delay by the service provider in replying to the complainants' formal complaint

The Arbiter deemed it highly inappropriate for the service provider to take six months to send its reply to the formal complaint raised by the complainants through their representative. There was no reasonable excuse to justify such excessive and unnecessarily lengthy delay and procrastination for the provider to reply to the complainants' concerns.

Preliminary Plea - Request made by the complainants for the trustee to purchase illiquid assets

The Arbiter first dealt with the preliminary plea relating to the remedy that the complainants requested, that is, for the trustee to purchase any illiquid assets held within their retirement scheme. The service provider claimed that this remedy went contrary to the pensions rules applicable in Malta.

In granting a remedy, the Arbiter could not go beyond the powers given to him by the Act and namely beyond the provisions of article 26(3) of the Act.

The Arbiter observed that an official from the Malta Financial Services Authority (MFSA), who was called as witness to the case, had referred to a condition in the rules for personal retirement schemes that prevented a retirement scheme from engaging directly or indirectly in transactions with any of its members. The purchase of any illiquid assets would be tantamount to a transaction and would thus run counter to the rules.

Considering the facts and particular circumstances of this case, and in the light of existing pension rules, the Arbiter determined that he did not have the powers to order the trustee to purchase any illiquid assets from the members, The remedy being requested did not fall within his powers.

In that regard, the Arbiter was unable to consider further those complainants whose request for remedy in their complaint was limited only to a request for the trustee to acquire any illiquid assets from them and transfer such proceeds to their respective pension fund.

The Arbiter also observed that even if the complainants' request involved a demand for the payment of 'an amount of compensation for any loss of capital or income or damages suffered by the complainant as a result of the conduct complained of ...', as permitted in terms of Article 26(3)(c)(iv) of the Act, he would still have been unable to uphold the request as no loss of capital or income, or claim for damages, had been clearly, adequately and sufficiently substantiated by the complainants.

Request by certain complainants to the transfer out of their retirement scheme

The Arbiter then considered the other specific request made by those complainants who requested a transfer out of the retirement scheme to their identified UK scheme, a community interest company.

The Arbiter noted that, in terms of pension rules in Malta, the trustee of the scheme was required "… to take all reasonable and practical measures to preserve and safeguard the interests of the Scheme and its Members and Beneficiaries and/or the Retirement Fund and its unitholders/ Investors as applicable."

The Arbiter observed that the service provider had certain concerns in relation to such UK scheme and this following a due diligence exercise it had carried out.

He observed that recent publicly available information with respect to the financial standing, common links, regulatory status and track record of parties related to such UK company and who were mentioned in this case had led to such due diligence process to fail from reaching a satisfactory conclusion.

For instance, it was established from information sourced publicly on the website of the UK Companies' House as to the financial status and common links of the claims management company, the pension scheme into which the transfer was being requested and the trustee of such scheme, all of which were linked to the complainant's representative, had a net deficit position according to the indicated statements.

This confirmed the common links highlighted by the service provider and the potential conflict of interest arising from having a common party involved.

The Arbiter also established that none of the companies featuring in the claims/transfer appeared to be regulated. Despite extensive documentation provided by the representative, no supporting evidence was provided of the said companies' regulatory status.

The Arbiter accepted the arguments made by the service provider that it had to be adequately satisfied with the outcome of its due diligence exercise prior to proceeding with the transfer. The Arbiter also noted that the service provider had offered complainants to transfer out to an alternative pension provider if they still wished to do so. Although none of the complainants provided the service provider with an alternative, the option to transfer out was still available as long as a due diligence outcome would have provided reasonable satisfaction to preserve and safeguard the interests of the scheme and, thus, of the individual members' best interests.

Thus, the position taken by the service provider was considered by the Arbiter to be reasonable and justified, and he rejected the complaint.

The decision was confirmed in full on appeal.

Annex 1: A schematic description of informal and formal complaint-handling processes at the OAFS

	INFORMAL PROCESS	FORMAL PROCESS		
Nature/type	Minor cases, enquiries, fact finding, valve-release / dissatisfaction	Complaints relating to the conduct of a financial services provider		
Medium	By mail / Phone /E-mail / online / verbal	Online / By Mail / Meetings / Hearings		
Technique	**Negotiation / Conciliatory**	**Mediation / Investigation and Decision**	MEDIATION	INVESTIGATION AND DECISION
Process	Fact seeking / Information provision / conciliation	Mediation, Arbitral process	Voluntary and consensual. Mediator convenes mediation session. If rejected or unsuccessful, process moves to INVESTIGATION AND DECISION	Obligatory and adjudicative. Hearings convened by Arbiter. Evidence by parties; final submission; Decision by Arbiter
Norm applied: substance	Law/ industry practice / previous cases / jurisprudence / regulatory / reasonable expectations	• Laws, rules, regulations, industry practice • Fair, equitable and reasonable in the particular circumstances and substantive merits of the case		

Norm: procedure	Flexible, some discretion depending on the type and complexity of the issue, containment of consumer dissatisfaction, pacification	• Eligible customer v financial services provider authorised by MFSA
		  • *Specify the financial services provider*
		  • *Reason for the complaint*
		  • *Remedy*
		• Procedurally - fair, informal, economical and expeditious
		• Time-limited by statute		

Force	Provision of information, advisory (non-legal), non-binding, therapeutic	Binding	Binding if parties agree at mediation	Binding
Transparency of outcome	Private	Private / Public	Private. What happens at mediation stays at mediation.	Public. Decision is made public (pseudonymised for complainant).
Application	Individual	Individual / Collective	Individual	Individual / Collective
Cost	None	€25 (refundable) complaint fee payable by eligible consumer; nil cost for the provider	If mediation is successful, complaint fee is refunded	Arbiter decides who is to bear costs of proceedings
Force of outcome	Non-binding	Binding, subject to appeal	Binding, if mediation is successful	Binding, May be appealed (Appeal Court, Inferior)
Representation	Not required	Not required	Not required	Not required

Adapted from: Hodges C, 'A Model for Dispute Resolution in Europe' [2011] Foundation for Law, Justice and Society Policy Briefs.

Annex 2: Enquiries and minor cases' statistics for 2021

Figure 1 - Total enquiries and minor cases (2016-2021)

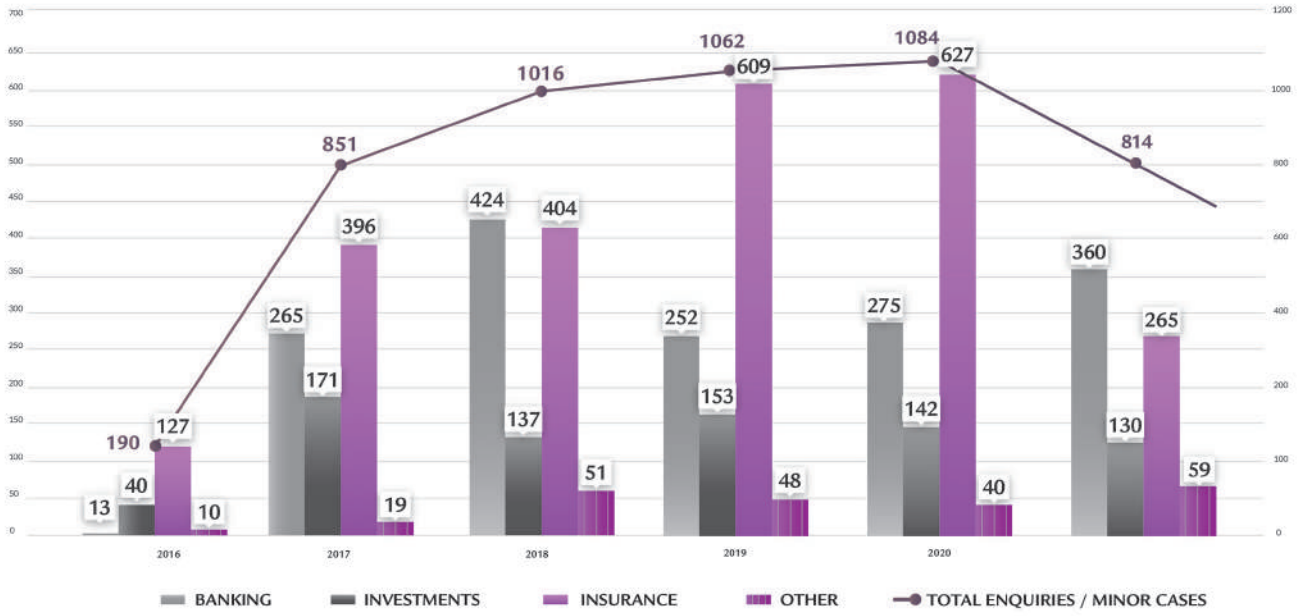


Figure 2 - Enquiries and minor cases (by origination)

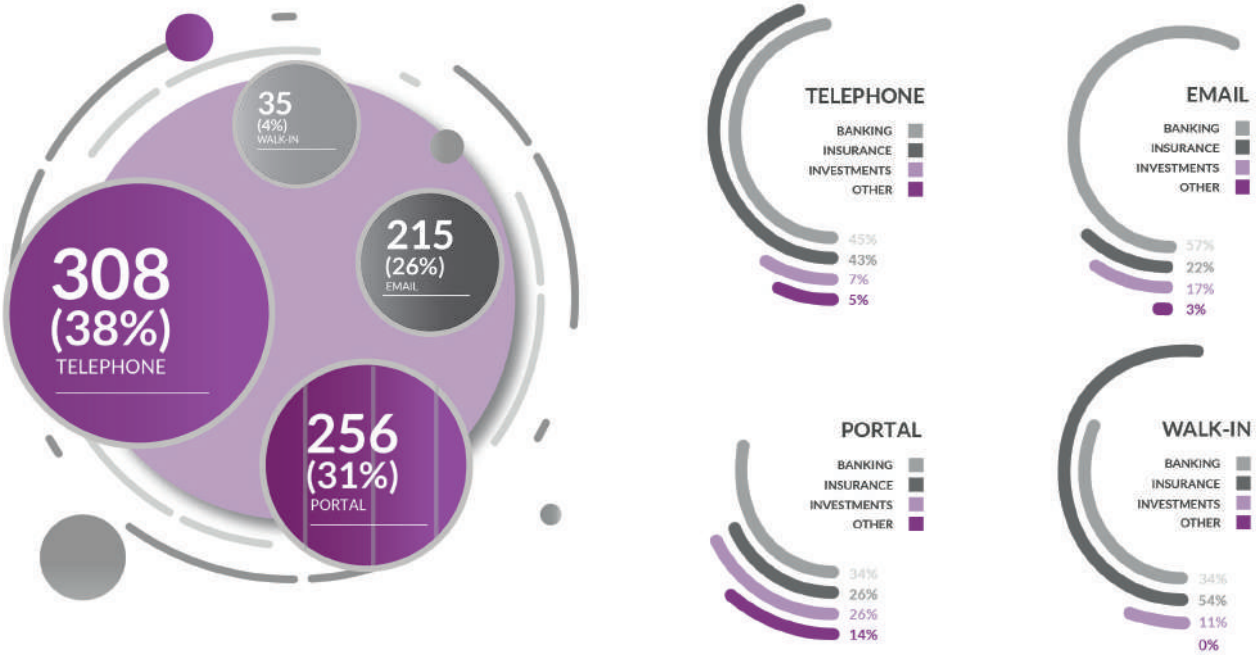


Figure 3 - Enquiries and minor cases (by outcome)

Figure 4 - Enquiries and minor cases (by sector and outcome)

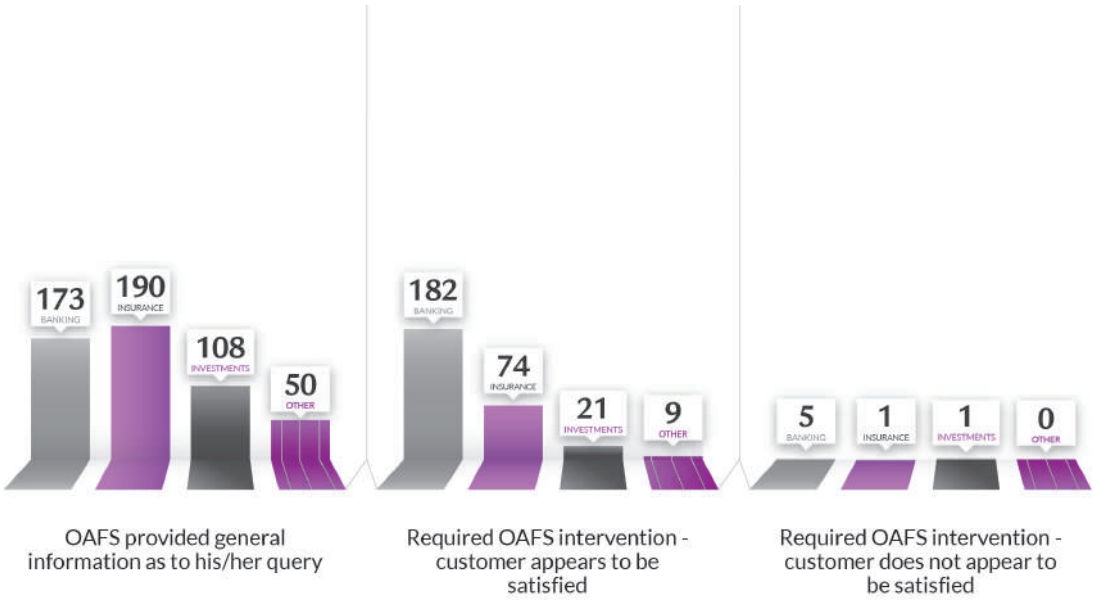
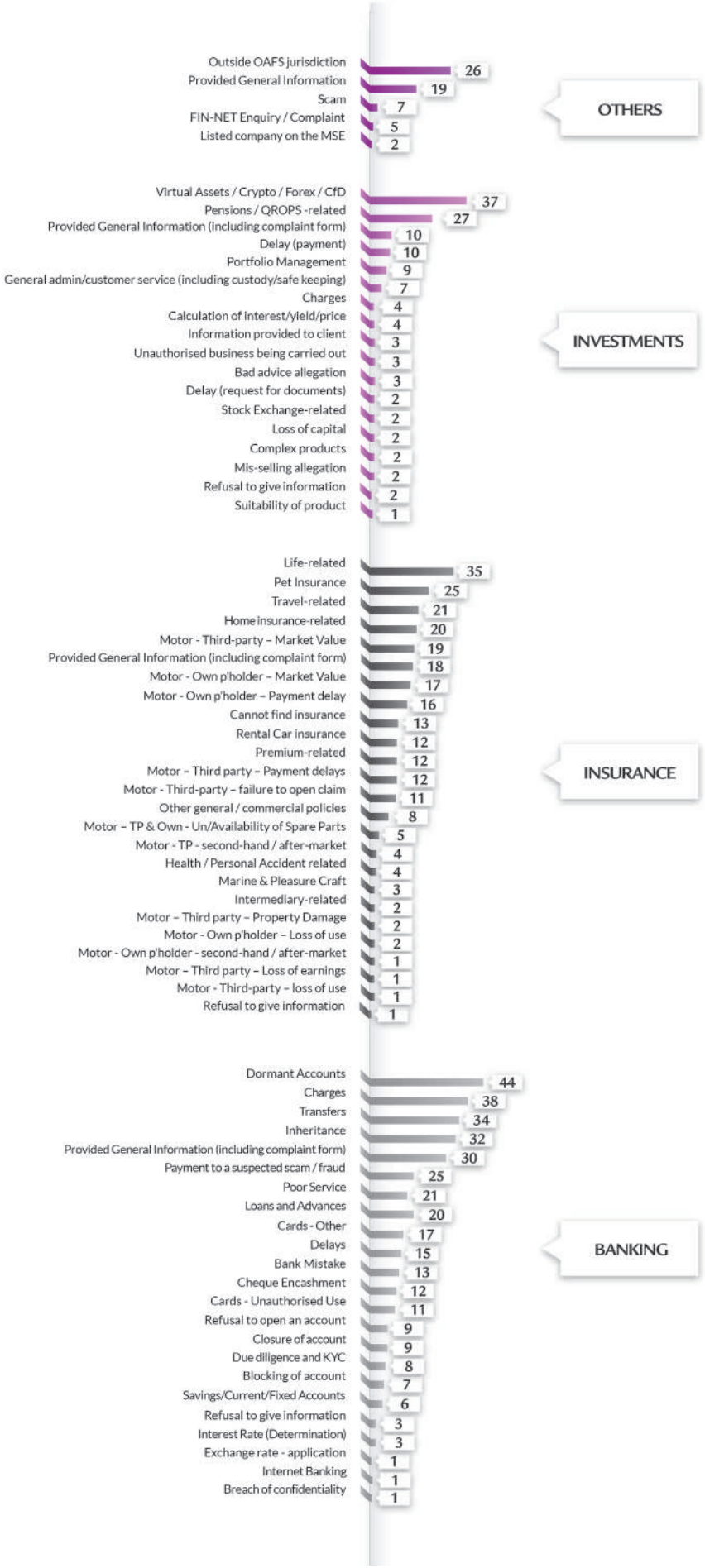


Figure 5 - Enquiries and minor cases (by type)



Annex 3 - Formal complaints' statistics for 2021

Table 1 - Total number of formal complaints (2016-2021)

	2021	2020	2019	2018	2017	2016[1]
Banking and payment services	38	22	32	39	40	13
Investments	48	34	30[3]	134	112	138[2]
Insurance	81	89	48	19	23	21
Others	/	/	/	/	/	1
Total	**167**	**145**	**110**	**192**	**175**	**173**

[1] The number of complaints for 2016 (June to December) has been adjusted to reflect the actual number of cases received, rather than the number of complainants collectively making up such cases.

[2] This includes nine cases (comprising 400 complainants) which were treated as one collective complaint (Case reference 28/2016) given that their merits are intrinsically similar in nature, and a further 38 complaints filed separately by different complainants. In the latter cases, each case was treated on its merits. All these cases concern a collective investment scheme.

[3] One complaint is made up of 56 individual complainants as their merits are intrinsically similar in nature.

Table 2 - Complaints registered (by product and issue)

BY PRODUCT	BANKING AND PAYMENT SERVICES	INVESTMENTS	INSURANCE	TOTAL
Life-related			47	47
Pensions-related		26		26
Cards	14			14
Crypto / Virtual Financial Assets		12		12
Pet-related			11	11
Transfers	11			11
Savings/Current/Term Account	7			7
Rental Car-related			5	5
Miscellaneous (securities and funds)		5		5
Home (Building & Contents)-related			4	4
Forex dealing / CfD / Binary Options		4		4
Travel-related			4	4
Other personal lines			3	3
Home Loans	3			3
Motor – Own p'holder			3	3
Other business lines			2	2
Othe loans and advances	1			1
Portfolio Management		1		1
Commercial policies			1	1
Health-related			1	1
Basic payment account	1			1
Safe Custody	1			1
Total	**38**	**48**	**81**	**167**

BY ISSUE	BANKING AND PAYMENT SERVICES	INVESTMENTS	INSURANCE	TOTAL
Value at maturity			46	46
Administration/Management/Custody		32		32
Rejection of claim			28	28
Suspected irregular activity	17			17
General admin/customer service		5	2	7
General admin/customer service	5	1		6
Unauthorised use	4	1		5
Opening/Closure	5			5
Mistake / Incorrect application	2	2	1	5
Charges	3	1		4
Misselling / Suitability		4		4
Delays	2		1	3
Calculation of price/interest		2		2
Market value			2	2
Premium-related			1	1
Total	**38**	**48**	**81**	**167**

Table 3 - Complaints registered (by sector and provider)

	BANKING AND PAYMENT SERVICES	INSURANCE	INVESTMENTS	TOTAL
AKFX Financial Service Limited			2	2
APS Bank plc	2			2
ArgoGlobal SE		4		4
Axeria Insurance Limited		1		1
Bank of Valletta plc	8	1		9
BNF Bank plc	3			3
Building Block Insurance PCC Limited		15		15
Calamatta Cuschieri Investments Services Limited			2	2
Crystal Finance Investments Limited			2	2
Deriv Investments (Europe) Limited			1	1
Dominion Fiduciary Services (Malta) Limited			3	3
Finductive Ltd	1			1
Foris Dax MT Limited	2		12	14
Fortegra EuropeInsurance Company Ltd		1		1
GasanMamo Insurance Limited		2		2
GlobalCapital Financial Management Limited			1	1
HSBC Bank Malta plc	3			3
HSBC Life Assurance (Malta) Limited		1		1
IDA Insurance Limited		1		1
Integrated-Capabilities (Malta) Limited			1	1
Island Insurance Brokers Limited		1		1
ITC International Pensions Limited			1	1
LifeStar Insurance Ltd		2		2
Mapfre Middlesea plc		4		4
Mapfre MSV Life plc		42		42
MIB Insurance Agency Limited		1		1
Momentum Pensions Malta Limited			3	3
MoneyMatrix Limited	1			1
Optimus Fiduciaries (Malta) Ltd.			1	1
Papaya Ltd	1			1
Phoenix Payments Limited	7			7
Satabank p.l.c.	2			2
Sovereign Pension Services Limited			3	3
STM Malta Pension Services Limited			15	15
TravelJigsaw Insurance Limited		5		5
Truevo Payments Limited	5		1	6
Trust Payments (Malta) Limited	3			3
Total	**38**	**81**	**48**	**167**

Table 4 - Complaint outcomes

Agreement was reached at mediation	22
Withdrawn prior to mediation	13
Withdrawn following mediation	6
Parties agreed to settle prior to commencement of mediation	10
Withdrawn and/or agreement reached prior to case hearing	1
Withdrawn following case hearing	1
Agreement reached during hearing before Arbiter	1
Cases in respect of which a decision has been issued by the Arbiter for Financial Services (includes one decision incorporating 60 complainants)	87

Table 5 - Decisions of the Arbiter (by sector)

		Banking and payment services	Investments	Insurance
Preliminary and Clarifications	5	1	1	3
Upheld in full	16	3	2	11
Partially upheld	36	1	13	22
Rejected	30	8	11	11
Res judicata	63	11	10	42
Appealed	19	1	16	2

Table 6 - Decisions delivered by the Arbiter in 2021 (breakdown by financial services provider)

The table below provides a breakdown of the type and nature of decisions by financial services provider during 2021, and whether the final decision has been appealed.

Financial Services provider	Sector	Final Decisions	Preliminary & Clarifications		Upheld	Partially Upheld	Rejected		Appealed	Not Appealed	
AKFX Financial Services Ltd.	Investments	1		1			1	1	1		1
APS Bank plc	Banking	2		2		1	1	1		2	2
ArgoGlobal SE	Insurance	1		1	1			1		1	1
Atlas Insurance PCC Limited	Insurance	2		2	2			2		2	2
Axeria Insurance Limited	Insurance	1		1		1		1		1	1
Bank of Valletta plc	Banking	3	1	4	3			3		3	3
Building Block Insurance PCC Limited	Insurance	11		11	6	1	4	11		11	11
Calamatta Cuschieri Investment Services Limited	Investments	1		1		1		1	1		1
Citadel Insurance plc	Insurance	1		1	1			1		1	1
Crystal Finance Investments Limited	Investments	1		1	1			1		1	1
Eagle Star (Malta) Limited	Insurance	1		1		1		1		1	1
Elmo Insurance Limited	Insurance	1		1		1		1		1	1
Fortegra Europe Insurance Company Ltd	Insurance	1		1			1	1		1	1
HSBC Bank Malta plc	Banking	4		4			4	4	1	3	4
HSBC Bank Malta plc	Investments	2		2			2	2	1	1	2
Integrated-Capabilities (Malta) Limited	Investments	2		2			2	2	2		2
Island Insurance Brokers Limited, Mapfre Middlesea plc	Insurance	1	1	2			1	1		1	1
Laferla Insurance Agency Limited	Insurance	1		1			1	1		1	1
LifeStar Insurance Ltd	Insurance	1		1			1	1		1	1
Mapfre Middlesea plc	Insurance	2		2	1		1	2	1	1	2
Mapfre MSV Life plc	Insurance	19	1	20		18	1	19	1	18	19
Momentum Pensions Malta Limited	Investments	9		9		7	2	9	7	2	9
Propgen Limited	Insurance	1		1			1	1		1	1
QIC Europe Limited	Insurance		1	1							
Sovereign Pension Services Limited	Investments	1		1		1		1	1		1
STM Malta Pension Services Limited	Investments	5	1	6		4	1	5	3	2	5
TMF INTERNATIONAL PENSIONS LIMITED	Investments	1		1			1	1		1	1
Triton Capital Markets Limited	Investments	2		2	1		1	2		2	2
Truevo Payments Ltd	Banking	3		3			3	3		3	3
Truevo Payments Ltd	Investments	1		1			1	1		1	1
		82	5	87	16	36	30	82	19	63	82

Data featured under "Preliminary & Follow-up" includes decisions on initial legal pleas (such as if the service provider is contumacious), any clarification requests that the parties to a complaint might have requested the Arbiter to issue following delivery of a decision, as well as decisions referred back by the Court of Appeal (Inferior Jurisdiction) following delivery of an appeal judgement. When this happens, the Court of Appeal would request the Arbiter to revalue the compensation award to the complainant regarding a financial instrument or instruments that would be subject to the dispute.

Data featured under the "Appealed" column has been obtained from the eCourts website and is subject to change as cases might have been decided or ceded following publication of this report.

Office of the Arbiter for Financial Services

Audited Financial Statements as at 31 December 2021

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Report of the Auditor General

To the Office of the Arbiter for Financial Services

Report on the financial statements

We have audited the accompanying financial statements of the Office of the Arbiter for Financial Services set out on pages 1 to 9, which comprise the statement of financial position as at 31 December 2021, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

The Office of the Arbiter for Financial Services' responsibility for the financial statements

The Office of the Arbiter for Financial Services is responsible for the preparation of financial statements that give a true and fair view in accordance with International Financial Reporting Standards as adopted by the European Union, and for such internal control deemed necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal controls relevant to the preparation of financial statements of the Office, in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Office of the Arbiter for Financial Services, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements give a true and fair view of the financial position of the Office of the Arbiter for Financial Services as at 31 December 2021, of its financial performance, changes in equity and cash flows for the year then ended in accordance with International Financial Reporting Standards as adopted by the European Union, and comply with Act XVI of 2016 and 2017 of the Laws of Malta.

Auditor General
23 August 2022

BOARD OF MANAGEMENT AND ADMINISTRATION REPORT

Board of Management and Administration submit their annual report and the financial statements for the period ended 31st December 2021.

Objects

The Office of the Arbiter for Financial Services is an autonomous and independent body setup in terms of Act XVI of 2016 of the Laws of Malta. It has the power to mediate, investigate and adjudicate complaints filed by customers against financial services providers.

Results

The statement of comprehensive income is set out on page 3.

Review of the period

The Board reports a surplus of €69,485 during the period under review.

Post Statement of Financial Position Events

There were no particular important events affecting the entity which occurred since the end of the accounting year.

Statement of the Board of Management and Administration responsibilities

In terms of the licensing regulations applicable to Goverment entities, the entity is to prepare financial statements for each financial period which give a true and fair view of the financial position of the Entity as at the end of the financial period and of the surplus or deficit for that period.

In preparing the financial statements, the entity is required to: -

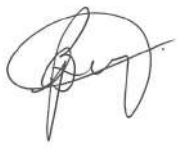
- adopt the going concern basis unless it is inappropriate to presume that the Entity will continue to function;
- select suitable accounting policies and apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- account for income and charges relating to the accounting period on the accrual basis; and
- prepare the financial statements in accordance with International Financial Reporting Standards as adopted by the European Union.

Statement of financial position

	Notes	2021	2020
		€	€
ASSETS			
Property, Plant and Equipment	6	**17,150**	**22,083**
Intangible Asset	7	**26,550**	**39,825**
		43,700	**61,908**
Current assets			
Trade and other receivables	8	**3,158**	**2,706**
Cash and cash equivalents	9	**196,645**	**106,113**
		199,803	**108,819**
Total assets		**243,503**	**170,727**
EQUITY AND LIABILITIES			
Equity			
Accumulated Funds		**230,736**	**161,251**
		230,736	**161,251**
Current liabilities			
Trade and other payables	10	**12,767**	**9,476**
		12,767	**9,476**
Total liabilities		**12,767**	**9,476**
TOTAL EQUITY AND LIABILITIES		**243,503**	**170,727**

The accounting policies and explanatory notes on pages 6 to 9 are an integral part of these financial statements.

The financial statements have been authorised for issue by the Board of Management and Administration and signed on its behalf by:



Date: 18th August 2022

Mr Geoffrey Bezzina
Chairperson

Statement of comprehensive income

	Notes	2021	2020
		€	€
Income	3	**678,187**	**642,312**
Administrative expenses	4	**(608,288)**	**(571,592)**
Financial costs	5	**(414)**	**(346)**
Surplus for the year		**69,485**	**70,374**

The accounting policies and explanatory notes on pages 6 to 9 are an integral part of these financial statements.

Statement of changes in equity

	Accumulated fund	Total
	€	€
Balance at 1 Jan 2019	**63,476**	**63,476**
Surplus for the year	27,401	27,401
Balance at 31 December 2019	**90,877**	**90,877**
Surplus for the year	70,374	70,374
Balance at 31 December 2020	161,251	161,251
Surplus for the year	69,485	69,485
Balance at 31 December 2021	230,736	230,736

The accounting policies and explanatory notes on pages 6 to 9 are an integral part of these financial statements.

Statement of cash flows

	Note	2021	2020
		€	€
Operating activities			
Surplus for the year		**69,485**	**70,374**
Adjustments to reconcile profit before tax to net cash flows:			
Non-cash movements			
Depreciation of fixed assets		**18,208**	**20,142**
Working capital adjustments			
Increase in trade and other receivables		**(452)**	**(124)**
Increase in trade and other payables		**3,291**	**(882)**
Net cash generated from operating activities		**90,532**	**89,510**
Investing activities			
Purchase of property, plant and equipment		**-**	**(3,848)**
Purchase of Intangible Asset		**-**	**(53,100)**
Net cash used in investing activities		**-**	**(56,948)**
Cash and cash equivalents at 1 January		**106,113**	**73,551**
Net increase in cash and cash equivalents		**90,532**	**32,562**
Cash and cash equivalents at 31 December	9	**196,645**	**106,113**

The accounting policies and explanatory notes on pages 6 to 9 are an integral part of these financial statements.

Notes to the financial statements

1. Corporate information

The financial statements of the Office for the Arbiter for Financial Services for the year ended 31 December 2021 were authorised for issue in accordance with a resolution of the members. Office of the Arbiter for Financial Services is a Goverment entity.

2.1 Basis of preparation

The financial statements have been prepared on a historical cost basis. The financial statements are presented in euro (€).

Statement of compliance

The financial statements of Office for the Arbiter for Financial Services have been prepared in accordance with International Financial Reporting Standards as adopted by the European Union.

2.2 Summary of significant accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these financial statements.

Intangible assets

An acquired intangible asset is recognised only if it is probable that the expected future economic benefits that are attributable to the asset will flow to the entity and the cost of the asset can be measured reliably. An intangible asset is initially measured at cost, comprising its purchase price and any directly attributable cost of preparing the asset for its intended use.

Intangible assets are subsequently carried at cost less any accumulated amortisation and any accumulated impairment losses. Amortisation is calculated to write down the carrying amount of the intangible asset using the straight-line method over its expected useful life. Amortisation of an asset begins when it is available for use and ceases at the earlier of the date that the asset is classified as held for sale (or included in a disposal group that is classified as held for sale) or the date that the asset is derecognised.

The amortisation of the intangible asset is based on a useful life of 4 years and is charged to profit or loss.

Amortisation method, useful life and residual value

The amortisation method applied, the residual value and the useful life are reviewed on a regular basis and when necessary, revised with the effect of any changes in estimate being accounted for prospectively.

Property, plant and equipment

Property, plant and equipment is stated at cost less accumulated depreciation and accumulated impairment losses. Such cost includes the cost of replacing part of the plant and equipment when that cost is incurred if the recognition criteria are met. Likewise, when a major inspection is performed, its cost is recognised in the carrying amount of the plant and equipment as a replacement if the recognition criteria are satisfied. All other repair and maintenance costs are recognised in profit or loss as incurred.

Depreciation is calculated on a straight line basis over the useful life of the asset as follows:

Fixtures, furniture & fittings	10 years
Computer equipment	4 years
Office equipment	4 years

Depreciation is to be taken in the year of purchase whereas no depreciation will be charged in the year of disposal of the asset.

Notes to the financial statements (continued)

Summary of significant accounting policies (continued)

An item of property, plant and equipment is derecognised upon disposal or when no future economic benefits are expected from its use or disposal. Any gain or loss arising on derecognition of the asset (calculated as the difference between the net disposal proceeds and the carrying amount of the asset) is included in profit or loss in the year the asset is derecognised. The asset's residual values, useful lives and methods of depreciation are reviewed and adjusted if appropriate at each financial year end.

Cash and cash equivalents

Cash and cash equivalents in the balance sheet comprise cash at bank and in hand and short term deposits with an original maturity of three months or less. For the purposes of the cash flow statements, cash and cash equivalents consist of cash and cash equivalents as defined, net of outstanding bank overdrafts.

Trade and other payables

Trade and other payables are shown in these financial statements at cost less any impairment values. Amounts payable in excess of twelve months are disclosed as non current liabilities.

3. Income

Income represents Goverment funding, complaint fees and EU funding.

	2021	2020
	€	€
Government Funding	675,000	640,000
Complaint Fees	3,187	2,312
EU Funding	-	-
Total Income	**678,187**	**642,312**

4. Expenses by nature

	2021	2020
	€	€
Staff Salaries	492,839	479,284
Office maintenance & Cleaning	12,517	11,465
Car & Fuel Expenses	17,538	18,749
Advertising (Recruitment costs)	2,178	1,313
Telecommunications	7,057	5,666
Professional Fees	11,513	7,115
Depreciation charge for the year	18,208	20,142
Other expenses	46,438	27,858
Total administrative costs	**608,288**	**571,592**

Notes to the financial statements (continued)

4. Expenses by nature (continued)

Average number of persons employed by the office during the year:	2021	2020
Total average number of employees	**12**	**13**

5. Financial costs

	2021	2020
	€	€
Bank and similar charges	**414**	**346**

6. Property, plant and equipment

	Furniture, Fixtures & Fittings	Office Equipment	Computer Equipment	Total
	€	€	€	€
Net book amount at 1 January 2020	19,984	1,636	3,482	25,102
Additions	-	3,553	295	3,848
Depreciation charge for the period	(2,819)	(2,172)	(1,876)	(6,867)
Net book amount at 31 December 2020	**17,165**	**3,017**	**1,901**	**22,083**
Additions	-	-	-	-
Depreciation charge for the year	(2,819)	(1,094)	(1,020)	(4,933)
Net book amount at 31 December 2021	**14,346**	**1,923**	**881**	**17,150**
As at 31 December 2021				
Total cost	28,194	8,687	17,204	54,085
Accumulated depreciation	(13,848)	(6,764)	(16,323)	(36,935)
Net book amount at 31 December 2021	**14,346**	**1,923**	**881**	**17,150**

Notes to the financial statements (continued)

7. Intangible Asset

	Website and Case and File e-Solution	Total
	€	€
Net book amount at 1 January 2021	39,825	39,825
Additions		-
Depreciation charge for the period	(13,275)	(13,275)
Net book amount at 31 December 2021	**26,550**	**26,550**

8. Trade and other receivables

	2021	2020
	€	€
Prepayments	**3,158**	**2,706**
Other receivables		**-**
	3,158	**2,706**

9. Cash and cash equivalents

For the purpose of the cash flow statement, cash and cash equivalents comprise the following:

	2021	2020
	€	€
Cash at bank and in hand	**196,645**	**106,113**

10. Trade and other payables

	2021	2020
	€	€
Other payables	**931**	**6,707**
Accruals	**11,836**	**2,769**
	12,767	**9,476**

Administrative expenses

	2021	2020
	€	€
Staff Salaries	**492,839**	**479,284**
Training	**1,114**	**300**
Office Consumables	**772**	**199**
Cleaning	**8,341**	**8,856**
Office Maintenance	**4,176**	**2,609**
Printing and Stationery	**4,118**	**2,889**
PC/Printer Consumables	**615**	**1,254**
Other Office Costs	**1,978**	**1,619**
Other Office Equipment	**-**	**518**
Telecommunications	**7,057**	**5,666**
Website Expenses	**18,532**	**1,226**
Postage, Delivery & Courier	**2,517**	**2,406**
Insurance - Health	**11,106**	**9,382**
Insurance - Travel	-	**51**
Insurance - Business	**257**	**1,690**
Memberships & Subscriptions	**1,220**	**1,691**
General Expenses	**75**	**289**
Vehicle, leasing and fuel expenses	**17,538**	**18,749**
Travelling Expenses	**-**	**285**
Advertising (Recruitment)	**2,178**	**1,313**
Legal Fees	**-**	**-**
Professional Fees	**11,513**	**7,115**
Payroll Fees	**-**	**308**
Accounting Fees	**4,134**	**3,751**
Depreciation Charge	**18,208**	**20,142**
	608,288	**571,592**

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