ARBITER FOR FINANCIAL SERVICES

ANNUAL REPORT 2020

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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

5 July 2021

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 2020.

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.

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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
MFSA	Malta Financial Services Authority
MiFID	Markets in Financial Instruments Directive
OAFS or the Office	Office of the Arbiter for Financial Services
PSD	Payment Services Directive
RSA	Retirement Scheme Administrator
QROPS	Qualifying Recognised Overseas Pension Scheme
TTA	Trusts and Trustees Act

Report of the Arbiter for Financial Services

Dr Reno Borg

When we started operating five years ago, we were confident that the creation of the Office of the Arbiter for Financial Services (OAFS) would make a difference in the resolution of disputes between consumers of financial services and service providers. As of the end of the reporting year, we have helped more than 5,000 customers and, by the end of this year, it is hoped that the Arbiter would have given more than 500 formal decisions.

The year 2020 presented us with challenges that no one was expecting. COVID-19 affected the whole world and we therefore had to adjust our operations to safeguard the health of our staff members and the public in general. Due to our mission of receiving complaints from all over the globe against financial services providers authorised in Malta, from our inception we had to adopt modern technology because it was never considered feasible to ask customers living in remote countries to come over to Malta for oral hearings. Our reliance on technology facilitated our work during the pandemic and we succeeded in continuing to offer our services without any interruption.

Although some customers and their professional advisers insisted on physical meetings at the beginning of the pandemic, our reliance on remote meetings for the safety of all proved to be the correct decision. Indeed, we extended virtual hearings even to persons residing in Malta, thus guaranteeing the uninterrupted flow of hearings and facilitating the life of both consumers and service providers. Professionals assisting customers also expressed satisfaction that cases moved on and the majority agreed that virtual meetings had saved them a lot of time in travelling and parking.

During 2020, our Customer Relations Officers dealt with over 1,000 minor cases and enquiries and managed to solve several cases at the initial stage, thus avoiding the parties the formal mediation and investigation/adjudication stages.

Although customers may not always have a justified complaint and may not always see the dispute resolved in their favour, we are satisfied that the professional service we provide convinces the stakeholders involved that we do not consider them as mere statistics. This has earned us respect and appreciation, irrespective of the outcome of the dispute.

Five years ago, in my first report, I tried to kindle the hope that over the years, the mediation culture would gain ground. I am pleased to note that during the year under review, 73 cases were referred to mediation, a considerable increase over the previous years. Mediation was successful in 16 cases and a further 13 cases were withdrawn following mediation.

These may seem small numbers, but they are a great improvement over previous years where the parties were not prepared to mediate because they expected that investigation and adjudication would secure their whole pound of flesh.

Mediation sessions during 2020 were similarly carried out remotely via web-conferencing software. This was the first time that mediation sessions were held in this manner as, usually, parties would meet physically at our centrally-located

offices. Alternative arrangements to conduct mediation via tele-conferencing are also in place in the (remote) possibility that the parties concerned would not have internet access.

Mediation is the cornerstone of any Alternative Dispute Resolution (ADR) procedure and we are intent to persevere in spreading the culture of mediation with the hope of securing even more success in this field. As more stakeholders realise the importance of mediation, our mission of concluding cases in a reasonable period of time would be better served.

The Arbiter delivered 125 decisions during the year under review, of which 122 were final while a further 3 were preliminary or follow-up decisions.

One decision comprised 39 individual cases that were lodged separately by complainants against the same financial services provider. Each of these cases was heard separately. Following a review of the respective complaint files, the Arbiter determined that these cases were to be treated collectively as their merits were intrinsically similar in nature. The Arbiter is empowered to connect cases by virtue of Article 30 of the Arbiter for Financial Services Act (the Act).

In the year under review, 60 of the 78 investment-related decisions concerned the administration/management of private retirement schemes. These latter complaints were particularly complex to assess due to the diverse content of each case, its particular merits and the voluminous information that was submitted at review stage.

In the deliberation of cases, it is not always easy to decide which way a decision should go and considerable thinking and research is necessary to reach a just decision. The losing party may not be happy with the outcome, but it is the Arbiter's duty to be impartial and decide cases on the basis of equity, fairness and reasonableness within the correct legal framework.

The Act introduced in 2016 proved to be a very efficient tool in deciding cases. Its pragmatic outlook and the powers given to the Arbiter were instrumental in facilitating the conclusion of formal cases. However, every piece of legislation is tested over time, and we never adopted the myopic view that our legislation is perfect and should be carved in stone. Over the last five years, the Act was amended several times to make its provisions more complete and certain.

At the beginning of 2021, we proposed two amendments. The first one related to the definition of a financial services provider whereby the Arbiter is now in a better position to determine whether the activities pursued by the provider (which are the subject of the complaint) are deemed to be of a financial services nature.

The second amendment further clarified the situation where a complainant had already filed a similar complaint before another ADR entity, particularly in foreign jurisdictions. The raison d'être behind the amendment was to avoid the possibility of conflicting decisions and the avoidance of double jeopardy to service providers.

These amendments were only possible with the full co-operation of the Minister for Finance and Employment who piloted the amendments in Parliament and

the constructive participation of Members of the House of Representatives of both sides of the political divide who discussed the amendments with an open mind and even improved our proposals.

We appreciate the suffering of people who might have lost all their life's savings, or those who were misled into believing that a particular investment would serve them well when they retire, only to find out that the promised land was just a distant mirage. We equally appreciate the situation of persons who are disappointed by a refusal of their claim through an unjust or pedantic interpretation of their insurance policy.

We also face situations where accountholders feel that their bankers had let them down after being loyal customers for a good number of years. It is of concern to meet situations where customers have their accounts closed without being given a valid reason. However, in this respect, certain customers fail to realise that the more stringent rules for combating money laundering (and the financing of terrorism) entail their cooperation in providing banks with more personal details and added information so that bankers could comply with the law.

In this regard, banks and regulatory bodies tasked with the supervision of the prevention of money laundering should engage in a practical and sincere dialogue that, while guaranteeing the prevention of money laundering, provides a solution to lessen unnecessary bureaucracy that may make the life of customers difficult and may also hinder investment in financial services thereby negatively affecting the economy. The sooner this is done, the better.

Moreover, bankers should also embark on an educational campaign to explain the new rules and why clients are expected to conform. The lack of proper communication between bankers and their clients gives rise to unnecessary disputes which can be avoided only through a simple and adequate line of communication.

The Arbiter also meets cases where information about a particular product or service is so scarce that customers feel that they have been cheated into buying a product or service which was unsuitable to their particular need. Selling techniques should respect consumer rights which are clearly defined in various laws and regulations covering the financial services sector and also in the Consumer Affairs Act.

On their part, complainants should avoid filing frivolous and vexatious complaints which cost the OAFS a lot of precious time.

The challenges we faced in 2020 were unique but with the cooperation of our staff and the Ministry of Finance and Employment, which unconditionally provided us with the necessary funds, we managed to continue in our mission of helping persons solve their problems in a fair and just way.

Finally, I would like to thank the Chairman and Members of the Board of Management and Administration for their full support and cooperation and the members of our staff for their continued dedication in providing a professional service with a smile.

Statement from the Chairman of the Board of Management and Administration

As in previous years, this annual publication, the fourth since the Office of the Arbiter for Financial Services has been set up in 2016, provides detailed information about the Office's operations and achievements in the year under review - 2020.

Even though the Arbiter's decisions are published online, and the new website of the Office has enhanced their accessibility as users can now narrow down decisions through a range of search criteria, the comprehensive choice of decisions that are summarised in this report portrays a successful consumer redress process that has grown and matured over a relatively short period of time. The publication of summaries in English, along with the publication of decisions online, enriches research in the field of financial services consumer protection in Malta and beyond.

The year under review has been extraordinary and will surely be remembered for the manner and the speed with which society had to adapt to 'new' ways of working, socialising and enjoying free time.

In our 2019 report, which was published in June 2020 when Malta was still in strict lockdown, the Arbiter provided a detailed overview of how the Office transitioned to teleworking. The safety and well-being of our staff and stakeholders remain our utmost priority; but we are also mindful of the high service standards that our stakeholders expect to receive, and which we have strived to reach since the setting up of this office in 2016.

We have done our utmost to minimise the inconvenience and to manage the expectations of our stakeholders. The relative ease with which stakeholders can reach out to us has been maintained, if not improved. We have tried to be as responsive as possible, maintaining a short lead time for responses to an ever-increasing number of enquiries and small cases. There will always be room for improvement, and we are committed to taking onboard criticism and feedback when our stakeholders' service-level expectations are not met.

The Office has now switched to hybrid working arrangements. While some staff are working from home only, others have been given the possibility to alternatively work from the office and/or from home, according to agreed planned schedules.

All mediation sessions and hearings have been and are being conducted and convened via a web-conferencing application. This method has allowed us to offer all services without any disruption.

Geoffrey Bezzina

Our investment in a new web-based case and file management system could not have arrived at a more opportune time. The system commissioned by the Office required careful and long periods of planning, involving long discussions with the developers who had to understand our varied processes, substantial testing and bug fixing and, naturally, extensive training for staff. As we explain in another section of this report, the system is fronted by a new website that makes it easy for users to access and submit enquiries/small cases and complaints online. In turn, this allows designated staff to monitor the progress of all enquiries and complaints, at their various stages. The system has proved its worth as during the first quarter of 2021, during which this report is being prepared, staff continued to process incoming enquiries and complaints without interruption for the entire period that they were required to exclusively work remotely.

Our case files are also scanned as they progress through the stages of the complaint process. This has enabled the Arbiter and the case analysts to have electronic access to case files without resorting to physical files.

It has been a challenging and busy, yet rewarding year, as we have achieved much, despite the anxiety and health considerations that the pandemic has inflicted. We could not have been able to get thus far had it not been for our staff members' commitment, diligence and team spirit, even during the periods during which we were teleworking.

Lastly, I am also grateful to the members of the Board for their advice and continued support, and to the Arbiter for his leadership.

The Office of the Arbiter for Financial Services – Overview

The legislative framework

Act XVI of 2016, the Arbiter for Financial Services Act (Chapter 555), came into force on 18 April 2016. The Act sets out the administrative, operational and jurisdictional framework of the Office. It also lays down the functions and accountability of the Office. The Act provides the necessary legal framework for the appointment, functions, powers and competence of the Arbiter. It also provides for the appointment of a Substitute Arbiter, where this is necessary.

In 2020, the Act was amended to allow parties to a complaint to submit and exchange communication and documentation by electronic means, other than the post or courier service. These amendments were published by means of Act No. VIII of 2020.

At the start of 2021, the Act was further 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.

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 him 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.

Role and functions of the Board of Management and Administration

The Board of Management and Administration is appointed by the Minister for Finance and Employment for a renewable five-year tenure. Its functions include:

- provision of support in administrative matters to the Arbiter in the exercise of his functions;
- monitoring the efficiency and effectiveness of the Office and advising the Minister on any matter relevant to the operations of the Office;
- 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 penalties that are payable by a person who fails to settle on time or in full the amount due; and
- 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 2021 was presented to Parliament and is available on the Office's website.

The Board convened seven times in 2020; 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.

Office Setup

Dr Reno Borg
The Arbiter

Board of Management and Administration

Geoffrey Bezzina
Chairman

Peter Muscat
Member

Dr Anna Mallia
Member

Bernard Briffa
Secretary / Customer Relations Officer

Staff Members

Robert Higgans
Senior Case Analyst

Francis Grech
Officer in charge of mediation

Samantha Gatt
Case Analyst

John Francis Attard
Customer Relations Officer

Rita Debono
Registrar (Investigations and Adjudication) and PA to the Arbiter

Valerie Chatlani
Administrative Assistant

Ruth Spiteri
Receptionist

Paul Borg
Delivery person/ Driver

Gaetano Azzopardi
Facility Officer

Administrative Report

Case and File e-Solution System

As reported in our Annual Report for 2019, since 2018 the OAFS has been preparing to procure a robust and scalable software system to encourage more consumers to seek the OAFS' services by enhancing its visibility through a revamped internet portal (the front-end part). It also sought to improve the effectiveness and efficiency of its handling and processing of enquiries and complaints by way of a case and e-file management system (the back-end).

The Case and File E-Solution System was meant to be implemented during 2020. However, due to various logistical and administrative challenges during the year, the formal deployment of the entire system (front-end and back-end) was delayed to 1 January 2021. This decision was taken as it was not practically and administratively feasible to deploy the system halfway through the year.

Moreover, in view of additional new processes that had to be deployed throughout the year to cater for remote working and remote sittings, the limited human talent available at the OAFS was thinly spread across a number of new and existent processes, apart from the rigorous testing of the system which was specifically built to mirror the OAFS' specific requirements and processes. In hindsight, the delay to deploy the system to the start of 2021 was beneficial as it allowed more time for the training of staff in a test environment.

At front-end, the website (www.financialrbiter.org.mt) has been completely re-designed and upgraded. It is more user-friendly for all stakeholders who want to obtain information about our Office. Moreover, consumers are now able to lodge enquiries and complaints online in Maltese and English. A user who submits an enquiry will receive an e-mail and/or text message to acknowledge receipt of the submission. Users (both individual consumers and micro-enterprises) who wish to lodge a complaint online will need to create an account online. This enables complainants to save the complaint at regular intervals and return to the last saved version at a later stage. Supporting documents (PDF and JPG files) may also be attached to complaints. Once the complaint is submitted, it is reviewed by an OAFS officer. Once accepted, the complaint fee may be paid online. The system will automatically generate a unique identity reference for a complaint whose fee is paid online. If the user prefers to pay the fee via a bank transfer, the reference number is generated internally at back-end (see below) by an OAFS staff member.

All decisions delivered by the Arbiter are now categorised to make it easier for users to search for such decisions online. Users are now able to narrow their search to particular cases by selecting one or more fields in the search function. As an added service, the database also includes the reference number of the case if the Arbiter's decision is appealed at the Court of Appeal (Inferior Jurisdiction).

At back-end, all enquiries and complaints are managed via a web-based Case and File Management System (CFMS). The CFMS has several important features to enhance work-flow processes within the office. These include:

i. Each OAFS officer can access a dashboard listing all his respective pending enquiries and complaints;

ii. All enquiries and complaints submitted online are given a unique registration number and are assigned internally to an OAFS case manager, who in turn is able to track the progress of the case accordingly. If the complaint is not in line with the requirements of the law and does not contain all relevant supporting documents, the case manager emails the user listing all pending issues. The user will be guided to access his submission from his account, carry out the necessary amendments and re-submit. Once the complaint is accepted, payment of the complaint fee may be done online or via bank transfer (details are provided by email which the system automatically generates);

iii. The system generates a number of automated emails and letters (in both Maltese and English), such as acknowledgements, covering notices to complaint submissions and notices of hearings. The letters are meant to be used if postal services are availed of to communicate with the respective parties;

iv. A database of all financial services providers licensed by the regulator in Malta is uploaded on the system. The database is updated as required. Internally,

OAFS staff may also access contact persons (names, contact numbers and emails) of compliance and other relevant officers for each respective financial services provider. These details are linked to automatic emails/correspondence referred to in (iii) above.

As a result of such automation, the OAFS is now able to generate ad hoc periodic reports for all enquiries and complaints received during any interval selected by the user.

The system was partially funded following a call for proposals by the European Commission under its 2018 Work Programme that provided grants for joint actions with Member States to support access to alternative dispute resolution mechanisms for consumers. Projects accepted for funding under this programme were eligible to a co-financing rate of 50% of eligible costs. The remaining funding for the project were sourced from reserves accumulated by the OAFS (mainly complaint fees) and Government subventions.

International Engagement

FIN-NET

The Office is an active member of FIN-NET, the network of cross-border financial dispute resolution between consumers and financial services providers in the EU and EEA. FIN-NET owes its existence to European Commission Recommendation 98/257/EC of 30 March 1998 on the principles applicable to the bodies responsible for the out-of-court settlement of consumer disputes. It was set up by the European Commission in 2001 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.

The Office of the Arbiter for Financial Services became a member of FIN-NET in 2017; it qualifies and complies with the principles set out in the ADR Directive.

Any resident of an EU and EEA state, wishing to complain about a foreign service provider that is domiciled within this area, can approach the complaints settlement scheme in his home country. The home scheme will assist to identify the relevant complaints scheme in the service provider's country and indicate the next steps that the complainant should follow. The consumer may choose to contact the foreign complaints scheme directly or else submit the complaint with his home country scheme, which will pass it on to the respective foreign scheme accordingly.

The Commission has a dedicated website to promote FIN-NET among consumers and financial services providers. For consumers, the website contains guidelines about the consumer redress bodies for financial services in every EU and EEA jurisdiction.

The chairman of the Board of Management is also a member of the Steering Group, chaired by the European Commission (DG FISMA), which prepares the agenda for FIN-NET's bi-annual plenary meetings.

INTERNATIONAL NETWORK FINANCIAL SERVICES OMBUDSMAN SCHEMES

The Office is 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.

Formalised in 2007, INFO Network facilitates cooperation among its members to build expertise in external dispute resolution by exchanging experiences.

Office of the Arbiter for Financial Services

A schematic description of informal and formal complaint-handling processes

	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.

Operational Review

Enquiries and minor cases

A statistical analysis of the type of enquiries and minor cases processed in 2020 is available in Annex 1.

Our approach

Customers who have an enquiry about common aspects of financial services – that is, banking, investment services, private pensions and insurance – or who would like information about the Office's complaints procedure may contact the OAFS for information and guidance.

This service is overseen by two experienced Customer Relations Officers (CROs) who are an integral part of the OAFS team.

When an enquiry is made, the CROs ask questions to elicit further information about the issues which gave rise to the customer's contact, as well as to establish the level of complexity of the customer's claim.

In most cases, such enquiries relate to what we term a "minor case". Depending on the situation at hand, the CRO concerned may suggest 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 positive working rapport 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.

During the year under review, 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 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.

In a number of cases, the 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 situation in respect of which the OAFS was asked to intervene.

This process is usually pursued when the enquiry would present itself as being particularly uncommon or somewhat complex. The CROs would then assess the merits of such enquiries before approaching the provider concerned in an attempt to identify and suggest (where possible) a practical solution to the issue at hand. In certain circumstances, the CROs may intervene to get a situation sorted out but, at times, they may only be able to propose a specific course of action to the customer (such as seeking legal or other professional help). 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.

Complainants' venting of anger and frustration is also integral to the complaint-handling process. Further discussion can ensue with the customer and the provider in an attempt to reach a fair compromise. Sometimes, the Office's informal intervention can break an impasse which might have existed between the parties concerned. The cases that are reproduced in summary in this section are real situations in which the CROs had intervened and which they brought to a mutually satisfactory ending.

Many customers 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. In such cases, the CROs address all enquiries that are made by such customers and would normally direct them to

access the Office's website or alternatively send them a complaint form, together with a leaflet explaining the complaints procedure in further detail.

Some enquiries or minor cases could also lead to a formal complaint being lodged with the Office, especially when the issue may be too complex to be resolved amicably or informally, or when the provider declines the CRO's intervention.

Analysis

The extraordinary circumstances caused by the pandemic in 2020 brought about quite a few challenges as to the way our Office processed enquiries and minor cases during the year. Whereas in the past, it would have been quite normal for customers to reach out to us physically by visiting our offices, during the year under review, customers were directed to contact us by phone, WhatsApp or email exclusively. Initially, many customers were rather reluctant to discuss their personal financial matters over the phone, rather than meeting face-to-face with our CROs. However, the health and safety of staff was, and remains, a priority. The same can be said for our visitors. However, over time, (many) customers have grown to accept that a phone call is just as effective as attending a meeting, and when email is unavailable, the post can still deliver the documents that the CROs would need to process an enquiry or minor case.

In 2020, the CROs processed 1,084 unique enquiries or small cases, a marginal 2% increase (year-on- year) from 1,062 in 2019. The figures are testimony to the general public's increasing awareness of this Office to which it refers seeking assistance and support in respect of their 'problematic' relationship with the service provider concerned.

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

Insurance-related enquiries

Just under 58% of enquiries related to insurance cases, that is 627 out of 1,084 cases. This reflected a 3% increase year-on-year – from 609 in 2019.

The onset of the pandemic in 2020 understandably triggered a considerable number of travel insurance claims. Indeed, 213 cases relating to travel-insurance enquiries were processed, representing the highest number of enquiries compared to the different categories of enquiries/minor cases (see Figure 1 In Appendix 1).

Flights were cancelled by the operating airlines; the same can be said for cruises. Additionally, national airports and borders were also closed.

The policyholders were not always satisfied at the manner in which their respective claims for compensation were handled by the insurers concerned. Several claimants called our offices for general guidance in regard to their claim and the extent to which provisions relating to cancellation and curtailment in their respective travel policy documents were applicable. Policyholders were recommended that they refer to the policy document of their respective insurer and lodge a complaint in writing if they disagreed with the insurer's refusal to honour the claim.

In the case of cancelled package holidays, local insurers referred their claimants back to the travel agency from which they were purchased.

A number of insurers declined claims in cases where the policyholders had meanwhile accepted the compensatory voucher(s) issued to them by the airline and/or the hotel concerned.

A number of local insurers implemented one of the following three remedial measures in order to meet their policyholders' request for a refund of the insurance premium, namely,

1. The rescheduling of the travel dates on the policy to a subsequent period.

2. A partial premium refund, net of a percentage premium retention. The latter was intended to make good for the insurer's "time on risk" in respect of the cancellation cover which would have been automatically in force since the inception of the policy.

3. A full premium refund, without any deduction for "time on risk".

Motor insurance has also been a major source of different enquiries during the year under review. As in previous years, many enquiries concerned the value of motor vehicles, especially second-hand or imported cars, as well as the handling of any respective claims following road

accidents in which such vehicles have been involved.

Policyholders complained about the compensation offered by their insurer – based on its estimate of the vehicle's market value at the time of the accident – which would not have met their expectations.

Many enquiries of the type described above were directed to the OAFS, which tried to assist the enquirer in the most practical way. Enquirers were also provided with information about the process that would have enabled them to lodge a complaint with the OAFS.

Most enquiries originate from individuals who would not be covered by a comprehensive motor insurance policy and would therefore be claiming on the policy of the tortfeasor. An improvement in the offer that is made by the tortfeasor's insurer is subject to that insurer's discretion and amenability to resolve the impasse fairly and without delay. However, some insurers may take a hard stance and refuse to consider making a better offer. In that case, the third party's options may be limited to either accepting the offer made or to refer the case to arbitration or a tribunal. It is to be noted that the actual handling of such cases is not envisaged in the relevant legislation which set up the OAFS since such third parties would not fall under the definition of 'eligible customers' in the Act.

Whilst many providers voluntarily agree to equally engage with the OAFS on such cases, a practical legal and/or operational solution should be identified for such third parties to be able to resolve issues of the nature discussed above informally and fairly, prior to referring the matter to arbitration.

Similar to previous years, the OAFS received multiple enquiries in respect of pet insurance. Pets tend to get into all sorts of scrapes; they also tend to suffer from sudden and unexpected illnesses. Hence, the availability of an insurance policy would prove quite handy to compensate the cost of the treatment required, which is usually quite expensive. The issues about which there tended to be disagreement with the insurer centred on the allegation by the insurer of pre-existing medical conditions. It is indeed positive to note that, in a growing number of cases, the insurers concerned agreed to honour the claim by pet insurance claimants after the latter referred their case to the OAFS at enquiry stage.

In the life assurance segment, the enquirers' single bone of contention was the perceived considerable shortfall in the maturity value of investment policies (termed "With Profits") when compared to what they had been allegedly led to believe at the purchase stage that would be actually provided on maturity. These would all have been long-term policies, ranging from 20 to 30 years in duration, whose premiums would have, in many cases, been paid at a financial sacrifice by the policyholders concerned. Many of the enquiries received in this area related to information about our complaint procedure; indeed, many enquirers proceeded with lodging a formal complaint against the relevant financial provider.

Banking-related enquiries

As to banking-related enquiries, 275 cases were recorded during the year in review, a 9% increase over the previous year (2019: 252 cases).

The pandemic created quite a few challenges for the banks and their customers. Similar to many organisations, such as ours, which are consumer-facing, all banks adopted a number of measures in line with the health authorities' recommendations to stifle the spread of the virus. Many banks (and similar financial institutions) curtailed some of their branch operations and encouraged their customers to use electronic means of banking (such as ATM use for mundane cash withdrawals or deposits) or internet/mobile banking to effect transfers. Some banks also increased the minimum limit of cash withdrawals at branches, with the intention of nudging bank customers away from branches to ATM usage for routine cash withdrawals.

The intent and purpose behind these measures were primarily (and importantly) taken to safeguard the health and safety of the staff that operate the branches as well as of the bank clients concerned. Unfortunately, however, the speed with which these measures had to be taken – always in pursuit of staff and customers' wellbeing – caught many consumers unprepared to adapt to such new realities. Consumers who, for years, preferred to while their time in queues simply to withdraw some cash from their account or to encash their pension or social security cheque payment were "expected" to adapt and/or reconsider their options nearly overnight.

Many consumers got in touch with the Office lamenting (what they perceived to be) the "harsh" decisions taken by banks. Some were evidently confused as they felt they were being 'forced' to learn how to use ATMs (or internet banking) when they had never felt the need to do so after being serviced personally by branch staff for years. Others, regrettably, interpreted the bank's measures as a restriction to dissuade them from accessing their money.

Although many consumers may have adapted to the new realities of banking, one cannot however detach this presumption from the fact that many consumers struggle or are simply unable to transition to new ways of banking. Cultural barriers, as well as general literacy and age considerations, have rendered many consumers vulnerable and unnecessarily distressed. It would be unfair and unrealistic to presume that such cohorts of society should be able to adapt, similar to their peers, without assistance and empathy. The OAFS received multiple calls from elderly persons who shared with our CROs their anxiety of being unable to use ATMs (with or without assistance) and of being 'forced' to withdraw more money than they needed or in excess of their pension because of minimum limits imposed by some banks for in-person cash withdrawals. Regrettably, there is scant or sporadic discussion about the manner in which vulnerable financial consumers have been hit by the pandemic. In the meantime, it is important for stakeholders not to lose sight of such financial services users and to actively embark on outreach programmes to kick-start or improve financial literacy overall.

The OAFS has also been at the receiving end of many calls and emails from irate bank customers who, in the midst of the pandemic, "discovered" new charges being applied to their account or being unable to avail themselves of some bonus services or features linked to their account which their bank had offered for a number of years. Besides informing the respective bank of the queries received, the CROs engaged informally with the respective banks about the timing and practice adopted to roll-out such changes which, admittedly, caught many consumers unaware.

As in previous years, an issue that has also caused some to express consternation with our Office concerned banks' updating of customers' personal records, including source of wealth. Customers who called the OAFS enquired not only about the approach taken by banks to block accounts unless the requested information was provided in a timely manner, but also the relevance of the whole exercise especially if the customer's patronage spanned many years.

Some customers also contacted the OAFS complaining that they had been refused a basic account by the bank that they approached for this purpose. Others also called to complain about their bank's decision to close their account. On many occasions, the motive behind a bank's decision to refuse the opening of an account, or to terminate a banking relationship, boiled down to the lack of cooperation by the customer to provide the necessary information as part of the bank's due diligence processes. While the OAFS dedicates substantial time to respond to such individual and diverse enquiries, it is imperative for the financial services community to collectively explain to consumers about such new processes and why they are being employed.

Investment-related enquiries

As to investment-related cases, the number of enquires in 2020 amounted to 142, a drop of 7% over the previous year. During the year, a number of calls received by the CROs related to the effect of regulatory action taken against an investment firm whose customers were required to transfer their holdings to other firms. The Office habitually engaged with the firm's appointed administrator regarding such queries.

Enquiries against providers who provide services from other countries

Many consumers have been in touch with the Office concerning issues relating to financial providers who are not licensed by the financial regulator in Malta. These are usually internet-only financial providers, providing banking services in many jurisdictions under a European authorisation regime that allows them to do so in any EU Member State by virtue of a single licence (issued in one EU Member State, but accepted across the entire Union).

As we have stated in an earlier part of this report, the Office is an active member of FIN-NET, the network of cross-border financial disputes resolution between consumers and financial services providers in the EU and EEA. Through this network, redress bodies – such as the OAFS – would assist consumers to identify and contact EU financial redress bodies that would be responsible to handle complaints against providers falling within their competence.

There were several occasions in which the OAFS acted as interlocutor between local consumers and the financial redress bodies in other EU countries regarding complaints arising against providers licensed outside Malta.

Selection of enquiries and minor cases

Over the course of the year, there were several occasions in which the Office's Customer Relations Officers actively engaged with the financial services provider concerned to assist with the resolution of minor cases and enquiries in an informal manner. This section provides a summary of a few of these cases and their outcome.

Case 1: The enquirer, a director of a small firm in Malta, contacted the OAFS explaining that a few years ago, he held an insurance policy which was pledged in favour of a bank. After some time, he appointed another insurance company and asked the bank to cancel the standing order to the first insurer. He had also arranged to pledge the new policy with the bank. Upon reconciling his overdraft account, the director noticed that the bank was still debiting the account with the premium due to the first insurer. The bank, however, informed the director that the first policy was still pledged in favour of the bank and was thus unable to cancel the standing order. The first insurer confirmed to the bank that the policy had stopped being renewed with it for quite some time, but it had still continued to receive the premia for such policy. The director claimed that, despite providing the bank with the necessary information to correct their mistake, it failed to take immediate action and refund the funds paid in error. Following the CRO's intervention, the bank refunded the money that had erroneously been debited to the small firm's overdraft account, including fees and debit interest that had accrued in the meantime.

Case 2: An accountholder of a bank reached out to our offices explaining that she had incurred hefty charges after entering an incorrect IBAN while submitting a payment instruction intended for a local bank via its mobile banking service. After enquiring as to the reason why payment never reached its intended beneficiary, she admitted to erroneously using an IBAN convertor on the website of a bank which then transpired to belong to a foreign, rather than, the local bank. This resulted in the intended domestic payment being issued to a bank outside the EU, which subsequently returned the payment after levying bank charges at its end. The CRO concerned engaged with the accountholder's bank, which in turn explained that although its mobile platform performs IBAN validation checks and that the IBAN being availed for the transfer was valid, it would not perform further validation as to precisely which beneficiary bank the IBAN belongs to or the country where the account is located. Although the bank did not identify any error on its part, it still refunded part of the charges as gesture of goodwill.

Case 3: The enquirer had held income protection insurance for several years; following which, he had been advised by an intermediary to transfer his cover to the existing Insurer. This advice was supported by the intermediary's confirmation that such continuation of an existing cover would exonerate him from the initial 120-day claim excess applicable under the new policy. The COVID-19 pandemic had resulted in the redundancy of the enquirer. However, when he submitted his claim for compensation in respect of his four-month unemployment period, this was declined by

the insurer concerned precisely because it had been submitted during the aforementioned exclusion time period. Following discussions with the provider, the CRO successfully managed to secure the insurer's agreement to settle the claim in accordance with the £3,000 monthly benefit envisaged in the policy, resulting in an overall payment of £12,000 to the claimant.

Case 4: While holidaying in Italy, the enquirer's car had sustained damage while parked in a private parking area. A police report had been filed and a claim was submitted to the parking insurance. On returning to Malta, the enquirer had submitted a claim under his comprehensive insurance policy. Though the required repair had been carried out, the enquirer contended that he was still out of pocket in respect of the claim excess he had to pay as well as the increase in his policy premium due to the effect on his no claims discount. The OAFS intervened in the case through its CRO. During the course of such discussion, the provider managed to recover its outlay from the parking insurance. The enquirer was reinstated to the same position he was in before his unfortunate accident and was refunded the policy excess (€55) and the no claims discount (€250).

Case 5: The enquirer's marine craft had sustained considerable damage to its propulsion system while cruising off Gozo. It was stranded at sea and had started to drift without any control whilst the prevailing current started to drag the craft further out to sea. Frantically seeking assistance, the enquirer finally managed to identify a salvage firm which was prepared to come over from Mistra Bay and to tow his craft to its mooring all the way to Marsaxlokk (the southern-most port of the island) where the necessary repair could be organised. In settling the claim, the insurer concerned had objected to the cost of the salvage / towage fee, contending that it was on the high side. It further insisted that its policyholder should have sought a closer port of refuge than Marsaxlokk as this would have reduced the overall expense and in accordance with its policyholder's duty to mitigate the extent of his loss. At the end of the protracted discussion with the CRO, the insurer revised its initial position and compensated the enquirer the amount of €6,190 for the overall claim, inclusive of the salvage / towage charges.

Case 6: In this case, the enquirer was the innocent third party in an accident which happened in a parking lot. His vehicle was hit and seriously damaged while parked. Two separate vehicles were involved in the collision, as a result of which one of them ended up damaging two parked cars, one of which belonged to the enquirer. The enquirer requested the intervention of the OAFS, contending that no tangible progress had taken place in his claim settlement after his damaged vehicle had been inspected on a without prejudice basis. The CRO concerned engaged in discussion with the insurers of the two collided vehicles and established that the enquirer's case had indeed stalled pending the outcome of the discussions in progress between the said insurers about the apportionment of liability for the accident in question. In his discussions, the CRO insisted that such party, who was clearly not to blame for the accident in question, should not bear the consequence of the insurers' inability to reach an agreement. Following, the intervention of the CRO, the two insurers concerned agreed to share the responsibility for the accident equally between themselves, on a 50/50 basis. The enquirer was then compensated accordingly.

Formal complaints

A comprehensive analysis of the nature and type of complaints registered in 2020, and a statistical overview of the decisions delivered by the Arbiter, are available in Annex 2

Registration and lodgement of cases

Broadly speaking, a complaint is an expression of dissatisfaction or displeasure made by an eligible customer (as defined in the Act) concerning the conduct of a financial services provider in respect of the type or quality of a product or service given by such provider: it would normally involve a claim by the customer that he has suffered, or may have suffered, financial detriment. Sometimes, the customer may also allege material inconvenience or distress. All complaints accepted by the Office must be in writing and should clearly specify the name of the financial service provider, the reason(s) for the complaint and the remedy that is being sought. Eligible customers may either lodge a complaint using our form or log into our website and submit a complaint online.

When a completed complaint is received by the Office, it is assessed in line with a number of criteria as set out in the Act. Complaints which fall outside the scope of such criteria are rejected and an explanation is provided to the applicant as to the grounds for which the complaint has been declined.

During the year under review, the OAFS registered 145 new formal complaints, an increase of 32% (35 complaints) over 2019, but still lower than the number of complaints received in the first three years of the Office's operations. For the second consecutive year, there was a marked increase of 85% in the number of insurance complaints, reaching a total of 89 complaints, up from 48 in the previous year. On average, the number of investment complaints remained roughly at par with previous years. As to banking complaints, there was a 31% decrease in the number of complaints (from 32 in 2019 to 22 in the reporting year), thus continuing the downward trend in this complaint category.

Complaints may be lodged against all financial services providers, which are or have been licensed or otherwise authorised by the financial services regulator in Malta and have offered their financial services in or from Malta. Following amendments to the legislation, the Arbiter is now able to determine, at the very early stages of a complaint submission, whether the activities pursued by the provider (which are the subject of the complaint) are deemed to be of a financial services nature.

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 financial firm is licensed or domiciled.

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.

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.

Complaints submitted during the year were predominantly filed by natural persons (139 complainants), the remaining six being submitted by micro-enterprises. Around 63% of the overall number of complainants were resident in Malta (92 in all), while the remaining (53) were overseas residents, mostly from the UK.

Seventy percent of complainants (101) chose not to be assisted during the complaint process.

The law prevents the Arbiter from reviewing 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 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.

Complaints submitted to the Office are required to be clearly legible and word-processed. Customers are required to submit a copy of their complaint letter to the provider and its reply (if available). They are also encouraged to attach copies of supporting documentation to their complaint.

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 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.

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 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.

In 2020, 73 cases were referred to mediation, a considerable increase over the number of cases referred in the previous years. Mediation was successful in 16 cases and a further 13 cases were withdrawn following mediation.

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; in which case the 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 had been 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 2020 were carried out remotely via web-conferencing software. This was the first time that mediation sessions were held in this manner as, usually, parties would meet physically at our centrally-located offices. Alternative arrangements to conduct mediation via tele-conferencing are also in place in the (remote) possibility that the parties would not have internet access.

As expected, there was some initial resistance from both complainants and providers (and their respective representatives) as, naturally, physical meetings were (and possibly remain) the preferred option, compared to virtual sessions. However, the Office took the stance that the aggravating factors brought about by the pandemic should not impinge on the administration of cases. After explaining to the parties that the Office was not prepared to stall a case from being mediated and heard, all parties embraced technology and thus justice was not delayed but rather proceeded swiftly in the interest of all parties concerned.

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, all hearings, except those held during the first two months of the year, were held remotely using web-conferencing software, an ubiquitous communications medium during the pandemic. The application of such software for oral hearings was not really an innovative development to our office as the OAFS had been convening virtual hearings for non-resident complainants since it had been setup in 2016.

The restrictions and social distancing measures necessitated by the pandemic simply extended the use of online hearings to include cases lodged by local complainants. The new alternative of convening hearings virtually appears now to be an accepted practical solution, which also enables all parties to manage personal time and resources more efficiently.

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, 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.

The Arbiter delivered 125 decisions during the year, of which 122 were final while a further 3 were preliminary or follow-up decisions. One decision comprised 39 individual cases that were lodged separately by complainants against the same financial services provider. Each of these cases was heard separately. Following a review of each of these respective complaint files, the Arbiter determined that these cases were to be treated collectively as the cases' merits were intrinsically similar in nature. A summary of this decision, along with several others delivered by the Arbiter during the year, feature in the next section of this report.

Preliminary decisions deal with decisions on legal pleas, such as when the service provider alleges that the Arbiter does not have jurisdiction to hear the case and pleas regarding prescription. A follow-up decision takes

place in the unlikely decision that the Court of Appeal (Inferior jurisdiction) requests the Arbiter to review awarded compensation.

Around 52% of the final decisions (64 in all) were not appealed and are therefore *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.

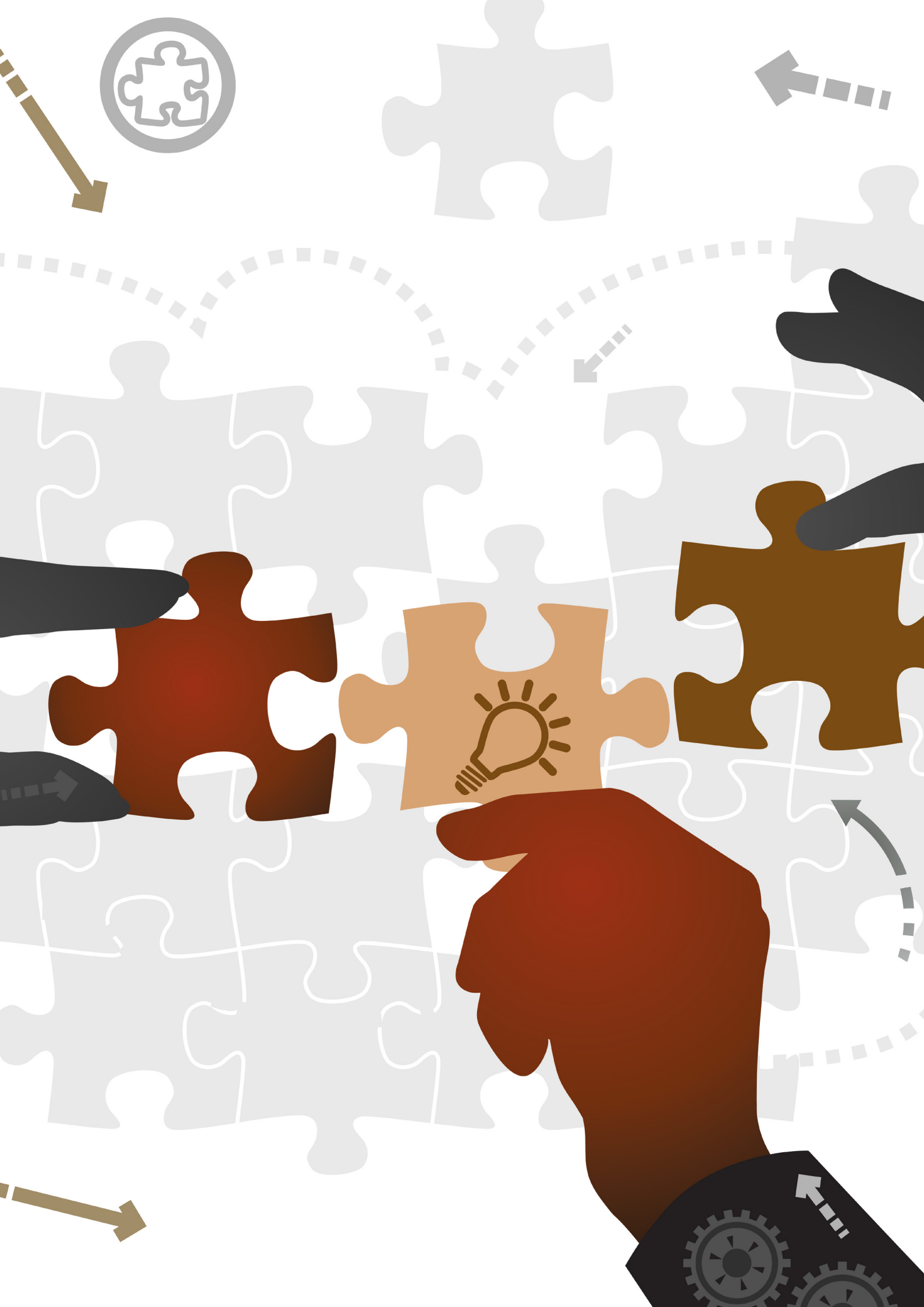
Whereas some cases may be decided within a short time, other complex cases require extensive research and reflection before a final decision is published.

A couple of cases took longer to be decided than expected as in one case, the lawyer assisting the complainants was indisposed for some time and in another, extensive analysis of voluminous documentation relating to investment products was required.

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 179 days for banking-related and 225 days for insurance-related complaints.

In the year under review, 60 of the 78 investment-related decisions concerned the administration/management of private retirement schemes. These latter complaints were particularly complex to assess due to the diverse content of each case, its particular merits and the voluminous information that was submitted at review stage. Such cohort of complaints took on average 430 days for the final decision. The remaining 18 complaints took an average of 493 days, a clear indication of the complexity of such cases.

Sometimes the parties themselves ask for an extension to prepare their defence which goes beyond established time frames. The Arbiter has to balance the expediting of cases with the fundamental requisite of an adequate and fair hearing. Overall, cases are being decided in a reasonably short time considering the amount and complexity of 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

Accessing the final decisions of the Arbiter

Our internet portal provides comprehensive access to the full text of the Arbiter's decisions in the original language they are delivered.

The new website enables users to refine their search, of over 400 decisions, by the name of the provider, the language of the decision, the date and/or the year of the decision, by the sector and the outcome of the Arbiter's decision.

To respect the privacy of the complainants, the published version of the decision removes the full names of the complainants and replaces them with 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, thus providing a comprehensive tool for researchers and consumers as to the rich source of retail financial services jurisprudence in Malta.

A representative selection of cases in summary format

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

During the year under review, the Arbiter delivered decisions concerning 125 cases, 39 of which were considered intrinsically similar in nature and consequently were treated collectively in terms of Article 30 of the Act.

This section includes summaries of over 30 decisions covering banking, insurance, investments and private pensions. The last part of the section also includes a summary of a collective decision which relates to the administration of a retirement scheme and the responsibilities of a trustee operating within a retirement pensions scheme.

A selection of banking-related complaints

Online internet fraud following use of a bank card (ASF 016/2019)

COMPLAINT UPHELD

Online card fraud; complainant deceived by a fraudster; application of Directive 1 of the Central Bank of Malta and PSD2 provisions; gross negligence; responsibilities of the cardholder and the bank.

This complaint relates to online internet fraud. The complainant claimed that he was purchasing a two-year software licence from a reputable company, when it then transpired that he was defrauded. He was told that the software licence would cost GBP7 but, after verifying transactions through his bank's internet banking service, the complainant noticed that he had been debited USD791 and USD1191 by a company in Bangladesh. He was also charged a currency conversion fee of €16.87 and €11.20.

The complainant immediately contacted the bank's call centre to stop the cards and was advised to visit his closest branch to compile a dispute form. He claimed that the card he had used came bundled with free purchase protection insurance which he could use for such instances. The complainant claimed that not only did the bank refuse to refund the above amounts, but that the bank had blamed him for providing his card details to third parties or to have provided card details when he had no control over his computer.

He requested the bank to refund all amounts debited from his account, including the currency conversion charges.

The bank rejected the complainant's claim on several grounds, which include the following:

a) Concerning the company in Bangladesh which featured on the customer's statement, the bank held that it was not a party to any transaction which the complainant may have transacted or contracted with such third party. On this basis, it could not be held responsible for any transaction to which it was not a party.

b) It claimed that the complainant allowed third parties to access and work on his computer without exercising proper lookout and diligence. Moreover, the complainant inputted bank details online while such third parties had access to his computer. The bank maintained that, in allowing third parties such unfettered access to his computer, the complainant was grossly negligent and submitted that it should not be held responsible for the complainant's actions in that regard.

c) Although it was not obliged to do so, the bank had reached out to the merchant in Bangladesh informing it that the complainant did not receive the service for which he had paid and requested a refund of the debited amount. The bank stated that the merchant provided the bank with evidence that showed it had provided the service requested by the complainant.

During cross-examination, the bank exhibited copies of a document that the firm in Bangladesh had provided to it. The complainant countered that he had never had sight of such documents. The bank claimed that the documents relate to contracts between the fraudsters and the firm in Bangladesh, and not between the complainant and third parties.

It claimed that the documents were relevant as the complainant gave the fraudsters control over his computer and not to the firm in Bangladesh. It also claimed that it did not carry out further investigations to check if what the firm in Bangladesh was claiming was true or otherwise.

Whilst noting that this was clearly a case of fraud over the internet, the Arbiter further observed the following:

1. According to the complainant's statement of events, a situation had presented itself to appear genuine but then resulted to be fraudulent, as was also confirmed by the bank. Such cases, the Arbiter claimed, could not be deemed as 'normal transactions'. In this case, both the bank and the client had been defrauded. However, there were special laws that apply in such circumstances, namely the Payment Services Directive 2 (PSD2) and Directive 1 issued by the Central Bank of Malta.

2. The Arbiter delved deeply as to the level of protection that card users enjoy when an event - such as that under review – would present itself. He also observed that the relative legislation obliges

the consumer to use payment instruments, such as a bank card, diligently and in accordance with the terms and conditions governing the transaction. Moreover, the customer was also obliged to inform the bank on becoming aware of the loss, theft, misappropriation, or unauthorised use of the payment instrument.

3. It did not transpire that the complainant had failed to honour such obligations. According to the evidence and the statements made by the two parties, the complainant did not provide any confidential information online other than that he would normally have had to supply when doing an online transaction. On its part, the bank did not specify exactly what details had been divulged by the complainant and which would have contradicted the complainant's version of events.

4. The complainant notified the bank immediately when he noticed that something was amiss. He was diligent enough to check his bank account each time he conducted a transaction online.

5. The rules oblige a bank to refund its cardholder whenever a transaction is done without his consent, unless the consumer acted fraudulently. However, the same rules also provide that where there is misappropriation, that is when a transaction is made by a card that would have been stolen from its rightful owner, the first €50 of the loss would be borne by the cardholder.

6. On this aspect, the Arbiter considered whether the complainant had acted fraudulently and whether he had failed to observe his obligations with intent or 'gross negligence'. By making extensive reference to local jurisprudence relating to the concept of 'gross negligence', the Arbiter found that there was no evidence to support a claim that the complainant acted in a manner intended to cause harm to third parties or that he wanted to act negligently.

7. According to PSD2, for 'gross negligence' to be attributed, one had to look at the particular merits of the case. In this case, the complainant was deceived by a fraudster. The Arbiter was obliged to apply the criteria of fairness, equity and reasonableness in the context of how an ordinary person would have behaved in similar situations. By referring to the UK Financial Services Ombudsman's observations relating to ever-increasing sophistication of card fraud online, one had to "recreate the scene" and "think about [...] the environment that was created by the fraudster for the consumer" at the time of the transaction.

8. The provider had not submitted evidence in support of its claim that the complainant had provided his card details, together with the respective PIN, to third parties. The complainant thought that he was doing an online purchase, similar to others he had done online in the past. It was evident that the complainant had acted in the same way as any other ordinary person would have done in similar circumstances.

9. The bank ought not to have simply relied on information that the firm in Bangladesh had provided as it was evident that the documents it provided the bank were not signed by the complainant. The bank ought also to have contacted the police in such situations. It should have also insisted with the firm that the complainant was not provided with the service he had requested, thus meriting a refund of the money that had been debited.

The Arbiter upheld the complaint and ordered the bank to pay the complainant compensation amounting to USD1932.22 (or equivalent in Euro), which was net of €50 that is borne by the complainant as the withdrawn amounts occurred before the bank had been informed of the transactions. This was in line with Directive 1 of the Central Bank of Malta and PSD2.

The decision has been appealed.

Unauthorised use of a debit and credit card (ASF 044/2019)

COMPLAINT REJECTED

Bank's responsibility in terms of the Central Bank's Directive 1; Use of the PIN; cardholder's responsibility for unauthorised transactions due to his gross negligence.

The complainant lodged a complaint against his bank which had authorised the withdrawal of funds from his credit card account even though the three transactions had been carried out without his consent as the card had been stolen. The complainant stated that his credit card and debit card were in the wallet which was stolen from inside his shoulder sling bag while he was on holiday in

Santorini (Greece). Subsequently, three cash withdrawals were made using the credit card. The repeated attempts made using the debit card had all failed.

The complainant further stated that the bank had declined his request to be refunded for the total cost of the three transactions; and this because it had contended that the said transactions had been carried out using the correct Personal Identification Number (PIN). The complainant insisted that the said PIN was not stored in his shoulder bag or in his wallet; nor had he ever revealed it to anyone. He was therefore requesting the Arbiter to order the bank to refund him the amount of €935.35 in compensation of the stolen funds as well as of the bank charges incurred in the transactions and in the replacement of the stolen card.

On its part, the bank contended that:

a) It was not responsible towards the complainant in terms of Directive 1 on The Provision and Use of Payment Services issued by the Central Bank of Malta (which had transposed into Maltese Law the Payment Services Directive 2 [Directive EU 2015/2366]).

b) The complainant had been immediately alerted by the bank through text messages of both the withdrawals carried out using his credit card as well as of the failed attempts made using his debit card.

c) In addition to these repeated alerts sent to the complainant's mobile phone, a bank representative from the card fraud monitoring unit, had also contacted the complainant telephonically. The latter had manifestly avoided answering the representative's enquiry as to whether the PIN was stored with the cards.

d) The bank's records showed clearly that the actual cards had been used and not cloned versions of them; furthermore, they also showed that the person concerned was aware of the respective PIN.

e) The product information guide for the credit card stated clearly that the PIN must be kept secret and must not be recorded or disclosed to anyone, inclusive of the police and bank personnel.

f) Article 50 of Directive 1 stated clearly that the cardholder was to bear responsibility for unauthorised transactions incurred if acting in breach of his obligations.

In his deliberations, the Arbiter concluded that:

1. The complainant acknowledged that he had received repeated text alerts on his mobile phone from the bank about the transactions carried out using his cards. However, he denied that the withdrawer had the respective PINs as he did not keep this data together with his cards. He contended that, if this was the case, the attempted withdrawals through his debit card would not have failed.

2. The service provider had submitted clear evidence that the credit card transactions had been successful since the correct PIN was used. Similarly, the attempted debit card transactions had failed because the incorrect PIN had been inserted. Both PINs were encrypted in the bank's system for added security. Therefore, the withdrawer must surely have had access to the PIN for the credit card.

3. The fact that the correct PIN had been used was certified by the international card network itself and not by the service provider.

4. It was plausible that the PIN of the credit card had been stored by the complainant in his stolen wallet, together with the card.

5. The credit card withdrawals had been successful because the correct PIN had been inserted; they would not have been allowed by the system if an incorrect PIN had been inputted. The withdrawer must therefore have had access to the said PIN.

6. It had not been proven that the service provider had not respected or had breached its obligations under the Directive 1 issued by the Central Bank of Malta.

7. The said directive made the cardholder responsible for any unauthorised transactions resulting from gross negligence on his part. The aforementioned Payment Services Directive specifically cited, as an example of such gross negligence, the retention of the PIN together with the respective credit card; and this in a manner which made it easily accessible.

In the light of the foregoing, the Arbiter ruled against the complainant and did not accept the complaint. He decided that the bank was not required to refund the amount which had been withdrawn through the complainant's credit card.

This decision was not appealed.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Refusal to allow an account holder to withdraw funds from a bank account (ASF 77/2019)

COMPLAINT UPHELD

Operation of a bank account designated 'on account of'; instructions disallowing withdrawal of funds to the account holder; account mandate; terms and conditions; release of funds to the account holder.

The complainant claimed that he was the owner of a bank account but was keeping funds for the account of his son. The account held €1,500 in funds and there were no legal impediments on the account. He claimed that the bank was impeding him from withdrawing funds from the account as the consent of his former wife was required.

The bank, in its response, explained that:

a) The complainant and his ex-wife had first opened an account on behalf of their son. The signing instructions were 'anyone to sign'.

b) Sometime after, the complainant asked the bank to close the account. Based on the account's signing instructions, the bank agreed. On the same day, the complainant opened another account in his own name, but which was meant to be for the account of his son (complainant's name A/C followed by the son's name).

c) Subsequently, however, the bank requested the complainant to close the account and have the proceeds transferred to a new account in his and his former wife's name. The account was, in the meantime, blocked and the bank informed the complainant that funds would only be released subject to the ex-wife's signature.

d) The bank claimed that his ex-wife objected to the release of funds to the complainant and asked for the funds to be transferred to a new account in their son's name.

The Arbiter made the following observations and considerations, based on evidence and submissions during hearings:

1. The account holders of the first account were the complainant and his former wife. The son's name is shown in the 'Alternative Account Designation'.

2. The bank had acted correctly when it allowed the complainant to withdraw funds deposited in the account; and this on the strength of the signing instructions that allowed the account to be operated on "any one to sign" basis.

3. The bank had also acted correctly when it allowed the second account to be opened in the name of the complainant 'for the account of' the son. It was noted that the account was a particular banking product that the bank was offering to promote savings for the benefit of children and teenagers.

4. The bank's insistence to obtain the signature of his former wife for the release of funds to the complainant had no legal basis. The funds did not belong to the Community of Acquests as the withdrawal request was made after its dissolution. The wife's name did not feature in the account documentation for this second account and a simple objection on the part of the former wife was not enough reason for the bank not to execute the complainant's request.

5. The bank's assertion that the account was designated in favour of the son and that only he could withdraw the funds was also incorrect. The account opening/mandate form shows the complainant as the account holder. There were no conditions attached to the manner the account had to be operated, except for those in the terms and conditions. Moreover, the type of account that the complainant had opened was quite clear in that it belonged to the account holder and the son had no legal right (to the account).

6. According to the account's terms and conditions, the account would have been automatically terminated on the son's 16th birthday. The son was nearly 17 years old by then and therefore the term of the account had lapsed. Accordingly, upon closure, any funds in the account would have passed on to the account holder, subject to the bank receiving alternative instructions from the latter.

7. On this basis, the complainant had every right to withdraw the funds from the account as he was the rightful owner of the account.

The Arbiter thus ordered the bank to release the funds to the complainant, with interest from the date the complaint was submitted up till the date of effective payment.

The decision was not appealed.

Refusal to open a bank account (ASF 105/2019)

COMPLAINT REJECTED

Basic bank account; rights and obligations arising from opening of a basic bank account; due diligence process; proving genuine interest in support of an application to open a bank account with basic features.

The complainant claimed that the bank had refused to open a basic bank account notwithstanding that he had submitted several supporting documents (such as his employment agreement, copies of ID card and passport, tax forms for the two previous years, a statement from a different bank, and various reference letters) during the onboarding process. Furthermore, he was not given a reason by the bank for its refusal but simply informed him that the refusal was due to 'internal policy'.

The complainant claimed that, during the bank's due diligence process, he had fully cooperated with the bank. However, he claimed that bank staff misrepresented information that he had conveyed to them, such as how he had paid for his house in his native country. He also claimed that he was gainfully employed with a local firm and had no separate business apart from his employment. He also confirmed that he held a bank account with another bank in Malta.

The complainant thus requested the Arbiter to order the bank to open a basic bank account.

The bank claimed that it had multiple reasons for refusing the complainant's new account application; these are summarised below:

a) It claimed that the complainant provided conflicting information and documents during the onboarding process. For instance, the bank claimed that there were inconsistencies regarding the complainant's occupation and employment income, his rent payments and his involvement in two local Maltese companies.

b) The complainant was also involved in entities operating in sectors which were outside the bank's risk appetite.

c) It had no obligation to open an account for an applicant save in circumstances permitted by law. It claimed that banks may reject an application if an applicant already holds a payment account with another bank or where to do so would result in a breach of any anti-money laundering legislation.

In his deliberations, the Arbiter made extensive reference to local legislation relating to the opening of payment accounts with basic features, and the banks' obligations in this regard. Furthermore, the Arbiter observed that:

1. An application by a consumer for the opening of a payment account with basic features does not give the consumer an automatic right to such account. The consumer must prove that he has a genuine interest in opening the account.

2. Banks were also obliged to conduct a thorough due diligence process in respect of their obligations to combat money laundering and the funding of terrorism. If the credit institution is not satisfied that the applicant is a bona fide client, and there are serious doubts that the opening of the account may breach rules and regulations, the credit institution was obliged to refuse the application.

3. He held reservations about the contention made by the bank that one of the reasons for the refusal of a basic payment account was that the complainant did not fall within its risk appetite as the relevant local legislation did not contemplate such a situation.

4. The complainant explained that he had a genuine interest to open the account to transfer his salary to the account and to pay his rent. The bank did not dispute the complainant's explanation and the Arbiter had no doubt as to the complainant's intentions. For that reason, the Arbiter found nothing untoward regarding the complainant's request to open a basic payment account.

5. However, a bank may also refuse the opening of an account with basic features where a consumer already holds a payment account with any credit institution located in Malta. From the evidence as presented, the complainant already held accounts with another bank in Malta, an aspect which was not disputed by the complainant. Therefore, the Arbiter could not oblige the bank to open a basic account to the complainant.

For the above-stated reasons, the Arbiter rejected the complaint.

The decision has not been appealed.

Bank's refusal to allow withdrawal from an account (ASF 027/2019)

COMPLAINT UPHELD

Jurisdiction of the Arbiter; complainant not the subject of a garnishee order; bank refusal to allow withdrawals from an account; application of Articles 381 and 382 of Chapter 12 of the Laws of Malta; the holder of an account.

The complainant was the holder of an account with a local bank solely designated in his name. In summary, the complainant explained that:

a) He had opened the account with the minimum amount allowed by the bank. His mother used to donate her salary to him, which he used to deposit in that account. He explained that he rarely used that account, except for deposits.

b) A few years ago, he had called at the bank to withdraw the money from his account, but the bank refused to process his transaction.

c) He sought the assistance of a lawyer who wrote to the bank asking for an explanation. The bank, however, did not provide a reply.

The complainant requested the Arbiter to order the bank to release the funds held in the account as the funds belonged to him.

The provider submitted the following:

a) The complainant's mother had been served with two garnishee orders. She was channelling her salary to her son to be able to use part of her earnings, while donating the rest to her son.

b) It confirmed that the garnishee orders were specifically instituted against the mother. It had refused to authorise the withdrawal of the funds from the account so as not to violate the Court's order which issued the relative garnishee orders and so be in breach of the law.

c) It further submitted that, as the garnishee orders against the mother were still in force and it did not wish to violate the Court's order, it had requested the complainant to obtain a Court decree that would authorise him to withdraw the funds from the account; or, alternatively, the mother could obtain a counter warrant for the garnishee orders she had been served with.

d) The bank believed that the money passed on to the son was indeed a donation, as the son was capable of earning a living. It claimed that the transfers were being made for the mother to bypass the garnishee orders served against her.

The Arbiter, in his deliberations, made the following considerations:

1. During cross-examination, the complainant stated that the funds credited to his account were his mother's salary and originated from her employer. As he was the only child, his mother used to donate her salary to him. He wanted access to his money as he was about to sign a promise-of-sale agreement and needed to withdraw the money to pay for the property.

2. The garnishee orders were issued against the complainant's mother, and not against the complainant. That meant that the bank had no legal right to block the complainant's account as it had no order by the Courts to block an account that was not subject to such garnishees.

3. Pursuant to Articles 381 and 382 of the Code of Organisation and Civil Procedure (Chapter 12 of the Laws of Malta) an amount of up to €698.81 of the mother's salary was not subject to an attachment order as the legislator intended those served with a garnishee to have a decent living.

4. The mother had a part-time job and it appeared evident that hers was a living wage. As the law allows protection of up to €698.81, the mother had every right to spend this amount of money in any way she wanted, even donating it to her son.

5. As long as this amount was not exceeded, neither the employer nor the mother was breaching any Court order as a garnishee would only apply in excess of this amount. Not even the Court was able to issue an attachment order for this amount as this was protected by law.

6. The declaration, that was made in a letter which the complainant's lawyer had submitted to the bank stating that the complainant's mother was channelling her salary to bypass the garnishee orders, was quoted out of context. The mother was actually contending that, as she had limited access to her money, she wished her son to receive her earnings as a donation.

7. Indeed, the complainant had wanted to withdraw the money as he had signed a promise-of-sale and

wanted access to the money. No evidence to the contrary was put forward in this regard. The bank had expressed doubt but had not substantiated it.

8. The bank had not provided any evidence or legal basis to show how the garnishees affected the complainant who had no link to any debts which his mother might have had. The bank's decision to block the complainant's account was not based on any Court order and such decision was taken unilaterally by the bank without any court authorisation.

9. The request made by the bank to the complainant to seek Court authorisation was also not in order as the complainant was not part of the garnishee procedures against his mother. If the bank had any doubts, it should have sought direction from the Court itself and not pile responsibility on the complainant whose funds were blocked without having a garnishee served against him. The bank's actions were thus incorrect.

As neither of the parties failed to provide information about the amount of money that the complainant was receiving from his mother on a monthly basis, the Arbiter was somewhat limited as to the remedy he could provide.

In his decision, the Arbiter directed that if the amount did not exceed €698.81 a month, then the bank should release the full amount held in the complainant's bank account. If the amount exceeded such sum, and the bank had any doubts, then the bank should seek direction from the Court and proceed with taking such direction as the Court may provide. In such case, the bank was required to do so within one week from the date of the decision and to inform the complainant of the Court decision in that regard.

The decision has been appealed.

Termination of a banking relationship (ASF 071/2019)

COMPLAINT REJECTED

Terms and conditions; ongoing due diligence, obligation to provide information; justifiable grounds to end a banking relationship; duty of a bank to provide a reason for terminating a relationship.

The complainants claimed that the bank closed their accounts without a valid reason. They held the view that the bank's decision to do so was in reaction to their right to request and receive an adequate explanation as to why they were being required to provide more information than that which the bank already held in their regard.

They also claimed that there were other reasons behind the bank's decision, including that resulting from a past personal circumstance involving one of the complainants and the bank.

They also claimed that their requests for clarification were either not answered in full, or not answered at all. They further claimed that their banking relationship spanned five decades during which they had always operated their account diligently.

They insisted that the bank should prove that the termination of service was justified; in the absence of which, the Arbiter should censure the bank for such discriminatory action.

The provider countered that it was within its powers to terminate the banking relationship of the complainants and this in accordance with its terms and conditions. It claimed that:

a) In terms of its statutory and regulatory duties, the bank was required to conduct ongoing monitoring of its commercial relationship with its customers, and this had been well explained to the complainants.

b) The complainants had refused to provide the necessary documents that were relevant to the Know-Your-Customer process and, as a result, the bank had no other option but to close the accounts.

c) The complainants had lost their trust in the bank and this was evident from a number of articles the complainant had penned in the printed media which tended to put the bank in a bad light and the difficult attitude he had adopted in his correspondence with the bank.

Prior to deliberating on the case, the Arbiter drew a timeline of events that led to the escalation of the complainants' dispute with the bank. He observed that the relationship between the bank and the complainants had severely deteriorated over time, including when one of the complainants had suffered injuries to his hand while using the bank's deposit machine.

The Arbiter, without entering into the merits of that incident, held the view that both sides ought to have approached the whole issue with greater sensitivity and

mutual understanding. However, the main contention in this complaint was whether the bank was justified to close the complainants' accounts based on the facts as presented.

The Arbiter observed the following:

1. In its submissions, the bank contended that its terms and conditions allowed it to terminate the complainants' accounts for any reason and after giving customers at least 60 days' advance notice. He disagreed that a bank could terminate a contract without having any reason for doing so. Although banks can terminate a banking relationship, in the absence of extenuating circumstances such as money laundering and terrorist financing, it is expected that the customer is given a reason for such a decision, even if it was a generic one.

2. In this case, the banks' terms and conditions provided reasons that could trigger an event that may lead the bank to terminate a relationship. Banks were obliged, and have a right, to seek information from their clients to assess their risks and to conform with rigorous rules relating to the prevention of money laundering and terrorist financing.

3. The bank had provided multiple explanations as to the legal basis on which it was requesting such information, and it was one of the complainants who was nit-picking in an effort not to provide the requested information. It may be understandable for a customer to resist a bank's requests following a long professional relationship, but banks were still obliged to ensure ongoing due diligence, as otherwise they would be sanctioned for not doing so.

4. The bank was not being unreasonable when it requested information from the complainants in conformity with anti-money laundering and anti-financial crimes rules. The complainants, on the other hand, had no valid reason to refuse to pass on information that the bank requested of them.

The bank, thus, did not act without justification when it terminated its commercial relationship with the complainants. In this case, as mutual trust between the bank and the complainants had soured considerably, the Arbiter felt that there was no scope for such a commercial relationship to be revisited.

The complaint was thus rejected.

The decision was not appealed.

Card malfunction while on a business trip abroad (ASF 024/2020)

COMPLAINT REJECTED

Debit and credit cards; malfunctioned cards; extent of inconvenience caused to cardholder.

In November 2008, the complainant went on a business trip to Hong Kong and informed the bank of the dates of his trip prior to departure. The complainant had two international debit cards issued by the bank and both failed to function when presented at the hotel in which he was lodging. He claimed that he had to stay in his hotel room for an extended period while alternative arrangements were being made by him to transfer funds into an account held with another bank with which he held another international debit card.

On his return from the trip, the complainant discussed his complaint with the bank. The complainant claimed that the bank reneged its duty to provide a reliable service, even though he had advised it of his travels before he left Malta. The complainant did not have access to his bank accounts and was unable to withdraw from ATMs and pay at shops. He spent the first two days in his hotel room as he did not feel safe to do otherwise without access to his money. He confirmed that his cards were accepted in Dubai on his stop-over, but were rejected by the hotel and the place where his conference took place. When he returned, he felt that the aim of his trip had not been accomplished. He refused the bank's offer of €500 as a gesture of goodwill. The complainant requested that, as a remedy, the bank ought to pay him €709.66 for the airline ticket, €353 hotel expenses and €178 for the conference fee.

The provider rejected the complainant's request, on the following grounds:

a) It claimed that the complainant visited Hong Kong between 30 October 2018 and 4 November 2018. The conference was on 1 and 2 November 2018.

b) It had investigated the complainant's contentions. As remedy, it first offered him €400 and then increased its offer to €500, acknowledging that its cards had malfunctioned.

c) It observed that all expenses relating to the trip and conference, including meals, were all prepaid from Malta.

d) The cards in the complainant's possession had only failed where the complainant was lodged, but not in other places such as Dubai. The cards were, therefore, not defective.

e) Prior to his departure, the complainant had also exchanged €573.55 into HK dollars. The availability of these funds signified that he was not financially disadvantaged in any way.

f) From further investigation, it also transpired that although the complainant had access to the bank's website, through which he could have informed himself of the procedure for contacting the bank in such instances, it had no record that the complainant actually contacted the bank via its internet banking or call centre.

The Arbiter held that:

1. The bank had acknowledged that the malfunction had created inconvenience to the complainant, even if the bank submitted that the complainant had another two cards, one issued by the same bank (which he did not use) and another card issued by another bank. The bank had offered him €500 for the inconvenience but made it clear that they were doing so as a gesture of goodwill as the purpose for which he travelled was not affected in any way.

2. The malfunction of the cards was not enough reason for the complainant to miss the first day of the conference. The bank noted that the distance from the complainant's hotel to the conference venue was short and there was nothing that impeded him from taking inexpensive transport to attend the conference.

3. The HK5000 in cash he took with him from Malta could only have been used in Hong Kong and was enough to keep him going as all expenses had been paid before his arrival in that country. Moreover, the objective of his trip had indeed been attained as he had also presented a paper during the conference.

4. He rejected the complainant's contention that the objective of his trip had not been attained due to his inability to use his cards.

5. It was true that the cards' malfunction created inconvenience to the complainant but not to the extent that the complainant was claiming. To this end, the Arbiter disagreed with the complainant's request for compensation.

The Arbiter concluded that the amount of €400 that the bank had first offered the complainant was fair and the complainant ought to have accepted it. In this regard, he ordered the bank to pay the complainant €400.

The decision was not appealed.

Deposit into a 'fake' bank account (ASF 175/2018)

COMPLAINT REJECTED

Scam website purporting to be of an actual bank; investment account.

The complainant, residing outside Malta, claimed that he was a client of a local bank. He further claimed he had made a deposit of €50,000 with the local bank and a particular firm established in Belgium had transacted this on his behalf. He also claimed that the deposit and investment transactions were done via a particular website which had the bank's name on it.

As of a particular date, the website he claimed to have deposited and transacted investments with was no longer accessible. He claimed that his online custody account had a value of €50,000 of which €29,643.55 was in cash.

The service provider rebutted the complainant's claim as unfounded in fact and in law. It claimed that the complainant was never the bank's client and he never held any account with it. It further claimed that the complainant was not known to the bank and that it never had any contact with the complainant until June 2018 when it received his complaint. The bank also claimed that it had nothing to do with the website mentioned by the complainant and that it had never had any relationship with the firm which the complainant claims to have acted as its distributor.

In his decision, the Arbiter concluded that:

1. In his statement, the complainant described how he was approached by a particular firm based in Brussels and Zurich which offered to take over a number of shares in an investment he held. This had to be done through the Maltese bank.

2. He claimed to have opened an account and was able to trade the shares via the bank's portal. Copies of the transactions were submitted by the complainant

in support of his claims. At one point in 2018, the account was no longer accessible.

3. The service provider submitted that it never had any relationship, banking or otherwise, with the firm mentioned by the complainant.

4. The bank also confirmed that the complainant was never a client on any of the bank's platforms. The webpage referred to by the complainant, through which he said he accessed his account with the bank, was not known to it. Moreover, the local bank did not offer the services of securities accounts to its clients.

The Arbiter, after considering all the evidence presented by both parties, accepted the bank's submissions that the complainant never had any relationship with the bank and therefore there was no legal obligation to accede to the complainant's requests.

The decision was not appealed.

A selection of insurance-related complaints

Travel insurance – broker's failure to place cover resulting in lack of compensation (ASF 002/2019 and ASF 003/2019)

COMPLAINTS UPHELD

Cancellation of travel; submission of a medical certificate; broker's obligation to place cover.

The complainants separetely lodged two complaints against an insurance broker and an insurance agency following the rejection of their claim for compensation of unrecoverable travel costs amounting to €930 per claim (which amount was supported by adequate documentation). They claimed under their joint travel policy following the unavoidable cancellation of their planned trip abroad as a result of an emergency hospitalisation.

On its part, the insurance agency contended that it could not entertain any claim from the complainants since there was no insurance policy in force covering the intended travel period.

In his deliberations, the Arbiter noted that:

1. The insurance agent stated that it marketed its travel policy only through the brokers; and this in accordance with predetermined and agreed authorisation terms and conditions, one of which was the submission of medical certification in respect of persons aged over 65 years. There was clearly no juridical relationship between the complainants and the insurance agent; however, this was certainly not the case vis-à-vis the broker.

2. The elderly complainants, both over 65 years, had purchased their insurance policy from the brokers and had duly adhered to its request to submit a medical certificate on a prescribed form, duly completed and signed by their doctor, confirming their fitness to travel.

3. One of the claimants had personally delivered the certificate by hand to the broker. Her friend and traveling companion was similarly required to submit such medical certification which, at the broker's specific invitation, she had returned by post.

4. One of the claimants had a valid and serious medical reason to cancel her intended trip abroad. She had to be hospitalised for two weeks and, at one time, she was even in danger of losing her life. Her travelling companion was reluctant to travel on her own (and also on the advice of her travel agent) and was forced to unavoidably cancel her intended trip abroad.

5. The broker declined to accept the complainants' compensation claim contending that the travelling companion's certificate had not been received in time for the travel policy to be issued, thus precluding the issue of the joint policy that was to cover both of them. The insurance agent in fact contended that the broker concerned had never placed the complainants' travel cover with it.

6. The first claimant had adhered completely to the broker's requirements; and this through the submission of a medical certificate as well as the payment of the premium. The latter had been accepted by the broker which had confirmed that all was in order as far as she was concerned. The broker had accepted the risk and was obliged to place the desired cover with the insurer concerned which it had failed to do.

7. As to the travelling companion, in addition to paying the premium which the insurance agent had accepted, the complainant had scrupulously adhered to the broker's only other requirement; namely, the submission of an alternative medical certificate on a prescribed form (in addition to that already submitted at the outset) confirming her fitness to travel. She was not responsible for any postal delay; such delay was evidenced by the two separately dated postal stamps on the self-addressed envelope. As far as she was concerned, she rightly deemed herself to be fully insured with the broker. The completion of a second certificate was merely for procedural reasons; and this bearing in mind that the first certificate had already confirmed her fitness to travel.

In the light of the foregoing, the Arbiter decided that it would be neither just nor equitable and reasonable for the complainants to be deprived of compensation simply

because the broker had failed to place the required travel insurance cover with the insurance broker.

He therefore ordered the broker to pay the amount of €930 to each of the complainants.

Both decisions were not appealed.

Travel insurance – partial compensation for cancelled trip (ASF 003/2020)

COMPLAINT REJECTED

Principle of "utmost good faith"; late notification of claim; gesture of goodwill; limitation of loss by the insurer; policy conditions.

The complainants disagreed with their provider's partial declinature of their claim for compensation of the total cost of their booked cruise following its unavoidable cancellation due to the emergency hospitalisation of one of them.

They contended that they had provided the insurer with appropriate medical certification proving their inability to travel.

They further contended that the insurer should therefore provide a full compensation (for the amount of €1,500) instead of the partial one (€1,000) it had offered.

On its part, the service provider submitted that:

a) The complainants cancelled their holiday on the same day that one of them was discharged from hospital. They had then submitted the claim under the travel policy nine days later; that is, just three days before their scheduled departure.

b) One of the conditions of their travel insurance policy required the policyholder to notify the insurer "immediately" he / she became aware of any reason(s) for which a journey had to be cancelled or curtailed.

c) The complainants' manifest delay in submitting their claim had prejudiced the insurer's chances of reselling the holiday package, albeit at a discounted price, in order to offset its own costs.

d) Despite the fact that the aforementioned policy condition entitled the insurer to decline the claim (€1,500) in its entirety, it had still offered a partial settlement (€1,000) to the complainants.

In his deliberations, the Arbiter noted that:

1. Other than on the date when one of the complainants had actually visited the offices of the travel agent in order to cancel the cruise, the parties were otherwise in agreement on all the facts of the case.

2. In his view, the two-day variation in such date was a mere detail which had no particular bearing on the issue at stake on which he had to decide. Either way, the complainants would still have had at least a ten-day period at their disposal to notify the insurer of their claim.

3. The insurer was refuting the claim due to late notification; that is, due to a breach of the relevant policy condition. It was not contending that there were insufficient reasons for the cancellation of the planned cruise.

4. There was nothing legally wrong in the inclusion of this condition in the travel policy. However, it had to be interpreted in a just, equitable and reasonable manner and this in accordance with the principle of "*uberrima fides*" (utmost good faith) on which insurance policies are based.

5. The complainants had a valid reason to cancel their cruise. This had been acknowledged by the insurer which had offered to settle their claim, although in a partial manner.

6. It was reasonable for an insurer to seek to limit its financial exposure when settling a claim. It was equally reasonable for a policyholder to assist the insurer concerned in this regard and in this specific case, by notifying it as early as possible of any decision to cancel a planned holiday.

7. The complainants had not explained why they had not notified the insurer of their decision to cancel their cruise on the same day in which they had informed the travel agent about it; that is, at least ten days before their departure. Instead, they had informed the insurer just three days before their scheduled departure.

Therefore, in the light of his considerations, the Arbiter was of the view that the insurer had acted reasonably in offering a partial settlement to the complainants and ordered the service provider to pay the complainants the sum of €1,000.

This decision was not appealed.

Travel insurance – declined compensation for injury (ASF 085/2019)

COMPLAINT REJECTED

Definition of permanent total disablement; policy terms and conditions.

The policyholder lodged a complaint against the provider following its refusal of his claim for compensation in respect of his accidentally injured foot which, he contended, would never recover completely.

However, he stated that the service provider was ready to pay him for travel expenses as per policy.

He requested the Arbiter to award him €20,000 as compensation for his permanently disabled left foot.

On its part, the service provider submitted that:

a) The complainant's claim was filed under the personal accident section of his travel insurance policy. From the medical evidence he submitted, the complainant broke his left ankle in an accidental fall whilst on holiday.

b) The said travel policy section provided compensation in respect of Permanent Total Disablement (PTD), which was specifically defined as: "permanent and total disablement from engaging in or attending any kind of profession or occupation". The injury in question did not fall within such definition.

c) A specific policy condition in respect of PTD compensation required the claimant to be in full-time employment. However, the complainant did not meet such condition since he was a pensioner. He was therefore ineligible to submit his claim.

The Arbiter held that:

1. The complainant had purchased a basic travel insurance policy in exchange for a comparatively low premium. This policy provided reduced compensation benefits. The maximum amount of compensation available for PTD was €5,000. Therefore, the complainant's request of €20,000 was clearly outside the policy limit.

2. The complainant had declined the provider's offer to be compensated the travel expenses incurred due to the premature return from his holiday. This included the airline ticket and the taxi costs.

3. The injury sustained by the complainant resulted in a permanent disability, but of a partial and not of a total nature.

4. Furthermore, the travel policy specifically provided that in order for compensation to be paid by the insurer, the claimant had to be in fill-time employment. The complainant was ineligible under both these policy conditions.

Therefore, in the light of his deliberations, the Arbiter rejected the complaint. Nevertheless, he affirmed that the provider was still bound to compensate the travel expenses incurred by the complainant.

This decision was not appealed.

Health insurance – declined compensation of medical costs (ASF 023/2019)

COMPLAINT PARTIALLY UPHELD

Pre-existing medical condition; lengthy duration of claim processing; compensation for stress.

The policyholder lodged a complaint against the provider following the latter's declinature to pay the cost of an MRI (£347), which procedure had necessarily to be undertaken due to the investigation of his medical condition.

He further requested the Arbiter to award him €2,000 as compensation for the unwarranted stress caused by the provider's lengthy assessment of his claim as well as for its initial refusal to cover the surgery costs relating to the removal of his cancerous left kidney.

The complainant stated that the provider's refusal of his claim was based on its assertion that his medical condition pre-dated his policy. This despite the availability of a scan which showed two healthy kidneys some years before.

On its part, the service provider submitted that:

a) On being informed of the case, it had first authorised only an initial consultation. It had subsequently

requested a GP referral and a consent form on the receipt of which it had requested the claimant's medical history from the GP's surgery.

b) The complainant's assertion that these were provided immediately was incorrect. Quite some time passed before the provider received the documentation and the medical data required.

c) The complainant was informed of the provider's decision about his claim just two working days after its receipt of his medical history.

d) The decision to initially decline the claim was based on the fact that the presented medical history showed that the complainant had already experienced the presence of blood in his urine in 2013 and 2014; and this when his policy incepted in 2018. This was clearly a pre-existing medical condition, which was excluded by the policy.

e) Nevertheless, after referring the case to its chief medical officer, the provider determined that there was no way of knowing conclusively whether the blood symptom related to the benign prostatic hyperplasia or to the bladder cyst that was diagnosed during the medical investigation undertaken by the complainant. It had therefore decided to compensate the complainant for his overall costs, excepting only the cost of the MRI.

f) The provider did not feel that the complainant was due any compensation for stress. It contended that this was a complex case which was actioned promptly as soon as the requested information was received.

In his deliberations, the Arbiter noted that:

1. His Office had meanwhile been informed in writing by the provider that it had agreed to compensate the entire cost of all the medical treatment related to this complaint.

2. The Arbiter was therefore assuming that the disputed cost of the MRI scan was included in such compensation. If this were not the case, the provider was to settle it as well.

3. The Arbiter was faced with conflicting versions as to the time taken by the provider to assess the complainant's claim and whether the duration of such time was justified or not.

4. However, concerning the complainant's request to be compensated for the stress, the Arbiter noted that Article 26(3)(c)(iv) of the Act clearly stipulated the reasons for which he could award compensation. Stress was not one of them.

Therefore, in the light of the facts and his considerations, the Arbiter ordered the provider to integrate the cost of the MRI in the overall compensation it had accepted to pay to the complaint.

However, he decided not to uphold the complainant's claim to be compensated for the stress which he had allegedly sustained.

This decision was not appealed.

Health insurance – provision of compensation after policy's expiry (ASF 042/2019)

COMPLAINT UPHELD

Compensation after policy's expiry; insurer's duty to be fair, reasonable and equitable.

The policyholder complained about the notification received from the provider of its decision to withdraw from the private medical insurance sector in the UK.

The complainant stated that, as a result of this unilateral decision, the insurer would not be providing compensation in respect of any treatment undertaken after the policy's termination. This even if the medical condition requiring such treatment was diagnosed while the policy was regularly in force.

The complainant explained that he required surgery for a shoulder injury. Due to his work commitments, he was unable to undertake this medical procedure before the policy's expiry date.

While admitting that he had still not submitted a formal claim to the provider about his case, he requested the Arbiter to order the insurer to compensate his treatment costs, estimated at between £7,000 and £10,000.

On its part, the service provider contended that:

a) It had decided to withdraw from the UK's private medical insurance market and would no longer be

offering this type of cover. Consequently, it was not offering the renewal of all existing policies once these expired.

b) It could not compensate the cost of any treatment undertaken after a policy's expiry; and this in accordance with the policy terms and conditions which clearly stated that compensation would only be provided for treatment undertaken during the policy period.

c) It would not be collecting any premium once an expired policy was not renewed.

d) Its actions were in accordance with UK insurance practice.

In his deliberations, the Arbiter concluded that:

1. The provider was not refusing to compensate the complainant because a claim was not lodged or was not lodged in time. Rather, it was basing its declinature on the fact that the required treatment was to be undertaken after the policy's expiry.

2. The complainant had not provided detailed information about his condition. For example, the nature of his ailment; how he had been injured; the date of the accident etc … However, this issue had not been raised by the provider.

3. The provider had been quite selective in its referral to the policy. In addition to what had been stated by the insurer, the wording further specified that the "rights to benefits relating to a time prior to the date of termination are unaffected".

4. In interpreting its own policy, it is the duty of an insurance company to abide by the principles of fairness, reasonableness and equity.

5. The medical certification provided by the complainant conclusively proved that his ailment had occurred during the policy period.

6. The wording quoted by the provider applied only to medical conditions which initially materialise after the expiry of a policy; in which case, it would be fair for the insurer concerned to decline the consequent claim since no policy would be in force and no premium would have been collected.

In the light of the foregoing, the Arbiter was of the view that the benefit claimed by the complainant was the direct result of the injury sustained while he was validly insured.

He therefore accepted the complaint and directed that the complainant was to file a formal claim form with the provider. Furthermore, the insurer should handle the claim in accordance with the policy's terms and conditions whilst keeping in mind that any event taking place before the expiry of a policy was insured by it.

This decision was not appealed.

Health insurance – provider's withdrawal from the medical insurance sector (ASF 053/2019)

COMPLAINT REJECTED

Arbiter's competence to handle complaints against insurers "unauthorised" in Malta; twelve-month validity of a policy; mis-selling.

The policyholders complained about the non-renewal of their policy by the provider after just one year that it had been in force. This due to the decision of its principal to withdraw from the private medical insurance sector in the UK.

They contended that, as a result of this unilateral decision, one of the complainants would not be covered in the eventuality of a recurrence of her breast cancer; while the other complainant had to join a twelve-month-long NHS waiting list for an ankle fusion operation.

The complainants admitted that the provider had offered them the possibility of an alternative policy – underwritten by another insurer – in substitution of their non-renewed policy. This was to be inclusive of a guarantee of no additional personal medical exclusions.

However, they highlighted the fact that their monthly premium expenditure for this alternative policy would more than treble when compared to the premium charged by the provider. Hence, such policy was beyond their financial reach, leaving them no other choice but to join very long hospital waiting lists.

The complainants further pointed to the fact that the alternative policy did not envisage an open-ended cover continuation but was based on a five-year moratorium.

They therefore requested the Arbiter to award them compensation of £51,675, which amount was calculated on the annual payment variation between the current provider and the prospective new insurer premiums multiplied for five years.

On its part, the service provider contended that:

a) The decision to withdraw from the UK's private medical insurance market was made only after careful consideration. However, this did not necessarily signify that the complainants were the victims of mis-selling.

b) The key facts document provided to all policyholders, inclusive of the complainants, clearly stated that the policy term was one of twelve months, at the end of which the insurer was not obliged to renew it and had the right to vary its terms and conditions. They further stated that, in case the policy was no longer available, no effort would be spared to offer an alternative one to the policyholder(s) concerned.

c) All contractual obligations under the policy had been respected while this was in force.

d) Furthermore, all policyholders, inclusive of the complainants, had been offered access to an alternative policy placed with another insurer. This included a guarantee that no additional personal medical exclusions would be applied in the "new" policy. However, no guarantee was offered in respect of automatic acceptance nor of the premium to be charged. The persons concerned had to apply for the alternative policy and their premium would be determined in the light of such application.

e) Acceptance of the alternative policy was voluntary on the part of the policyholder.

In his deliberations, the Arbiter noted that:

1. The policy's terms and conditions specified clearly that the policy in question had a twelve-month validity, at the end of which the provider had the option to decide whether to renew it and on what terms. This was not the case of a policy cancellation but of its non-renewal by the provider concerned.

2. The said provider had acted in line with the terms and conditions of the policy. The provider had not breached or failed to honour its obligations under the policy and was within its rights not to renew it after it had expired.

Therefore, the Arbiter rejected the complaint.

This decision was not appealed.

Motor insurance – declined compensation under a comprehensive policy (ASF 079/2019)

COMPLAINT UPHELD

Breach of policy conditions; withholding of material facts; the principle of utmost good faith.

The complainants, in their separate roles as the owner and the driver of the accidented vehicle, complained against the provider's declinature of the claim for compensation under the vehicle's comprehensive motor policy. The insurer was alleging that the damage sustained by the said vehicle would have prevented it from being driven from the accident site to another location, quite far away.

The driver of the vehicle had submitted a sworn statement confirming that the said vehicle was still driveable and that he had actually driven it to such other location (where he resided) after the road accident concerned.

The provider was offering a settlement of €6,500 for the vehicle if the owner opted to retain it; this amount was net of the car's wreck value, set at €1,500 by the provider.

On its part, the service provider contended that:

a) The accidented vehicle had sustained considerable damage after its driver lost control and collided with a crash barrier; and this to the extent that it had been declared a total loss (that is, beyond economical repair) by its surveyor who had inspected it.

b) The vehicle's initial inspection had determined that the serious extent of damage sustained precluded its further driving after the occurrence of the accident concerned. However, this was contradicted by the police accident report which appeared to confirm that the accidented vehicle had not been towed but had actually been driven away from the accident site.

c) The provider had therefore appointed an independent

surveyor to inspect the damaged vehicle once again. His findings had clearly established that it would have been impossible for the seriously damaged vehicle to be driven for such a distance as alleged by the complainants

In his deliberations, the Arbiter noted that:

1. He agreed with the fact that the driver of the vehicle did not have any contractual relationship with the provider; he would therefore be considering solely the complaint submitted by the vehicle's owner. Nevertheless, the driver would be considered as a witness to the accident concerned.

2. The car's driveability was confirmed in the testimony given by a panel beater and a mechanic; the former had stated that he had driven the car himself in order to take it up to the third storey of his garage while the latter had specified that the damaged car could still be driven, but at a speed not exceeding ten kilometres per hour.

3. In his testimony, the provider's representative highlighted the fact that the two surveyors, who had separately inspected the accidented vehicle, had both concurred that it was not driveable. He explained that the claim had been declined due to the breach of the policy conditions; namely, that the vehicle had left the site of the accident whilst the latter had not been reported to the police or to the wardens.

4. The provider had not specified which policy terms had been breached by its policyholder; and this both as regards the alleged withholding of material facts about the accident as well as about the driver's failure to report it to the competent authority.

5. The provider's contention about the accidented vehicle's lack of driveability was contradicted by the testimony of two technical persons who both confirmed the contrary.

6. The said policyholder had no means to verify the veracity of the driver's version since he was not on board the vehicle when the accident happened; he necessarily had to rely on the driver's contention that the vehicle had been driven. His right to obtain compensation should therefore not be prejudiced by such limitation.

7. The policyholder's version of the settlement offer made by the provider was credible; moreover, this appeared to be backed by the provider's own submissions in this case which stated that, if the claim was deemed by the Arbiter to be a valid one, it was prepared to pay its policyholder the amount of €6,200 net of the accidented vehicle's wreck value set at €1,800.

In the light of the foregoing, the Arbiter was of the view that there was no clearly defined reason or basis for which the claim could be declined. The Arbiter was further of the view that both parties appeared to agree that the accidented car's value was €8,000. However, in order to be returned to the same position he was in before the accident, the policyholder could not be required to retain the wreck; such retention (or otherwise) was entirely at his discretion.

One had to bear in mind that the wreck was of no financial value to the complainant. Rather, the provider would be in a comparatively better position to monetise correctly the wreck value through its established connections in the relevant market sector.

Moreover, the provider had initially been prepared to retain the wreck itself; this was evidenced by its garaging of the accidented car at its own premises as well as by its retention of the vehicle's logbook and its spare key. Consequently, the Arbiter ordered the provider to retain the wreck itself whilst paying the amount of €8,000 to its policyholder.

This decision was not appealed.

Life insurance – shortfall in profits' policy maturity value

DIVERSE OUTCOMES

1. COMPLAINT PARTIALLY UPHELD (ASF 001/2019)

Complainant's reasonable and legitimate expectations; use of the term "estimate".

The policyholder filed a complaint about the drastic shortfall in the maturity value of her 22-year Endowment with Profits policy. She contended that, when purchasing the said policy in 1996, she had been informed by the provider's sales representative that its maturity value was to be Lm19,280 (equivalent to €44,910). However, when the policy actually matured, the provider offered only €25,039.

The complainant contended that the said representative had never informed her of any risk inherent in the policy over the years of its currency; nor had he ever mentioned the possibility that its maturity value would be inferior to that indicated during the pre-purchase discussions or how such value was being calculated.

She was therefore requesting the Arbiter to award her the amount of €44,910.

On its part, the service provider contended that:

a) The amount of compensation requested by the complainant was entirely based on the quotation issued by the representative to the complainant as a prospective policyholder; the amount was a mere projected estimate which was not guaranteed.

b) Such estimate was based on the investment returns prevalent at the time, as well as on the circumstances prevailing in the investment market. Such returns had considerably reduced over the years that the policy in question was in force.

c) The policy's investment performance could be considered to have been a positive one and this because it had provided a rate of return of 4.25% and such outcome compared quite well with other investment options which were available to the complainant during the currency of the policy.

d) Additionally, the policy in question had provided the complainant with life assurance cover, which benefit was not generally available in savings products of this nature. The payment of such benefit was guaranteed in case of the complainant's death.

In his deliberations, the Arbiter noted that:

1. The manual quotations offered to the complainant by the provider's representative were the only documentation provided to her. These were not qualified by any disclaimer concerning the veracity of the amounts shown. In the absence of a policy document, these figures would naturally stick in her inexperienced mind and would certainly influence her decision about the policy's purchase. The complainant was evidently convinced that, if she honoured her obligation under the policy to regularly pay its annual premium, then she would have received the lucrative maturity value which had been promised by the provider's representative.

2. Other than the aforementioned quotations and the time allowed for her to think about the proposed policy, there was no evidence that the complainant had been provided with suitable and adequate information on which to base her decision about its purchase. The quoted amounts were therefore the crucial point on which the purchase of the policy was based and this because there was nothing else that could instil any doubt in her about the veracity of the maturity value which was being promised and about the possibility of its variation.

3. Despite the use of the term "estimate" by the provider and its representative, without an adequate explanation of its implications and/or without a disclaimer, did not signify that the policy's eventual maturity value could vary by about 50% from the projected amount.

In the light of the foregoing, the Arbiter was of the view that the provider and its representative had not treated the complainant in a just, equitable and reasonable manner, nor had they attained her reasonable and legitimate expectations.

He therefore upheld the complaint and ordered the provider to pay €29,039 to the complainant.

This decision was not appealed.

2. COMPLAINT REJECTED (ASF 005/2019)

Credibility of testimony; exertion of sales pressure.

The policyholders complained about the drastic shortfall in the maturity value of their 20-year Endowment with Profits policy.

They contended that, when purchasing the said policy, they had undertaken to pay an annual premium of Lm500 (€1,165) whereas the insurer concerned had undertaken to provide the amount of Lm25,169 (€58,643) at maturity date of the policy.

The complainants submitted that they had respected their part of the undertaking by regularly paying the required annual premium throughout the 20-year policy term and this even if such payment entailed a financial sacrifice on their part. Furthermore, they had trusted the provider to invest their premiums wisely and in the best manner possible.

However, the service provider was reneging its part of the said undertaking since it was offering only €34,563 as the policy's maturity value.

The complainants were therefore requesting the Arbiter to award them the payment of €58,643.

On its part, the service provider submitted that:

a) The amount of compensation requested by the complainants was entirely based on the separate quotations issued by the insurer and its representative (a bank) to the complainants as prospective policyholders. The amount was a mere projected estimate which was never guaranteed.

b) Such estimate was based on the investment returns prevalent at the time as well as on the provider's performance during the preceding years. This was clearly specified in the documentation issued by the provider and signed by the complainants, thereby acknowledging their understanding and acceptance of its content.

c) The provider had not misguided the complainants at any stage but had provided them with all the data necessary for them to make an informed decision about the purchase of the policy in question, during the currency of which it had not breached any terms agreed with the complainants.

In his deliberations, the Arbiter decided that:

1. There were two conflicting versions: the complainants' allegation that, at point of sale, they were not provided with an explanation, and the explanation of the sales representative who described in detail how the policy had been sold.

2. The Arbiter considered that during the sale of the policy, the complainants were made fully aware of the nature of an endowment policy and were made aware that the figures quoted were not guaranteed. Moreover, the complainants' version of events was inconsistent on several important facts. The provider's version was accepted by the Arbiter, who saw no valid grounds to award compensation.

The Arbiter rejected the complaint.

This decision was not appealed.

3. COMPLAINT REJECTED (ASF 006/2020)

Payment in full and final settlement; acceptance of payment; complainant's ability to understand the implications of such acceptance.

The policyholder complained about the drastic shortfall in the maturity value of her 25-year Endowment with Profits policy. She contended that, when purchasing the said policy, she had been informed by the provider that its maturity value was to be Lm10,425 (equivalent to €24,284). However, when the policy actually matured, the provider offered her only €12,577; that is, just 52% of the amount promised at the policy's purchase stage.

The complainant contended that she had trusted the provider in good faith to invest wisely the premiums she had paid during the 25-year currency of her policy so that the maturity benefit – as promised and agreed – could be attained.

She was therefore requesting the Arbiter to award her the amount of €11,707 representing the difference between the maturity value promised initially and that actually accorded.

On its part, the service provider submitted that it had already paid the said maturity value (€12,577) to the complainant who had accepted this amount and signed a document confirming the acceptance of such payment in full and final settlement and discharging the provider from any further liability under the policy. It also essentially submitted the same contentions as for the previous case.

In his deliberations, the Arbiter noted that:

1. The subject matter of this complaint was the maturity value of the policy in question (€12,577). This had already been paid by the provider to the complainant.

2. In accepting such payment, the complainant had acknowledged that it was being made in full and final settlement and that it discharged the provider from any further liability under the policy in question. This was acknowledged by the complainant through her signature of a document titled "Maturity Instructions" in which she had also provided the bank account in which the maturity proceeds were to be credited.

3. The complainant's payment acceptance had not been conditional, nor had she reserved any right to continue pursuing the provider for the remaining

amount of the improved maturity value which she was pretending to be paid.

4. The complainant held a senior managerial position in the public service. Furthermore, her educational background was of a tertiary level. She was therefore quite able to understand the implications of the "Maturity Instructions" which she voluntarily chose to sign.

5. Through such signature, the complainant had specifically exonerated the provider from any further responsibility under the policy.

The Arbiter decided that there was no further obligation on the insurer's part to provide any additional payment to the complainant and therefore rejected the complaint.

This decision was not appealed.

4. COMPLAINT REJECTED (ASF 187/2018)

Juridical relationship between the complainant and the provider; the broker as the agent of the Insured; basic common principles in the sale of insurance policies.

The complainant lamented the drastic shortfall in the maturity value of his 33-year endowment with profits policy. He contended that, when purchasing the said policy in 1984, he had been informed that its maturity value was to be Lm39,000 (equivalent to €90,854). However, when the policy actually matured, the provider offered only €18,687.

The complainant stated that he was only 22 years old when he purchased the policy in question; he contended that the lucrative maturity value promised to him was the main reason why he had opted for such purchase and to undertake the respective onerous premium payment over a 33-year period. He further contended that he would not have purchased the policy had he been aware that it would have delivered such a miserly return as was being offered.

He was therefore requesting the Arbiter to award him the amount of €90,854.

On its part, the service provider contended that:

a) It was not the lawful interlocutor of the complainant on this case; and this because the policy in question had been sold to him by an insurance broker. The latter was not its agent or representative but the agent of the complainant. Hence, any information provided by the broker to the complainant could not be considered to have been delivered by the provider. The provider could not be held responsible for the broker's actions and/or omissions. Its relationship with the complainant was regulated by the policy terms and conditions as well as by the proposal form. Therefore, the complaint should have been more properly directed against the broker concerned.

b) The amount of compensation being sought by the complainant was incorrect and unrealistic; and this for the following reasons:

   i. The "Illustration Table" issued by its principal (of which the broker had a copy) to gauge the estimated maturity value of a policy showed that the projected maturity value was €31,866 and not €90,854 as was being claimed by the complainant.

   ii. The table made use of the terms 'estimated' and 'illustration'. Hence, any amount derived from it was merely a projection based on the rates of return prevailing at the time. This could not be guaranteed since it depended on the performance of the underlying investment(s). Such performance had deteriorated over time; in fact, the bonus rates had started decreasing from 1991 onwards.

c) The complainant had not submitted any documentary evidence to substantiate the maturity value allegedly promised to him by the broker concerned.

d) The policy in question was not a complex one, and this particularly for the complainant who was professionally involved in the local insurance industry and was actually employed with the broker concerned when he purchased the policy in question. He should therefore have been aware that the estimated maturity value indicated to him was incorrect.

In his deliberations, the Arbiter concluded:

1) The provider did indeed have a juridical relationship with the complainant, with whom it was contractually bound through its policy and the respective proposal form which is deemed to be an integral part of it. The broker had served to bring the complainant and the provider together so that an insurance contract could be concluded between them. Furthermore, it was the provider which would have the final and definite say in the amount that would be paid to the complainant as maturity value.

2) According to the provider's own Illustration Table, the policy's correct estimated maturity value was €31,866 and not €90,854 as was being alleged by the complainant. According to the provider, the complainant may have mistakenly integrated the benefit potentially payable under the convertible term component of the policy (€58,234) in its estimated maturity value; this would have resulted in a total (erroneous) benefit of €90,100.

3) The complainant's employment in the insurance sector, at the time of the policy's purchase, signified that he should have been aware of the product he was purchasing. If not, he should have been able to ask all the relevant questions and request the respective documentation so as to elicit the required information.

4) The complainant contended that his work experience centred on marine and not on life insurance. However, though different in their scope, the sale of both policies envisaged the respect of basic and mutually common principles such as the provision of a policy document and its schedule as well as copies of the documents signed by the proposer.

5) The complainant was experienced enough to know that the illustrative amounts quoted to him were not guaranteed but merely estimates of potential future maturity values. His involvement and knowledge of the insurance sector signified that he could not be considered as an average retail client who might not necessarily appreciate the implications of what he was purchasing.

6) The complainant had not provided conclusive proof that the broker and the provider had breached their respective duties in his regard.

The complaint was therefore rejected.

This decision was not appealed.

Pet insurance – compensation for veterinary treatment costs (ASF 092/2019)

COMPLAINT UPHELD

Relation between policy conditions and exclusions; test of reasonableness when interpreting a policy; insurance terms must be interpreted fairly, equitably and reasonably; insurer should not easily avoid a claim.

The policyholders complained about the refusal of two claims for compensation of the costs incurred in respect of the treatment, including hospitalisation, required by their pet puppy as a result of breathing problems.

The first claim was in respect of pneumonia with the relative treatment costing £554.80; the second claim was in respect of lungworm, with the respective treatment costing £652.39, hence £1,207.19 in all. The complainants contended that the insurer concerned did not explain its refusal of the treatment cost for pneumonia by the veterinarians and appeared to claim that other veterinarians did not prescribe the proper treatment for lungworm.

The latter claim was denied by a letter issued by the clinical director of the complainants' vet confirming that the best veterinary practice was always followed in the treatment given. The complainants further insisted that the mentioned veterinary practices, which they consulted in good faith, were reputable entities with wide experience in puppy treatment.

On its part, the insurer contended that, prior to declining the claims, it had appointed a vet to review the two cases who advised that:

a) The treatment given, through the administration of a particular type of vaccine, was incorrect. The dosage should have been administered at a four-weekly interval instead of seven weeks, as had been the case.

b) The clinical symptoms evidenced by the puppy, when initially examined, could be indicative of pneumonia but were equally consistent with lungworm. The vets opted for the former diagnosis without carrying out a test for the latter.

c) The complainants had referred their pet for a second professional opinion since its condition had not improved and had lungworm all along.

d) The two claims had been refuted due to a specific policy exclusion stating that no cover was in force for *"Illnesses that your pet should be vaccinated against or where your pet has not been wormed or de-flead, including but not limited to lungworm"*.

In his deliberations, the Arbiter noted that:

1. The versions provided by the separate vets appointed by the complainants and the service provider

were sometimes conflicting. Nevertheless, this did not exonerate a vet from taking all the necessary precautions to avert this disease.

2. The complainants acted prudently and responsibly throughout, taking their pet to a licenced and reputable vet whenever it was unwell. It was then up to the vet concerned to diagnose the pet's ailment and to administer the required treatment for its cure.

3. The aforementioned policy exclusion cited by the insurer had to be read in the context of the said policy which requires the policyholder to ensure that the pet is vaccinated and wormed, with vaccinations being kept up to date.

4. If the two vets, both professionals, could not agree on the administration frequency of the medication, the insurer could not reasonably expect the complainants to be knowledgeable about the necessary treatment to be administered and the frequency of such administration.

5. The vet appointed by the insurer was unsure whether the seven-week administration of the vaccine, instead of a four-week interval, actually caused the pet to contract lungworm, stating only that this was a possibility.

6. There was no conclusive proof that the vets chosen by the complainants had not followed the correct procedures. Rather, there was only a doubt which was based on a mere possibility.

The Arbiter concluded that the service provider did not provide enough proof that it had acted fairly and reasonably in refuting the claim. Therefore, the Arbiter upheld the complaint and ordered the provider to pay £1,207.19 to the complainants.

This decision was not appealed.

Pet insurance – refusal of a claim for veterinary treatment (ASF 050/2020)

COMPLAINT UPHELD

Pre-existing condition; gesture of goodwill; insurer's responsibility to provide adequate reasons for the declinature of a claim.

The policyholder complained about the provider's declinature of his claim for compensation in respect of the cost incurred in the treatment of his dog for allergies it had suffered. The refusal was based on the insurer's view that the said allergies pre-dated the start of the policy cover. Yet this view was contradicted by the complainant's vet.

The complainant further submitted that a staff member at the provider's office, who was not a vet and had not examined the dog, could not properly decide on the case. He therefore requested the Arbiter to order the provider to reimburse him for the veterinary costs incurred amount to £1,349.59.

On its part, the service provider contended that:

a) It had declined the claim since the dog had displayed clinical symptoms of the claimed-for condition prior to the policy's inception. Hence, such declinature was in accordance with the policy's terms and conditions.

b) Though its claim assessors had not actually examined the dog, they were experienced and qualified veterinary nurses.

c) The claim had not been submitted within one calendar year, as specifically required by the policy. However, as a gesture of goodwill, this aspect had not been considered in the claim's declinature.

The provider therefore requested the Arbiter to reject the complaint.

The Arbiter noted that:

1. The complainant insisted that he had not been aware of any specific allergy symptoms afflicting his pet when he purchased the policy.

2. The complainant further insisted that, when submitting the claim in question, the veterinary nurse had mistakenly included all the dog's symptoms which predated the start of the policy. This may have led the provider to link these symptoms to the treatment claimed and to deem them pre-existing conditions.

3. This was contradicted by the complainant's vet who wrote to the provider asserting that, in the case under review, the pre-existing symptoms were not related to allergies at all but were symptoms that present themselves occasionally.

4. The provider, without actually examining the dog, had opted to disregard this professional opinion expressed by the vet who had actually examined the animal.

5. The provider's decision to decline the complainant's claim was not based on its gaining first-hand information by examining the dog but merely on its opinion that certain symptoms manifested by the dog prior to the policy's inception were directly related to the allergy treatment that was the subject matter of the claim.

6. The complainant's vet was in a comparatively better position to form a professional opinion because he had actually examined the dog and could therefore reach his conclusion through scientific evidence rather than through assumption. The vet had excluded any pre-existing condition on which the provider's declinature had been based.

7. Under any contract of insurance, the onus is on the insurer to provide adequate proof for the reason(s) behind the refusal of a claim; in the case under review, such proof was lacking.

In the light of the foregoing, the Arbiter accepted the complaint and ordered the provider to pay £1,349.59 to the complainant.

This decision was not appealed.

Home insurance – compensation for cost of alternative accommodation (ASF 031/2020)

COMPLAINT REJECTED

Delay in claim handling; duty of insurer to put the insured in his original position; insured's duty to mitigate his loss and not to profit from it.

The complainant lamented the refusal by the provider to pay him for damage sustained at his residence as a result of a fire. The claim related to the contents and alternative accommodation.

While admitting that he had been paid for the contents, the complainant contended that compensation for alternative accommodation was inadequate.

The complainant was therefore requesting the Arbiter to award him the additional amount of £25,500 (£4,250 monthly for six months). This amount comprised housing, storage and animal accommodation.

On its part, the service provider contended that:

a) The complainant had a composite policy covering the buildings and contents of his residence. Cover for the latter was placed with the provider while cover for the former was placed with a separate insurer.

b) The provider had paid the contents claim and had added £500 as compensation for the delay in the claim's processing and settlement.

c) The complainant had not accepted the buildings insurer's offer to repair his property, contending that this had to be demolished and rebuilt anew. He had taken his case to the UK Financial Services Ombudsman which, however, found in favour of the insurer concerned.

d) The buildings insurer was responsible for the claim for alternative accommodation in the composite policy, in respect of which it had agreed to pay the policy limit of £50,000.

e) Moreover, the complainant was still in alternative accommodation due to his declinature of the buildings insurer's settlement offer. Further delay had accrued since the complainant was seeking planning permission for works beyond repairing the damage caused by the fire.

f) Despite the foregoing, and the fact that there was a single £50,000 limit under the composite policy, the provider had agreed to pay the complainant an additional £25,000; thereby taking the total payment for alternative accommodation to £75,000.

g) It should not pay any further compensation for alternative accommodation costs and it asked the Arbiter to reject the complainant's pretences.

In his deliberations, the Arbiter noted that:

1. The complainant was not disputing the fact that the provider was insuring the contents of his residence and that it had paid for the fire damage to his residential contents and added £500 as compensation for its delay in such settlement. The provider and the

buildings insurer had jointly offered the complainant a compensation of £75,000 covering 18 months' rent for alternative accommodation.

2. The complainant was alleging that the provider had been late in settling his claim. However, when reviewing the case in its entirety, it transpires that much of the time was spent by the complainant in disagreeing with the buildings insurer about its proposed settlement.

3. The provider was not responsible for such delay as it depended on the buildings insurer first reaching agreement with the complainant on the cost of alternative accommodation so that it could then settle its share of such cost.

4. The case was governed by two important insurance principles: namely, that

   - The complainant had to be properly compensated for the loss suffered so that he could be returned to the position he was in before such loss had occurred.

   - The complainant could not take advantage of his loss and/or profit from it; rather, he had a duty to minimise his loss, where possible.

5. The complainant did not expressly deny the provider's contention that he was seeking to carry out works that went beyond the repair of his fire-damaged residential buildings (thereby 'profiting' from his loss). If such works needed planning permission, the time required for such permission to be obtained was not the responsibility of the provider.

6. The £75,000 compensation in respect of the overall cost of alternative accommodation, offered jointly by the buildings insurer and the provider, was reasonable and fair.

7. The provider's version of the case was more convincing.

Therefore, in the light of his deliberations, the Arbiter rejected the complaint.

This decision was not appealed.

A selection of investment-related complaints

Investor misled into investing in a professional investor fund (ASF 126/2018)

COMPLAINT UPHELD

Suitability; access to funds within a short term; wrong customer's categorisation; product due diligence; documents exonerating business from its obligation; preservation of capital; acting in the client's best interest.

The complainant stated that:

a) In November 2016, he sold his house in Ireland and paid a deposit on an apartment in Malta which he agreed to buy off-plan. He had shares that he wanted to transfer and, through an internet search, he became aware of the service provider and subsequently visited their offices in Malta.

b) In January 2017, he was advised by an official of the financial services provider to invest €230,000 in a fund. The fund had the objective to achieve long term capital growth by investing in a portfolio of Traded Life Policies.

c) The investment was made on the clear understanding that his capital would not be at risk and that he would eventually need to have access to his funds to finalise the purchase of his apartment towards the end of 2017. According to the complainant, the provider had informed him that access to the capital invested would be possible within a couple of weeks.

d) In early November 2017, he signed a redemption form for €230,000 and expected that this amount would be transferred to his bank account shortly afterwards. However, the service provider informed him that the fund required three months' notice for redemption and no concession could shorten such period.

e) On redemption, he received only €120,000 as the fund applied a penalty of €110,000. The service provider informed him that the penalty was only applicable when redeeming the fund within the first five years of purchase. The complainant claimed that he had not be informed about this at the time of investing.

f) The complainant insisted that he was totally misled as he was not aware of three important and relevant facts of the fund, that were: the three months' notice provision for redemption; its five-year duration and the redemption penalties during this period.

The service provider countered the complainant's submission and claimed that:

a) It was licensed to provide investment services, but not to provide investment advice. It offered investment services through an online platform. The mere provision of an explanation of the terms of a transaction was not deemed to be advice on the merits thereof.

b) It was the complainant who initiated the investment through the provider and selected the fund from a list that the service provider's official provided him. It submitted that it did not have any control on the performance of the funds, and neither could it alter its subscription/redemption conditions.

c) The complainant did not provide any documentary proof or any evidence of receiving any investment advice.

d) The complainant was categorised as a professional/elective professional client. He was fully responsible for the investment decision made as well as for the recognition and understanding of the risks taken. He had also acknowledged and agreed to the provider's binding documents and client classification documents, available online within the client's profile at any time.

In his decision, the Arbiter deliberated as follows:

1. He expressed reservations as to the complainant's classification as a 'Professional/Elective Professional'. Neither did the Arbiter share the service provider's arguments that it was the client who had selected the fund, who preferred to be classified as a professional investor, or that he was responsible for the investment decision.

2. During the proceedings, it emerged that the complainant had not traded in financial investments

to such an extent as to make him capable of having the knowledge to make investment decisions as a professional investor. The investor only had a few holdings in shares issued by three companies, one of which was a company with which he had worked before he retired.

3. The complainant did not even originally approach the service provider to invest. He just wanted the services of a stockbroker to look after his holdings in three stocks. It was only after the service provider's promise of a return of 4.55% and its offer to invest did the complainant agree to invest in the fund. The complainant did not want to speculate his money or to invest in a particular fund. The service provider was, to say the least, insensitive to the particular needs of the client who wanted to preserve his capital in order to pay for the property he was buying in Malta.

4. The service provider failed to conduct a proper due diligence of the product. At the time the product had been sold to the complainant, it did not have any information on the fund and the official who handled the transaction had not checked the internet for any information available online. Indeed, the official was neither aware of any lock-up period of the fund nor of any applicable redemption penalty. The service provider confirmed knowledge of the lock-up period and the redemption policy when the redemption form was submitted to the fund.

5. The terms of business that were presented during the proceedings were not signed by the complainant but signed only by the service provider, which contractually did not bind the complainant. The complainant categorically denied being shown or receiving an explanation of this document, which was presented by the provider with its reply. The 56-page document was also highly technical, and it would have been impossible for the provider's official to give a detailed and accurate explanation of such a lengthy document.

6. It was also observed that, at the end of the terms of business, the customer was asked to confirm acceptance of the document's content by pressing an "Agree" button. The Arbiter could not see a valid reason why, in the particular circumstances of this case, the complainant was not asked to sign this document since he visited the provider's office personally and was not transacting online.

7. The terms of business documents were only intended to exonerate the service provider from its obligations in case the investment failed, to satisfy the fund investment's criteria and to be in line with the MFSA's licence which limited the service provider's services to professional investors only.

The Arbiter concluded that the service provider should have exercised better judgement as to the type of investment it would suggest to clients. An investment must be suitable to the particular circumstances of the client and meet his/her particular needs.

At the time of the investment, the complainant was 73 years old, and it could hardly be argued that the long-term fund investment was suitable for him.

Moreover, the service provider did not act in the client's best interest. Once the service provider knew that its MFSA licence precluded it from offering an advisory service, it should have declined to suggest and invest the complainant's funds.

It also acted in bad faith when it classified the complainant as a professional investor when he was clearly a retail investor and therefore entitled to special protection as required by law.

For the above-stated reasons, the Arbiter upheld the complaint and ordered the reimbursement of €110,000 in respect of the penalty imposed on the fund's redemption.

The decision was not appealed.

Investment in two complex investment funds (ASF 054/2019)

COMPLAINT REJECTED

Mis-selling; investment in complex investments; suspended investments; investment experience; suitability test; previous investment experience.

The complainant submitted that the service provider had mis-sold her and her late husband two complex investment products, both offshore unregulated bond funds (Fund A and Fund B), and had failed in its professional and fiduciary duties towards both of them. The complainant argued that the service provider had acknowledged that the two funds were only suitable for experienced investors, when in fact both her and her late husband were not. She claimed that

the product documentation had clearly indicated that the two funds were for experienced and sophisticated investors.

She further claimed that her husband, who was the main decision maker, was 83 years old when he had been offered the two funds. She only became aware of the substantive facts of her complaint a few months after his passing.

As a remedy, she requested reimbursement of all her investment losses.

In its reply, the service provider claimed that:

a) The complainant and her late husband had a long-standing professional relationship with the provider going back to more than a decade, apart from the fact that they both had nearly two decades of investment experience.

b) Their first fact-find, compiled by the provider in 2003, showed the spouses' attitude to risk as being balanced/medium risk. Records showed that they had a diverse range of investments including an aggressive portfolio with another provider which was heavily weighted into Asian equities. Their attitude to risk remained the same in a follow-up fact-find compiled in 2014 and they had been investing in complex instruments and experienced investor funds since 2008, with positive returns.

c) Their overall wealth at the time exceeded GBP 1 million. The investment in Fund A represented around 3.5% of their invested wealth (excluding cash and property investments). The fund entered into administration in June 2016 and has been suspended with no set outcome ever since. The complainant and her husband were being kept updated until she elected to write-off the fund in August 2018, thereby waiving any rights to any future payments from the fund.

d) The investment in Fund B, the other investment, represented approximately 8% of their combined wealth (excluding cash and property investments). In November 2015, the fund suspended subscriptions and redemptions, and remained suspended ever since.

e) The provider disclaimed any responsibility.

After dealing with a number of legal pleas including those relating to prescription, the Arbiter observed the following:

1. When the 2014 fact-find was compiled, no capital was invested. However, the document indicated that the complainant and her late husband had gained understanding in complex and experienced/ professional funds over the previous years. The document contained details of both the number of complex instruments invested as well as the names of such investments.

2. The two contested funds were not the only two experienced investor funds that the complainant held, a fact which was not contested by the complainant. Neither was the suitability assessment, in respect of the other experienced investor funds, ever challenged.

3. As regards Fund B, it was evident that the complainant was continuously being updated by the provider as to the fund's restructuring. The fund remained suspended but still had value, according to information that was last made available. The complainant's claim that she suffered a loss is an inconclusive matter and the Arbiter was thus not in a position to decide the extent of such loss, if any.

4. As regards Fund A, such fund was being liquidated and there were little prospect that investors would get their money back.

5. As advice had been given, the provider was required to conduct a suitability assessment in terms of law.

6. The first requisite that needed to be established was whether Fund A met the investment objectives of the client in question. The first fact-find indicated that the complainant and her husband invested for capital growth and their risk profile was consistently shown to be in the medium range. Their investment into the funds was consistent with their objectives.

7. It was not disputed that the complainant and her late husband had accumulated years of experience in investing. The second fact-find provided an indication of the categories of investment products that the complainant and her husband had held with the service provider. Various complex investment funds were mentioned in that fact-find. The investment in the funds was part of a range of other investments that were held by the complainant and her late husband.

The complainant stated that her late husband was in charge of the investments, but she always accompanied him in meetings with the provider. This meant that she was aware of what her husband was doing, and she consented to the investments in question.

8. Lastly, as to financial forbearance, there was sufficient evidence to prove that the complainant and her late husband's portfolio was not insignificant and was able to absorb the loss from their investment in one of the funds which was declared worthless.

On the basis of information as presented, there was no evidence to suggest that the investment in Fund A was not consistent with other investments and portfolio strategies that were pursued by the complainant and her late husband over the years.

The Arbiter rejected the complaint.

The decision was not appealed.

Investment in a fund with high exposure to one single holding (ASF 041/2019)

COMPLAINT UPHELD

Breach of exposure limits in a prospectus; qualified report by the auditors; fund in liquidation; remote possibility for investor to recover initial amount invested.

The complainant claimed that a fund, in which he had invested, had been managed differently from the rules in its prospectus. He claimed that the fund had breached its own investment policy by exceeding the 10% maximum that it could invest in one single holding, as a percentage of the entire fund value.

The complainant further claimed that:

a) The fund had been proposed to him by a friend, who had sold him other investments when he had been employed with another firm. The investment had been proposed to him as a new investment and was thus priced at a nominal level. The fund's investment policy was part of a leaflet which the complainant had been given at the start of the investment.

b) The fund, as had been described to him, was meant to invest in uranium, a potential source of fuel for future power stations. The fund had the potential to increase in value over a span of a few years, was priced nominally and was licensed by the financial regulator.

c) A few years after he invested in 2017, he received a letter stating that the fund would be surrendering its licence. His attempts to contact the fund's directors and the fund manager proved futile.

d) Upon further investigation, he became aware that not only was the fund in breach of its own prospectus, but that the auditors of the fund had also qualified the accounts on the basis of such breach in investment restrictions. It was thus evident that the directors had mismanaged the fund.

e) He requested a refund of his initial investment as a remedy.

The provider rejected the complainant's claims on the grounds that:

a) The exposure to one single investment, amounting to just under 24% in 2016, was the result of market movements. The said investment had been de-listed from an exchange, but was still thinly traded at negligible value. This led the fund to exceed the maximum investment restriction of 10% of its assets. The regulator had been, in fact, informed of such exposure.

b) The necessary risk warnings were included in the fund leaflet and prospectus, and the investor ought therefore to have been aware of such risks.

In his deliberations, the Arbiter made the following observations:

1. The fund was licensed as a retail investor fund with a minimum subscription of €5000. It aimed to invest in uranium, its mining and the shares of companies that produced it. It was deemed to be high risk. In 2018, a resolution was passed to liquidate the fund. According to the liquidator, investors in the fund were likely to receive up to 10% of the value of their investment.

2. The person who had sold the fund to the complainant had been appointed a director of the same fund a few days before he offered it to the complainant.

3. The service provider confirmed that, as regards one specific holding, the fund's investment in shares of a particular company had constituted 24% of its asset value, when the limit was 10%.

4. The shares of the company, in which the fund was exposed to beyond the maximum 10% limit, were illiquid. As a result, the auditors of the fund were unable to establish a fair value for such holding. The breach of the 10% investment restriction had been constantly flagged by the auditor, investment management and custodian reports from 2014 and in subsequent years.

5. The investment leaflet handed to the complainant contained the fund's investment policy and it was evident that the fund had digressed from such policy. It was also evident that the management of the fund did not reflect its investment policy and the prospectus and that the breaches to the investment restrictions were already prevalent at the time the fund had been sold to the investor, and this without his knowledge.

On this basis, the complaint was upheld and the Arbiter ordered the fund to pay the complainant the full amount invested as there was no certainty he would receive even a partial value of his investment following liquidation.

The decision was not appealed.

Losses allegedly sustained on a portfolio of investments (ASF 172/2017)

COMPLAINT REJECTED

Execution only; discretionary portfolio management; high risk investments; capital growth; risk and return; suitability, knowledge and experience.

The complainant, a medical professional and tertiary education lecturer, complained that his portfolio of investments had suffered losses as his service provider had failed to deliver a professional service. He claimed that the service provider had terminated its relationship with him in early 2017 after 13 years of custom.

The complainant further explained that:

a) Between 2005 and 2009, securities comprised in his portfolio with the provider were transacted on 'execution only' basis. From 2010, he had entered into an agreement with the provider to manage the portfolio on a discretionary basis.

b) From 2011 up to the date of termination of service, investments comprised in the portfolio were losing value, some of which had collectively lost half of their value as compared to 2010. He attributed such losses to the provider's recklessness and failure to abide by rules and policies relating to how investors' portfolios should be managed.

c) In addition, over this period, the provider failed to supply him with information as to how his investments were being managed or why his investments were falling in value

In his original complaint, the investor claimed compensation of €800,000 for losses suffered between 2010 and 2016 during which time the portfolio was being invested on a discretionary basis. During the case review, the investor revised this amount to USD508,925 and €28,234.

The provider rejected the investor's claim that it had been negligent or reckless in managing his portfolio. It claimed that:

a) It was the investor himself who used to identify securities in which to invest his portfolio, a process which he used to pursue even before he transferred a portfolio from another firm to the provider in 2004.

b) The portfolio was largely composed of high yield bonds. When the portfolio was transferred, the investor continued to administer his portfolio on an execution only basis even after it was appointed to administer the portfolio on a discretionary basis.

c) The investor had been its client for 13 years and had been investing on the international markets even before transferring his portfolio to the provider.

d) The investor signed up for a discretionary portfolio management service in 2010. In 2015, another discretionary portfolio agreement was signed, in which the portfolio he had been managing on execution only basis was wholly transferred to allow the provider to administer it itself.

e) Between 2010 and 2016, the complainant had invested in 230 different high yielding bonds, 5 bond

funds and 6 local investments. This amounted to 901 purchase and 470 sale transactions. Between 2010 and 2016, the complainant earned a total return of €425,400 from the portfolio he held with the provider. In 2017, he transferred his portfolio to another financial provider after it had terminated its service agreement with the complainant.

The Arbiter analysed the voluminous documentation that was submitted during this case's hearings. In his lengthy deliberations, he observed the following:

1. According to the account opening forms that the provider compiled in 2004 to provide execution only services, the investor's attitude to risk was denoted as high. Capital growth was indicated as the preferred investment policy.

2. In August 2020, a discretionary portfolio service agreement was signed between the investor and the provider, for the latter to administer his portfolio. A further discretionary agreement was signed in September 2016. The contents of the two agreements were essentially quite similar in nature. When the two agreements were terminated in January 2017, a new account opening form was signed, and the provider agreed to provide an execution only service to the investor. The investor's risk category was indicated as 'High Risk (Aggressive)' with income from investments as the preferred investment policy.

3. Various valuation statements of the investor's portfolio were presented, including those relating to when the portfolio was held with a previous provider. During the period when the investor carried out investment transactions on an execution only basis (2004 to 2010), the complainant had invested in 119 different bonds through 400 transactions. The portfolio included emerging market bonds and exposure to several exotic currencies. Valuation statements during the time the portfolio was administered on a discretionary basis showed holdings in high yield bonds (at times varying between 5 to 13% in coupon interest), denominated in the three main currencies (GBP, USD and GP) but at times also in other currencies. Some bonds were issued by emerging markets.

4. With his final note of submission, the complainant submitted a list of securities, indicated as bonds, that he had selected for compensation purposes. The choice of bonds comprising this list were based on criteria which he himself had determined. The list was made up of securities that were purchased from 2010 onwards and sold during subsequent years up to the end of 2016. The amount of compensation that the investor sought was less than the actual loss sustained as the investor applied a further 20% reduction 'to make good for market movement'. The resultant loss on these bonds, after therefore applying an "80% cost" criterium, totalled USD508,925 and € 28,234.

5. The provider, on the other hand, argued that the investor earned €425,000 between 2010 and 2016, or 4.2% a year. These figures were not contested by the investor. Furthermore, even if one were to apply such 'Total Gain/(Loss) on 80% Cost' criterium, the investor would still have earned USD303,236 and lost EUR22,160 after considering the amount of interest earned from such securities.

6. The investment lists as submitted had various shortcomings. The list prepared by the investor excluded interest distributed by each security and securities that were purchased and sold during the same period on which the investor earned capital gains and/or interest, and which also formed part of the same portfolio. In addition, the investor did not contest other key figures which were presented by the provider, such as the amount of interest generated by the portfolio, which amounted to just over one million euro, or withdrawals from capital by the investor amounting to just under €550,000.

7. To the claim that was made by the complainant that the total earnings figure should exclude gains from investments that had been made on execution only, the Arbiter observed that part of the portfolio that was managed on a discretionary basis had originally comprised securities bought by the investor himself. Thus, such securities could not be disregarded from such computation. The investor should have calculated and shown the losses he allegedly sustained by taking into account not only interest earned and capital lost for all securities that he had selected himself, but also earnings, gains and losses from the other investments that formed part of the same portfolio that were subject to discretionary management during the period of the alleged shortcomings.

8. It was also observed that, in his submissions, the investor claimed to have suffered losses on individual investments whilst in others he claimed that earnings were not sufficient.

The Arbiter established that the investor had not proven his alleged losses. On this basis, the Arbiter was unable to provide a compensatory remedy.

As to suitability, it was evident that the investor had knowledge and experience in investing as, for a long time, he carried out transactions in investments of the same nature and risk that formed part of his portfolio. This apart from risky investment positions he took when he self-managed his portfolio on execution only before it started being managed on a discretionary basis by the provider. The frequency and substantial amounts transacted were such that the complainant was thus deemed to be sufficiently knowledgeable to understand certain responsibilities, terms and conditions for which he ultimately signed.

The complaint was rejected.

The Arbiter's decision has been appealed.

Investment in a capital guaranteed product (ASF 163/2018)

COMPLAINT UPHELD

Investment advice; investment product covered by an irrevocable capital guarantee; failure of the guarantor; provision of information; investment under nominee; requirement to conduct a suitability test; lack of suitability; product review.

This case relates to an investment made by the complainant which had been offered to him on the basis that it was secure, to the extent that the capital invested was being guaranteed. Such promises were made to him by the provider, both verbally and in writing, before the investment.

The complainant was also told that the investment conformed to his low-to-medium risk categorisation. The complainant explained that he was told that capital had to be repaid after a year from the date of his investment, that is in August 2016, together with a coupon of 4%. This was an important element in the complainant's purchase decision as he wanted access to his capital to enable him pay for newly acquired property.

However, the repayment of capital never materialised when the investment matured. A few months later, he was informed by the provider that the guarantor had reneged on its promise to honour its repayment guarantee. He was also informed that legal action was being pursued against the guarantor. It then transpired that the latter was being liquidated. He had learnt about this through the internet and not because the provider had informed him of such an important development.

The provider rejected the complaint on the following basis:

a) The complainant was a professional, had the capacity to read and understand the documentation, had a certain level of knowledge and experience in financial services, and the decision to invest was made solely by him.

b) The investment was covered by an on-demand irrevocable capital guarantee issued by an insurance company whereby, in the event of default, it would make good if the investment would not be able to repay capital in accordance with the investment's own conditions.

c) The insurance company (the guarantor) held a BBB rating, considered as investment grade quality. At the time when the investment was made, that rating had even improved to A, was stable and had positive prospects.

d) On the basis of the guarantee and the quality of the guarantor, the inherent risk of the investment had been lowered considerably to the extent that it allowed the provider to deem it as a quasi-cash investment opportunity, given that the investment would mature in the short term and was guaranteed by an A-rated firm.

In his deliberations, the Arbiter observed that the central issue of the complaint related to the information that was provided at the time of the investment, and whether such information was sufficient for the investor to make an informed decision. He further observed that:

1. The customer's professional relationship with the provider dated back to 2012. A client fact-find at the time showed that he wanted income and his risk profile was low-to-medium. At the time, the investor was familiar with term deposits and he was seeking a non-discretionary/advisory service.

2. He also held some holdings in shares and bonds issued by locally listed companies and units in collective investment schemes.

3. At the time of the investment, the investor wanted his funds to be secure as he had impending financial commitments which he had to honour without delay. The service provider was aware of this requirement.

4. The investor was offered three investment choices, and this was done via email, with their explanation provided telephonically. The first two options were deposits in local banks and the third was the investment on which the complaint was being made, offering a coupon of 4% and maturing in a year's time.

5. On multiple occasions, the investor asserted that he had been given reassurances that capital was guaranteed. However, he was never provided with information or documentation regarding the investment. Neither was he provided with information about the guarantee and the company which was offering it. He was only presented with a purchase contract note, which he presented with his complaint form.

6. It transpired, from documents issued by the issuing company, that the investment was purchased under nominee and the name of the provider featured as the investor. The total amount invested amounted to €1,800,000. This indicated that the provider gathered funds from different investors, including the complainant, and invested the whole amount in its own name.

7. Although the final terms of the investment were presented, the document did not specifically include details as to how the investment would have been operated. During hearings, officials of the provider provided contradictory information as to how the funds in the investment were to be employed.

8. The investor relied on the explanation that he was given in writing that the investment was 'capital guaranteed'. For an investor that always invested in bonds and shares on the local stock market, there were no grounds to doubt or to give an alternative meaning to the term 'capital guaranteed'.

9. As the service provided was an advisory one, the provider was obliged to conduct a suitability test to assess the complainant's investment objectives, knowledge and experience as well as financial forbearance.

10. The investor did not have the knowledge and experience to understand the product's inherent risk and its characteristics, bearing in mind that he was only familiar with low risk investments and bank deposits. The fact that he was an architect by profession did not imply that the investor was able to understand the product's characteristics; and this apart from the fact that he was not given a copy of the product documentation prior to the investment's purchase.

11. As to the investment objectives, it was evident that the investor was after the preservation of capital, so much so that he had a considerable sum in a bank account and was aware that the amount was only guaranteed up to €100,000. Indeed, he urged the provider to reduce his exposure to such bank and relocate the excess amount (over €100,000) elsewhere.

12. Although the amount invested into the fund was €50,000, given the substantial amounts held with banks, the third requisite (financial forbearance) appears to have been met. That stated, however, the provider could not lose sight of the two other requisites (investment objective and knowledge and experience).

13. The provider failed to submit evidence that it conducted a suitability test prior to recommending this investment to the complainant. If such a test had been carried out, it would have evidenced that this investment would not have been deemed suitable for the complainant as he would not have met all the three requisites of the suitability test.

14. Not only did the provider fail to conduct a suitability test, as it was obliged to do, but it had also failed to carry out a proper due diligence test of the investment and its underlying assets.

The provider, as an expert in financial services, failed to exercise proper diligence as expected of it and this led to the losses suffered by the complainant. The provider relied on the guarantee which, as explained above, was not sufficiently robust.

The Arbiter upheld the complaint and ordered the provider to repay the capital, less any interest, to the investor.

The decision has been appealed.

Investment in an equity-linked structured note (ASF 045/2018)

COMPLAINTS REJECTED

Unrealised losses; investment advice; investment in an equity-linked structured product; holdings in shares paid in lieu of capital; investment portfolio; premature submission of complaint.

The investors complained that they suffered substantial capital and interest losses following an investment in an equity-linked structured note which had an autocall option. They claimed that:

a) In September 2011, the service provider had advised them to invest €10,000 and US$23,000 in a product with a three-year duration. The product was structured in such a way that, if the market performance of the underlying investments was poor, the investment would have been left to mature in an effort to break the 50% barrier established in its terms and conditions, with the investor receiving the minimum capital possible.

b) On the other hand, if the market performance of the underlying investments was good, the issuer would have had the option to repay the capital back on specific observation dates before the product's maturity and, in this case, the issuer would choose to pay back the capital invested after only a few months.

c) The provider had advised them to re-invest proceeds in a similar product and in May 2012, they invested €102,000 and US$35,000. They claimed that they had no reason to doubt such advice as the previous investment had paid interest and capital after six months and it never occurred to them that the product had a number of inherent risks.

d) Shortly after the commencement of their investment in May 2012, the product took a downturn as one of the underlying investments (shares in a gold mining company) fell in value and ended up being the worst performer of the underlying holdings. Unlike the previous product, the product issuer did not recall the product early but left it to mature until May 2015.

e) In April 2013, the provider notified them that no interest would be paid that year as one of the equities in the underlying basket had breached the 50% barrier and this by reference to the same equity. The same happened in 2014.

f) On maturity, the investors were paid shares issued by the worst performer rather than the repayment of capital. In 2015, they were informed that they had been allocated 2,677 ordinary shares for their holdings in euro and 863 ordinary shares for their dollar-denominated investment. A valuation, received soon after their holdings in equity were allocated, showed that they suffered a capital loss of 74%, apart from foregone interest.

g) Upon receiving the valuation in July 2015, they lodged a complaint with the provider. They claimed that because of its complex nature, the product should not have been offered to them. They also contested the fact that the product had been offered to them as an Execution Only transaction and this without being afforded an explanation as to the nature of the transaction.

As a remedy, they asked the provider to reinstate them to their original position, and also to receive interest at a reasonable rate for the whole period they had been deprived of such return.

In its reply, the provider contested the complainants' claims on various legal and substantive grounds. It claimed that the Arbiter lacked jurisdiction to look into the complaint, that the Arbiter lacked competence to apply provisions from the Consumer Affairs Act (Chapter 378 of the Laws of Malta), and that the complaint was time-barred in terms of Article 2153 of Chapter 16 of the Laws of Malta, which envisages a two-year prescription period. The provider also claimed that that the complainants' claims for losses had been made prematurely.

In his deliberations on this case, the Arbiter made a number of considerations.

On prescription, the Arbiter quoted from previous decisions which were also confirmed by the Court

of Appeal. The Arbiter affirmed that there existed a contractual relationship between the parties as the provider gave advice and sold financial products to the complainants. Thus, the two-year prescription period, that the provider quoted and which would have rendered the complaint as time-barred, did not apply.

The Arbiter also quashed the provider's claim that he was unable to apply provisions from Chapter 378 of the Laws of Malta (the Consumer Affairs Act) on the grounds that such competence was vested only in the Consumer Affairs Tribunal and the ordinary Courts. By referring to the provisions of the law that set up his Office, the Arbiter stated that he was allowed to make reference to any applicable laws and guidelines, including those issued by local and European supervisory agencies, as may be the case.

The Arbiter then dealt with a legal plea relating to the untimely submission of the complaint. The provider claimed that the complainants' claims for losses had been made prematurely as the investment in regard to which the complaint had been made was converted to equity holdings as a measure to reduce risk. These shares were, in fact, still being held by the investors through the service provider. Thus, no losses had yet been crystallised, as was being argued by the complainants.

As this legal plea was of particular importance for the outcome of the complaint, the Arbiter deemed it appropriate to focus on this aspect first, prior to further deliberation on other matters. The Arbiter noted the following aspects:

1. The complainants had declared that they had not sold their equity holdings which the product paid in lieu of capital on maturity. Such holdings were still being held by the provider (as nominee). The complainants also claimed that when the service provider was asked whether it was possible to sell the product, the reply was that this was not possible.

2. The provider claimed that the complainants had called a number of times asking for information and clarifications in regard to the product. It further stated that the complainants had also asked for clarification as to the number of shares they were entitled to receive when the product converted the capital into shares. The provider claimed that the complainants knew precisely how the product worked and how much shares they were entitled to receive upon the product's maturity.

3. The product documentation confirmed the complainants' description of the investment's workings. If the level of the least performing underlying investment on the final observation date would have been lower than 50% of the initial spot price, the investor would have received a proportionate number of shares in accordance with a formula as outlined in the documentation. The least performing stock was that of the gold mining company, of which the complainants were allotted proportionate equity holdings.

4. When the product matured, the investors were notified by the provider as to how their holding in the product had been converted into shares, and this for both euro and dollar holdings. The same notification also outlined three options they could pursue. One of the options given was that of redeeming the investment. The provider claimed that, although it had repeatedly informed the complainants of such a possibility, nonetheless they refused to pursue such course of action.

5. The provider also claimed that in December 2013, it had informed the investors that the investment was liquid and that it could be sold at no more than 70c per share, compared to an original cost of 98c per share. The investors did not disclaim the provider's statement.

The Arbiter concluded that ultimately, the equity holdings were still being held, as nominee, by the provider, which was also confirmed by the complainants themselves. Thus, at no point did the complainants prove that they had suffered any real losses. In that regard, the complaint was lodged prematurely and was rejected, but without prejudice to the investors' future rights as applicable.

This decision has not been appealed.

Triple investment in a single high yield bond (ASF 145/2018)

COMPLAINT REJECTED

High yield non-investment grade bonds; execution only transactions; speculative investment strategy; investment portfolio.

Over a one-year period, starting in March 2016, with further investments in September and November 2017,

the complainant invested €31,260 in a bond paying a yearly 8.25% coupon interest. However, in August 2017, the bond issuer declared insolvency and started insolvency proceedings thereafter.

The complainant provided a copy of a declaration, prepared by the manager of the branch where he sought investment services, in which he asserts full responsibility for the investment. The complainant alleged that he was not quite literate and had thought that the document he was asked to sign was necessary to proceed with the investment.

He claimed that the branch manager had failed to explain the document's contents to him. The complainant claimed that it was incumbent on the bank to explain to him that the issuer had declared insolvency and that there was scant hope that the investment would have succeeded The bank, and its employees, had thus acted negligently and had failed to inform him that his money was being placed in a failed investment.

The complainant asked the Arbiter to order the bank to refund him the money he had invested in the bond, with interest and legal fees.

The service provider raised a number of objections to the complaint, as follows:

a) The investor was inclined to invest in high yield non-investment grade bonds with a high coupon rate with a risk to capital invested. Such risk was always repeatedly made known to the investor by the provider, as the investor declares in each transaction order.

b) Furthermore, the investor was willing to invest in volatile or unstable currencies, such as the Turkish Lira. It claimed that the investor had invested around €25,000 equivalent in Turkish Lira, generating exchange income of more than €4,000 (equivalent in Turkish Lira).

c) It further claimed that the complainant held a substantial investment portfolio, earning net income of over €108,000. The investment in the bond could not be isolated from the rest of the portfolio, which reflected the preferred typology of investments, his risk appetite and the net overall position of the portfolio.

d) The service rendered to the investor was Execution Only and it never provided him with financial advice. It was the investor himself who approached the provider in March 2016 requesting the purchase of €30,000 in the bonds. The provider's representatives had informed the investor that the bond issuer was not financially sound and any investment in the company was speculative in nature and of risk to capital. The investor still requested the provider to invest in these bonds, despite the fact that he was provided with a risk warning and signing a declaration to that effect. In December 2016, the investor approached the provider with the intent of purchasing further bonds of the same type, which was at a low price of €85.50. The transaction was not successful, however.

e) In August 2017, the investor again requested the bank to add further holdings of the same bond to his portfolio. The provider forewarned the investor of the risks but still proceeded with investing in the bond at his behest. The transaction was again carried out on an Execution Only basis.

f) Despite the poor performance of the bonds in question, the investor again requested a further investment in the same bonds in October 2017. The transaction was cancelled as a result of a change in price, but the investor attempted again a month later and invested a further €10,000. The investor had earned €3,147.24 in interest from his investment in the said bonds.

The Arbiter, after hearing both the complainant's and the provider's version of events, observed the following:

1. The investor had been investing with the provider since 2013, with a propensity to invest in high risk investments. He did not deny such a claim, so much so that according to a bank official, his portfolio generated an average of €1200 in income a month.

2. Prior to investing in the contested bonds, the investor had already made other investments with the provider. Transactions were made on Execution Only as, according to the bank, it never provided advice on such investments.

3. Although the investor used to be forewarned not to continue investing in the same bonds, even after being informed that the issuer was in a difficult

financial situation, he still persisted in adding more risk to the extent that he was willing to sign declarations to that effect.

4. The declarations signed by the investor, in which he was assuming responsibility for the risk of the investment, were not written in a manner that rendered him unable to understand their contents. He himself declared that when he last purchased bonds in the contested investment, he had done so after being forewarned by the provider that the issuer was in liquidation.

5. The investor was not convincing when claiming of being unaware of the contents of the declaration he was asked to sign. He himself had declared that he was taking a risk when purchasing at a low price with the prospect of selling on price recovery. That showed that the investor had the experience to take an informed decision.

6. The investor failed to provide evidence in support of his claim that the bank and its officials were negligent in their duties for failing to inform him of the risks to invest in a failed bond. It was unfair and unreasonable for the investor to attribute negligence to the bank and its officials, when it was them who provided a good service over the years so much so that he earned good income and continues to use the provider's services.

7. Despite the allegations raised against the provider, and its employees, the investor did not deny that he was still availing himself of the provider's services and persisting in the same strategy of investing in high yield non-investment grade bonds.

The Arbiter was thus unable to find evidence that the provider was negligent in regard to the investor, and rejected the complaint.

The decision has been appealed.

Investment in a complex structured investiment (ASF 436/2016)

COMPLAINT UPHELD

Financial advice, portfolio diversification, complex and high risk investment; exposure to one single investment; knowledge and experience; maximum amount that can be awarded by the Arbiter.

The complaint related to the alleged losses suffered by the complainant on his investment portfolio following investment advice provided by the service provider. The complainant claimed that:

a) He had received investment advice from the provider between November 2005 to December 2011 over an investment portfolio that exceeded £3.5 million.

b) He had no knowledge of financial investments and left every decision completely in the hands of the provider.

c) He had insisted with the provider that his investments were to be safe and secure.

d) As a result of the provider's lack of prudence and diligence, between 2007 to 2010, he suffered substantial losses that could have been avoided.

e) In regard to a particular investment, in which GBP800,000 were invested in 2009, he made a loss of 75% upon maturity. The said investment offered a high potential return and was not a guaranteed product.

The complainant demanded adequate compensation due to the alleged shortcomings.

In its reply, the service provider essentially submitted the following:

a) The action against it was prescribed in terms of Article 2156 of Cap. 16 of the Laws of Malta given that any form of extra-contractual or contractual interaction that could have occurred between the parties and the direct relationships between them occurred much before the decadence of the applicable prescription periods.

b) The complaint and the allegations made by the complainant were frivolous and unfounded as the service provider acted within the applicable regulatory requirements and with the highest level of diligence required at law.

c) The complaint was not justified in that the loss suffered by the complainant was the result of market risk, a risk inherent in every type of financial investment especially when one considers that between 2005 and 2015 there was the greatest

financial crisis experienced in the past hundred years.

In his deliberations, the Arbiter concluded the following:

1. The Arbiter rejected the plea of prescription as raised by the service provider. He noted that Article 2156 of the Civil Code covers different types of prescription under different sub-articles and none of these has been specifically indicated. The Maltese Courts always held that the plea of prescription has to be clearly and specifically indicated as it was not their role to interfere between the parties, and clarify or raise the plea of prescription on their own motion.

2. The complainant explained that his working life was that of a property developer and had no knowledge of investment affairs. According to the fact-find compiled by the provider, the complainant is shown as a private client and had a portfolio of around GBP5 million spread over a number of investments. Attitude to risk was indicated as 'medium' in such fact-find, whilst the investment objective was indicated as 'capital growth'.

3. The complainant's instructions to the provider were that the investments comprising his portfolio should not be high risk. He wanted a decent return either through steady income or an increase in the value of the investment.

4. In regard to the investment in which the complainant lost 75% of the initial capital upon maturity, the Arbiter observed that the said investment was a structured note whose performance was linked to an underlying index. One key feature of this product was that the invested capital was at risk in case of a particular event occurring, such as the fall in value beyond certain specified barriers of the underlying index to which the structured note was linked. The investment was of a speculative and high risk nature reflected in the abnormal high annual coupon rate of 14% offered on this product.

5. The Arbiter observed that the provider had recommended the product on the strength of the high annual coupon and the fact that it provided 50% capital protection at maturity. The emphasis on the latter characteristic was misplaced and inaccurate as such protection was conditional on a number of factors and events occurring. Indeed, the events on which the 'safety net' was based did indeed occur, leading to the substantial losses realised on this product. Such important and crucial qualification was, however, not highlighted and not even mentioned in the provider's recommendation.

6. Apart from this, the investment constituted around a quarter of the portfolio, which exceeded the level of diversification and extent of individual weighting of 5% to 10% to any one single investment product that the provider had originally recommended to the investor.

7. The allegation by the service provider that the complainant had previous experience in structured notes was not proven.

8. The said investment on its own and within the context of the overall portfolio existing at the time, was not reflective of the medium risk attitude of the complainant, given the high risk nature of the investment and the extent of exposure it constituted within the overall portfolio as explained above.

9. The actual loss on the investment was that of GBP611,147, which sum exceeded the maximum limit of €250,000 that can be awarded by the Arbiter in terms of Article 21(3)(a) of the Act.

Although the Arbiter could have concluded his decision at that stage, he made a few other observations on some major investments within the complainants' portfolio. The Arbiter was of the view that the overall portfolio composition was not balanced and reflective of a medium risk attitude given the extent of high exposure to alternative asset classes and individual investments, such as that considered above.

The Arbiter ordered the provider to pay the complainant the sum of €250,000.

The decision was not appealed.

Execution of redemption instructions (ASF 050/2018)

COMPLAINT REJECTED

Structured products; delay for the execution of instructions to the provider; appointment of provisional administrators.

In October 2008, the complainants invested £51,741.28 in a structured investment product that was offered to them by the provider. They explained that, during the first year, they received interest that was due to them from such investment. They further claimed that:

a) In January 2010, they wanted to sell their investment with immediate effect. To that end, they sent a registered letter to the provider asking for their investment to be sold.

b) A few days after they sent the letter, a representative of the provider asked them to confirm whether they still had the intention to sell the investment and the investors confirmed so.

c) The provider failed to execute their instructions and, in fact, four months after their request, the provider informed them that the company that issued the investment product had failed.

d) The provider's failure to execute their instructions lead to substantial losses on their investments. Overall, the investors received £8,209.04 which was a comparatively small part of the amount they originally invested.

The provider rejected the complainants' claim that it failed to execute the complainants' instructions. It contended that it did send the investors' instructions to the product's issuer and thus it should not be held responsible for losses on an investment which it was not administering.

In his deliberations, the Arbiter observed the following:

1. On the one hand, one of the complainants claimed that after sending the instruction letter to the provider, they had been in contact with an official of the provider several times. He had spoken to this official on multiple occasions, and the latter used to tell him that there might be the possibility that the issue would be resolved.

2. Time passed, during which both the complainant and the provider's official continued with such exchanges. After a few years, the former received a letter from the provider stating that the investment was lost and that he would receive only 15% of the amount invested.

3. On the other hand, the provider confirmed it had sent the investors' instructions, including the complainants' January 2010 letter, to the paying agent. The paying agent replied and confirmed that the investment had been suspended from listing and its encashment was thus not possible. The provider had promised to supply further updates on the suspension in due course.

4. The provider claimed that it continued to supply a service to the complainants, so much so that in March 2020, it sent a circular in both English and Maltese to all investors who held the same investment, informing them of the appointment of provisional administrators to administer the suspended investment.

5. Subsequently, in July 2010, the provider again issued a circular to investors with additional information and informed them that part payment of capital and interest would be made.

6. Documented evidence clearly showed that, in February 2021, the service provider had already received a response regarding the investors' request. This therefore meant that the investors' instructions had been executed without delay. There was further evidence that the investors continued to receive regular updates from the provider (other than the partial payment of capital and interest).

On this basis, there was no evidence to suggest that the service provider had been negligent regarding the investors' instructions for the sale of the investment in January 2010.

The complaint was thus rejected.

The decision was not appealed.

A selection of private pension-related complaints

Losses on a retirement scheme (ASF 111/2017)

COMPLAINT PARTIALLY UPHELD

Retirement scheme administrator; trustee; level of diligence and probity required to be exercised by a service provider; bonus paterfamilias; financial advice; portfolio diversification; leveraged structure notes.

In his submissions to the Arbiter, the complainant claimed that he suffered financial loss in his retirement scheme following losses in its investment portfolio that comprised leveraged structured notes in which the scheme had invested on the advice of his investment advisor. The complainant explained that:

a) In March 2014, an application to become a member of the scheme was completed through his investment adviser.

b) The provider, as trustee and administrator of the scheme, failed to act in his best interests and did not comply with applicable procedures in relation to the retirement scheme.

c) The provider accepted the application for membership and the pension transfer into the scheme without checking to confirm whether the investment adviser was qualified to give advice to the complainant on the pension transfer.

d) The provider allowed investments (which were only intended for professional and institutional investors) to be made within the scheme, when such investments were extremely high risk and outside his risk profile as well as not reflective of an agreed benchmark.

e) The said investments consisted of leveraged structured notes that were only available to experienced or institutional investors. The complainant submitted that he did not fall under either of these categories of investors and reiterated that the investments within his portfolio were way outside his risk profile.

f) With respect to the scheme's investments, he had opted for a balance between capital growth and income. Although he was comfortable with a high-risk tolerance and as such was willing to accept a greater level of volatility in order to achieve greater returns, he had selected the FTSE 100 as benchmark. However, the investment adviser placed investment trades without his knowledge into highly leveraged structured notes.

g) The complainant submitted that as part of its responsibilities, the service provider should not have allowed the investments in the leveraged structured notes. He claimed that if such action had been taken, he would not have ended up suffering financial losses from such investments.

h) The complainant claimed that the provider had failed in its duty and responsibility towards him as a member of the scheme due to the indicated shortfalls.

The complainant requested compensation of GBP30,170 being the losses incurred on the underlying leveraged structured notes.

In summary, the service provider submitted that:

a) Its authority in pension arrangements excluded the power to monitor every investment. Its responsibility to observe investments made by the scheme which it administers lay only in the requirement for it to ensure that the investment restrictions in the pension rules are observed. It further argued that it was never in breach of its regulatory obligations.

b) The complaint should have been directed against the complainant's investment adviser as the recommendations in relation to investments comprising the complainant's pension were made solely by the investment adviser and not by the service provider.

c) It should not be liable to pay any of the losses suffered on the investments because there was no connection whatsoever between the loss and its acts or omissions.

In deciding the complaint, the Arbiter made the following observations:

1. The scheme was a trust domiciled and registered in Malta, and subject to Maltese law. According to the trust deed, the scheme was established and maintained solely for the purpose of providing retirement benefits for members in the event of their retirement or, in certain circumstances, for the dependants of members.

2. The provider allowed the complainant to appoint an investment adviser to advise him on the choice of investments as would be undertaken in a typical scenario of a member-directed scheme.

3. The investment objective of the complainant was to achieve balance between capital growth and income, where hedge funds were the only asset class of investments that were excluded. The risk tolerance was indicated as high, meaning that the complainant was very comfortable with risk and willing to accept greater volatility in order to achieve greater returns. The complainant had invested in the past, had knowledge of shares and mutual/managed funds, but not about leveraged structured products and their inherent risk.

4. According to valuation statements submitted as evidence, the five investments complained about were all bought in September 2014. Two of the five investments were sold at a considerable loss within just a few days of being bought, just to be again re-invested in an investment bearing the same name. The remaining three investments were also sold or matured at a loss within 3 months from the date of purchase. The total loss on the investments totalled GBP30,170.

5. The complainant claimed that he was unaware of the investments made by his advisers and was never provided with quarterly valuations as the provider was sending them to his advisers. He was not aware of the holdings in his pension until the appointment of other investment advisers. It was only then that he became aware of the composition of the underlying investments in his portfolio.

6. No term sheets or other product documentation in respect of the investment instruments were presented during the proceedings of this case. The said investments were described by the complainant as leveraged structured notes which were only available to professional and institutional investors. The service provider did not contest the nature of such investments in its submissions.

7. The provider on its part reiterated its position that there were no prohibitions in the regulatory framework for investing in the type of instruments mentioned and that it had fully complied with the applicable regulations.

8. Although the provider was not the entity which delivered the advice to invest in the financial instruments which suffered the losses, it nevertheless had certain obligations to respect in its role of trustee and scheme administrator. The functions and obligations of a trustee and retirement scheme administrator in respect of a retirement plan are important and critical for the proper functioning of such a plan. Such functions and obligations could have a substantial bearing on the operations and activities of the retirement scheme and may affect directly, or indirectly, its performance.

9. The appointment of the investment adviser was chosen by the complainant himself. The provider, on its part, accepted the unregulated investment advisor to provide investment advice to the complainant within the structure of the scheme. The appointment of a regulated advisor would have provided, inter alia, certain comfort regarding the qualifications to provide advice. However, the provider, a regulated entity itself, should have been duly cognisant of this. In the scenario, where an unregulated advisor was allowed to provide investment advice to the complainant, one would reasonably expect the provider, in its role of scheme administrator and trustee, to exercise even more caution and greater prudence in its dealings with such an unregulated party.

10. It was only reasonable to expect the scheme administrator and trustee, as part of its essential and basic obligations and duties in such roles, to have an even higher level of disposition in the probing and querying of the actions of such unregulated party in order to ensure that the interests of the members of the scheme are duly safeguarded and the inherent risks mitigated in such circumstances.

11. The lack of intervention by the provider stands out in the circumstances of this case. It was only

reasonable and proper for the provider to query and challenge transactions on such investments. Querying how transactions in these investments promoted the purpose for which the retirement scheme was created and intervening accordingly was only reasonable, prudent and appropriate, something which the provider had not done.

12. There was a certain lack of diligence by the provider with respect to the investments within the scheme and it did not exercise the diligence expected of a "*bonus paterfamilias*".

13. The inaction and lack of diligence exercised by the provider prevented the losses from being minimised and in a way contributed in part to the losses experienced. Such inaction impinged on the achievement of the scheme's objective.

In view of the fact that the provider had not itself supplied the advice on the failed investment instruments, which advice was provided to the complainant by an unrelated third party, and being cognisant also of other factors relating to the scheme including the extent of investments that were made into the high risk instruments which did not exceed 20% of the complainant's total invested capital at the time, the Arbiter considered it fair, equitable and reasonable to direct the provider to pay GBP10,056.67, representing a third of the loss from the contested investments.

The decision was not appealed.

Refusal to pay out retirement benefits under a retirement scheme (ASF 165/2018)

COMPLAINT REJECTED

Request to withdraw pay-out when reaching the age of 50; QROPS status of a Malta-licensed retirement scheme; abidance to UK and Maltese rules; tax and legal implication if rules are not followed.

This case relates to the complainant not being able to withdraw, at the age of 50, benefits under his personal retirement scheme (the Scheme).

In his submission, the complainant stated that:

a) After accepting the original terms of his personal retirement scheme, there was a change in the age at which the benefits could be taken where such change occurred without his knowledge.

b) He was accepted into the scheme in January 2014, after transferring his UK pension fund into the Scheme. He was already living and working in Malta at the time.

c) When he applied for membership of the scheme, he was able, in terms of the pension legislation in Malta, to undertake a drawdown of 30% tax free lump sum at the age of 50. It was further claimed that this was a major priority for the complainant as he intended to buy property in Malta when reaching that age.

d) In his application form for membership of the scheme, he had indicated that he would have liked to take a tax-free lump sum pension benefit at the age of 50. The provider accepted him as a member of the scheme on that basis, knowing that he wanted to drawdown the benefits at age 50.

e) He would be 50 in June 2019 and explained that when his financial adviser requested the service provider to commence the drawdown procedure, he was notified that, in accordance with updated legislation, he could not take any benefit until age 55.

f) The service provider, as his Retirement Scheme Administrator, did not at any stage inform him that the earliest age that benefit could be taken had increased from age 50 to 55. This had completely ruined his plans with regards to his property purchase in Malta and it was also affecting his health.

g) The complainant requested the service provider to agree to the original terms of the scheme and pay him the benefit at the age of 50 to enable him settle in Malta.

In its reply, the service provider essentially submitted the following:

a) The complainant transferred his UK pension to the scheme in Malta, which became effective on November 2013. On the scheme's application form, it was stated that *'Benefits can be taken at any time between the age of 50 (55 for transfers from the UK) & 70 unless otherwise agreed'*.

b) The document that attested adherence to the

scheme stated that the normal retirement date that would apply to a member would be the last day of the calendar month *"in which the member turns [] or such other date no earlier than age 50 (or 55 in the case of a UK transfer Member in the period from 6 April 2010), not greater than an age established by the Retirement Scheme Laws or by the Authority as shall be agreed between the Retirement Scheme Administrator and each Member"*.

c) Given the complainant's pension consisted of a UK transfer received into the scheme in January 2014, and all documentation signed by the complainant stated that in case of a UK transfer the minimum retirement age was 55, it was inconceivable how the complainant could, in such circumstances, have joined the scheme with the intention to take his tax-free lump sum at age 50.

d) The provider admitted that at the time the complainant had joined the scheme, individuals who were not transferring benefits from a UK scheme could have joined the scheme and expected to receive benefits under the Malta rules at age 50. However, these rules were changed in 2016 and the regulator had clarified that QROPS benefits were to be paid in line with UK HMRC (Her Majesty Revenue & Customs) rules. The provider submitted that the HMRC rules require a minimum retirement age of 55 years, except on grounds of ill health.

e) Other than being required to abide by the rules and conditions issued by the financial regulator in Malta, the scheme had also additional responsibilities in view of the fact that it qualified as a recognised overseas pension scheme and was therefore subject to the rules of the HMRC in the UK.

f) The complainant could not demand the scheme's administrator to contravene the regulations in order to meet his expectations.

In his deliberations, the Arbiter observed that:

1. The financial regulator in Malta had issued and updated a number of pension rules and conditions which explained the manner in which retirement benefits were to be paid, other than in case of death or permanent invalidity of a member. One such condition provided that the commencement of payment of retirement benefits to a scheme member *"may not be made on a date that is earlier than that on which such Member has attained the age of fifty, or not later than that on which the Member attains the age of seventy- five."*

2. Another condition, of particular relevance to the case in question, stated that in respect of UK transfer funds or UK tax-relieved funds *"members shall take benefits in a manner consistent with those provided for under UK Rules provided for under UK Authorised Member payments for pension income under UK legislation."*

3. In its submissions, the service provider referred to the HMRC Pensions Tax Manual, specifically the 'Pension Age Test'. This test set a limit for the earliest age from which benefits could be paid to the member and the scheme retained the ability to meet the requirements to be a QROPS. The said test applied from 6 April 2015, as also specified in the said manual.

4. According to the service provider, save for certain exceptions applicable with respect to serious ill-health, short service refund lump sum, refund of excess contributions and wind-up sums (none of which exceptions the complainant had claimed to qualify under), the HMRC manual clearly stated that a payment may only be made to a member aged under 55 if retiring due to ill-health.

5. The conditions outlined in the HMRC's manual were essential as the condition referred to above requires members to take benefits *'in a manner consistent with those provided for under UK Rules ...'*.

6. A QROP is indeed obliged to meet prescribed requirements, including the 'Pension Age Test' to maintain its status as indicated in the HMRC's Pensions Tax Manual. Withdrawing benefits prematurely and not in conformity with the applicable rules could trigger material tax implications on the respective member and even materially affect the status of a retirement scheme as a QROPS.

7. The Arbiter understood the complainant's position that he genuinely believed, at the time of joining the Scheme, that he could receive the retirement benefits at the age of 50 and the disappointment he felt when this transpired not to be the case. However, a member needs to ultimately follow and be guided by the applicable requirements that evolve over time.

8. The Arbiter considered valid the submissions put forward by the service provider that the scheme was not permitted, in terms of the applicable HMRC requirements, to make payments to the complainant at the age of 50 in the complainant's particular circumstances, and that should such payment be undertaken at that stage it would have adverse implications on the scheme with respect to its status as a QROPS.

9. Moreover, taking into consideration the disclosures in the scheme's documentation as already mentioned, the nature of the contributions made into the scheme which involved a transfer from an existing UK scheme and, ultimately, the applicable MFSA rules and those of the HMRC as outlined in this decision, the Arbiter did not find sufficient and justifiable basis on which he could identify shortcomings on the part of the service provider as alleged by the complainant in his complaint.

The Arbiter accordingly rejected the complaint.

The decision was not appealed.

Administration of a retirement scheme and the trustee's obligations

COLLECTIVE DECISION RELATING TO SIMILAR COMPLAINTS LODGED AGAINST THE SAME FINANCIAL SERVICES PROVIDER

Decision relating to 39 individually filed cases; Retirement scheme administrator; prescription; time frame within which the complainants had to file their claim with the provider; trustee; bonus paterfamilias; financial advice; portfolio diversification; structured products.

COMPLAINT PARTIALLY UPHELD

The OAFS received over 55 complaints against the same financial service provider ("the provider") which were all related to their personal pension scheme. The provider was the Retirement Scheme Administrator (RSA) and Trustee of the scheme. In order to establish the facts of each case and hear the submissions individually, the Arbiter appointed each case for hearing and invited the parties to make their submissions.

After this process, the Arbiter concluded that 39 complaints lodged against the provider were intrinsically similar in nature and consequently were treated collectively in terms of Article 30 of the Act. The purpose behind this provision was to avoid repetition and to offer an opportunity to the Arbiter to decide intrinsically similar cases expediently in the best interests of the parties themselves. Thus, regarding these 39 cases, the Arbiter issued one decision.

As to the remaining cases, the Arbiter determined that such cases had a number of legal and substantive elements that rendered them different from the cases that were to be treated collectively. Each such case was thus treated individually, and a separate decision issued accordingly.

THE CLAIMS MADE BY THE COMPLAINANTS

The complaints were related to a personal retirement scheme which was established in the form of a trust and administered by the provider. Every complainant had a separate investment account in the scheme, each with a diversely invested portfolio.

Essentially, the complainants claimed that they had experienced a loss on their portfolio, which they attributed to the provider not having adequately carried out its duties as RSA and trustee of the scheme and in line with the applicable requirements. The complainants also specifically referred to a particular firm that had given them advice ("the investment advisory firm" or "the adviser") on the underlying investments held in the scheme, which comprised substantial investments in structured notes.

The complainants also mentioned common alleged principal failures against the provider. They claimed that the provider accepted business from an unauthorised investment adviser and allowed an unsuitable portfolio of underlying investments to be created within the scheme that comprised high risk structured products of a non-retail nature. This was not in line with the applicable conditions relating to the portfolio composition and/or with their risk profile.

The complainants requested their respective investment to be restored to its original value.

THE PROVIDER'S REPLY

In its reply, the provider essentially submitted the following:

a) The investment advisory firm was a company registered in Spain. Before it ceased to trade, it provided financial advice to investors in Spain and in France under authority of another firm.

b) The service provider was neither authorised to provide advice nor linked or affiliated in any manner to the investment advisory firm.

c) The investment advisory firm had been appointed by the complainants themselves. In certain instances, the application form for membership of the scheme was signed by the adviser wherein the

adviser confirmed the suitability of the underlying investments and that the investment advice provided was within the investment guidelines.

d) The investment advisory firm had ceased trading in September 2017, which was also when the provider stopped accepting its business. Furthermore, in September and October 2017, emails were sent by the provider to members of the scheme to inform them of the suspension and subsequent termination of business with such advisory firm.

e) The only reason why the complainants had filed a claim against the provider, rather than against the investment advisory firm, was that the latter had ceased operating and trading. It submitted that the proper respondent to this complaint was the investment advisory firm.

f) It neither works on a commission basis nor receives from or pays commissions to any third parties.

g) In those cases where the complainants made specific claims that the provider failed in its duties, the provider replied that it had, at all times, fulfilled all its obligations with respect to the complainants and observed all guidelines, including investment guidelines.

h) With respect to the underlying investments, the provider replied that the investments made were in line with the risk profile of the respective complainant and in line with guidelines applicable at the time of application.

i) In those cases, where it was alleged by a complainant that the provider failed to communicate or explain the fees, or that the fees were high, it submitted that the complainant concerned had, however, agreed to the fee structure and that documents setting out the fees were sent to the complainant/s for signature.

The provider finally submitted that it should not be held responsible for the payment of any amounts claimed by the complainants and insisted that it had always fulfilled all its obligations with respect to all the complainants.

LEGAL PLEAS

Before dealing with aspects relating to the complainants' substantive merits of their case, the Arbiter dealt with submissions made by the provider that a number of complaints were time-barred in terms of two provisions in the Act.

1) Plea relating to Article 21(1)(b) of the Act

Article 21(1)(b) states that: 'An Arbiter shall have the competence to hear complaints in terms of his functions under Article 19(1) in relation to the conduct of a financial service provider which occurred on or after the first of May 2004: Provided that a complaint about conduct which occurred before the entry into force of this Act shall be made by not later than two years from the date when this paragraph comes into force.'

The Arbiter observed that, in a number of cases, the provider took around four months to send the complainants a reply to their formal complaint and provide the required documents. The Arbiter noted that the provider had not submitted a valid reason for such protracted delay; even more so, when the complainants were receiving similar general replies to their formal complaint from the provider.

The Arbiter deemed it as very unprofessional for a provider to procrastinate with its replies and then raise the plea of lack of competence on the pretext that the action was 'time-barred'. It was a long accepted legal principle that no one can rest on his own bad faith, the Arbiter observed.

As to the application of Article 21(1)(b), it was noted that the said article requires that a complaint related to the 'conduct' of the financial service provider which occurred before the entry into force of the Act should be made not later than two years from 18 April 2016, the date when this provision came into force.

The law does not refer to the date when a transaction takes place but refers to the date when the alleged misconduct took place.

Consequently, the Arbiter had to determine whether the conduct complained of took place before 18 April 2016 or after, in accordance with the facts and circumstances of each case.

In the case of a financial investment, the conduct of the service provider could not be determined from the date when the transaction took place. It is for this reason that the legislator departed from such date and laid the emphasis on the date when the conduct took place.

In these cases, the conduct complained of involved the conduct of the provider as trustee and RSA of the scheme, which role the provider occupied when the complainants became members of the scheme and which it continued to maintain beyond the coming into force of the Act.

The Arbiter noted, among other aspects, that the complaints in question related to the conduct of the provider during the period in which the investment advisory firm was permitted (by the provider) to act as the adviser of the complainants. The provider itself had declared that it no longer accepted business from the advisory firm as from September 2017. This implied that the investment advisory firm was still acting as the adviser to the complainants after the coming into force of the Act.

On this basis, the actions related to the scheme could not be considered to have occurred before 18 April 2016 and therefore the plea as based on Article 21(1)(b) could not be upheld.

2) Plea relating to Article 21(1)(c) of the Act

In the same cases, the provider alternatively also raised the plea that Article 21(1)(c) of the Act should apply.

Article 21(1)(c) states: 'An Arbiter shall also have the competence to hear complaints in terms of his functions under Article 19(1) in relation to the conduct of a financial service provider occurring after the coming into force of this Act, if a complaint is registered in writing with the financial services provider not later than two years from the day on which the complainant first had knowledge of the matters complained of.'

In that case, the complainants had two years to complain to the provider 'from the day on which the complainant first had knowledge of the matters complained of'.

The fact that the complainants were sent an Annual Member Statement, as stated by the provider, could not be considered as enabling the complainants to have knowledge about the matters complained of. The Annual Member Statement was a highly generic report which only listed the underlying life assurance policy. It was issued to complainants by the provider with no details of the specific underlying investments held within the respective account, which investments contributed to the losses and were being disputed by the complainants. Hence, the complainants were not in a position to know what investment transactions were actually being carried out within their respective portfolio of investments.

It was also noted that the Annual Member Statement sent to the complainants by the provider included a disclaimer highlighting that certain underlying investments could show a value reflecting an early encashment value or potentially a zero value prior to maturity and that such value did not necessarily reflect the true performance of the underlying assets. Such disclaimer did not reveal much about the actual state of the underlying investments to the complainants, and the whole scenario could not have reasonably enabled them to have knowledge about the matters being complained of.

Many complainants made a formal complaint with the provider between November 2017 and mid-April 2018, and in any case within the two-year period established by the Act.

The provider had not proven that the complainants raised the complaint 'later than two years from the day on which the complainant first had knowledge of the matters complained of'.

This plea was also rejected by the Arbiter.

THE MERITS OF THE COMPLAINT(S)

3) The complainants

The complainants were all British expatriates mainly living on mainland Europe (such as Spain or France) and deemed to be retail clients. They were all diversely accepted into the scheme between 2012 and 2015.

4) The legal framework

The scheme and the provider were subject to specific financial services legislation and regulations issued in Malta, including conditions or pension rules issued by the Maltese financial regulator (MFSA) in terms of the regulatory framework applicable to personal retirement schemes. The application of the Trusts and Trustees Act (Chapter 331 of the Laws of Malta) ('TTA') was also of relevance and application to the provider, even if the service provider did not make any reference to such an important legislative Act in its responses.

5) The Retirement Scheme in respect of which the complaint is being made

The scheme is a trust domiciled in Malta and was granted registration by the MFSA in 2011 and then in 2016, following amendments to the relevant legislation.

The cases in question involve a member-directed personal retirement scheme where the respective member could appoint an investment adviser to advise him respectively on the choice of investments. The assets held in each of the complainants' respective account with the scheme were generally used to acquire a whole-of-life insurance policy for each member.

The premium in each respective policy was in turn invested in a portfolio of investment instruments under the direction of the investment adviser, subsequently processed and accepted by the provider. The underlying investments in the respective portfolio comprised substantial investments in structured notes. For all the complainants, the provider had indicated a loss which excluded fees, thus rendering the actual loss much higher than shown.

6) Investment Adviser

According to notices issued to members of the scheme in September and October 2017, the provider described the investment advisory firm as an authorised representative/agent of a company that was authorised and regulated in Germany. The investment advisory firm was the company's authorised representative in Spain and France.

7) Underlying Investments

During the tenure of the investment advisory firm, the investments respectively undertaken within the life assurance policy of each complainant were at times solely or predominantly held in structured notes.

8) Responsibilities of the provider

One key duty of the RSA emerging from the primary legislation itself was the duty to act in the best interests of the scheme. Furthermore, various general conduct of business rules/standard licence conditions applicable to the provider required the RSA to act with due skill, care and diligence in the best interests of the beneficiaries and to arrange for the scheme's assets to be invested in a prudent manner and in the beneficiaries' best interest.

It was also required to organise and control its affairs in a responsible manner and to have adequate procedures (operational, administrative and financial) and controls in respect of its own business, for the scheme to ensure compliance with regulatory conditions and to enable it to be effectively prepared to manage, reduce and mitigate the risks to which it was exposed. The provider, in its additional capacity as trustee of the scheme, also had duties in terms of the TTA in Malta. As trustee, it was required to act as a *bonus paterfamilias* and was accordingly duty bound to administer the scheme and its assets to high standards of diligence and accountability.

The trustee, having acquired the possession of the scheme in ownership under trust, had to deal with such property as a fiduciary acting exclusively in the interest of the beneficiaries, with honesty, diligence and impartiality.

One other important duty relevant to the complaint in question related to the oversight and monitoring function of the provider in respect of the scheme, and its underlying investments. Although it was not authorised to provide investment advice, it nonetheless retained the power to ultimately decide whether to proceed with an investment or otherwise. The provider had accordingly the final say prior to the placement of a dealing instruction. If the provider deemed the level of diversification to be suitable and the member's entire portfolio to be in line with his attitude to risk and investment guidelines, the dealing instruction would have been placed with the insurance company and the trade executed. The trade instruction would have been rejected if the RSA would not have been satisfied.

KEY CONSIDERATIONS

9) Allegations in relation to fees

In a number of cases, the complainants claimed that fees were not being disclosed, fully explained and/or were high.

The Arbiter found insufficient evidence to uphold such claims. However, by way of a general observation, the Arbiter considered that the trustee and administrator of a retirement scheme had to be sensitive to, and mindful of, the implications and level of fees applicable within the whole structure of a retirement scheme and not just limit consideration to its own fees.

In its role of a *bonus paterfamilias*, the trustee was also expected to ensure that the extent of fees applicable within the whole structure of a retirement scheme was reasonable, justified and overall adequate when considering the purpose of the scheme. Where there

are issues or concerns, these should be reasonably raised with the prospective member or members, as appropriate.

10) The appointment of the Investment Adviser

The Arbiter observed that no evidence of any authorisation or any form of approval issued to the investment advisory firm had been mentioned by the provider. Additionally, neither had this been produced by it during the proceedings of the case. Indeed, no evidence was actually submitted by the provider that the investment advisory firm was regulated. The service provider did not produce any evidence the investment adviser was regulated or authorised by a competent authority to provide advice on investment instruments or investments underlying an insurance policy. Neither was evidence produced of any exemption from licence under the Markets in Financial Instruments Directive (MiFID) or that the investment advisory firm held an authorisation or exemption under any other applicable European legislation for the provision of the contested investment advice.

11) Investment into structured notes

The Arbiter noted that caution was reasonably expected to be exercised with respect to investments in structured products. This was relevant, taking into account the period since the date of registration of the scheme, its nature and specific objectives, and the extensive debates internationally, including reviews by regulatory authorities over the years, on investments in such products.

He observed that the exposure to structured notes allowed within the complainants' respective portfolio was extensive, with the respective insurance policy underlying the scheme being at times fully or predominantly invested into such products. Such excessive exposure to structured products occurred over a long period of time, sometimes even spanning a number of years or even throughout the whole period during which the investment advisory firm was acting as investment adviser.

The Arbiter noted that various fact sheets of structured notes, which featured in the respective portfolio of the complainants, highlighted several risks in respect of the capital invested in these products. Apart from aspects relating to the issuer's credit and liquidity risk, such fact sheets also highlighted risk warnings about the notes not being capital protected and the potential for the investor to receive less than the original amount invested, or potentially even losing the full amount invested.

12) Portfolio not reflective of the MFSA rules

The high exposure to structured products as well as high exposure to single issuers, which was allowed to occur by the service provider in the complainants' respective portfolio, was inconsistent with the regulatory requirements that applied to the scheme at the time. At times, individual exposures to single issuers exceeded the maximum limit applied in the rules (issued by the regulator) to diversified investment instruments, such as collective investment schemes whose performance was not materially impacted or determined by a single underlying asset.

The Arbiter also found evidence of non-compliance with other requirements detailed in the provider's own investment guidelines. This was particularly so with respect to the requirements applicable to the proper diversification, avoidance of excessive exposure and permitted maximum exposure to structured notes and/or single issuers.

Irrespective of whether any of the particular investments indicated had actually yielded a profit, as sometimes justified by the provider in its submissions, the fact that such high exposure to a single counterparty was allowed in the first place indicated lack of prudence and excessive exposure and risks to single counterparties that were allowed to be taken on a general level.

The Arbiter noted that the service provider had, along the years, revised various times the investment restrictions specified in its own 'Investment Guidelines' with respect to structured products, both in regard to maximum exposures to structured products and maximum exposure to single issuers of such products. The exposure to structured notes and their issuers was progressively and substantially reduced over the years in the said guidelines.

Although the provider did not produce any fact sheets of the structured notes that were invested into the respective portfolio, the Arbiter was still able to trace a number of such documents in respect of several structured products which featured in the portfolio of various complainants. Although the Arbiter was unable to verify that all the investments within the complainants' respective portfolio were all targeted for professional investors, the multitude of relevant fact sheets traced by the Arbiter in various portfolios was, in itself, indicative

of a trend taken by the provider in allowing products aimed solely for professional investors to be included in the portfolio of retail clients.
There was a lack of consideration by the provider with respect to the suitability and target investors of the structured notes. The extent of losses experienced on the capital of the complainants' respective portfolios, that was also indicated by the provider itself, was indicative of the failure to adhere with the applicable conditions on diversification and avoidance of excessive exposures. Otherwise, material losses, which are reasonably not expected to occur in a pension product whose scope is to provide for retirement benefits, would not have occurred.

CONCLUDING REMARKS

In bringing his overall deliberation to a close, the Arbiter observed that the complainants ultimately relied on the provider as the scheme's trustee and RSA, as well as other parties within the scheme's structure, to achieve the scope for which the pension arrangement was undertaken; that is, to provide for retirement benefits and also reasonably expect a return to safeguard their pension.

Whilst losses may indeed occur on investments within a portfolio, a properly diversified, balanced and prudent approach, as expected of a pension portfolio, should have mitigated any individual losses and, at the least, maintain rather than substantially reduce the original capital invested.

The Arbiter observed that there was a clear lack of diligence by the service provider in the scheme's general administration, particularly when it came to the dealings and aspects involving the appointed investment adviser, the oversight functions with respect to the scheme and portfolio structure, as well as the reporting to the complainants on their respective underlying portfolio.

The Arbiter also observed that there were various instances which indicated non-compliance by the service provider to applicable requirements and obligations. The service provider had failed to act with the prudence, diligence and attention of a *bonus paterfamilias*.

The Arbiter also considered that the service provider did not meet the reasonable and legitimate expectations of the complainants who had placed their trust in the service provider and others, believing in their professionalism and their duty of care and diligence.

In the light of the foregoing, the Arbiter determined the complaint to be fair, equitable and reasonable in the particular circumstances and substantive merits of the case and accepted it in so far as it was compatible with the decision. However, he observed that cognisance was required to be taken of the responsibilities of other parties involved with the scheme and its underlying investments, particularly, the role and responsibilities of the investment adviser to the respective members of the scheme. Hence, having carefully considered the case in question, the Arbiter considered that the service provider was to be only partially held responsible for the losses incurred.

Being mindful of the key role of the service provider as trustee and RSA, and in view of the identified shortcomings, the Arbiter concluded that the complainants should be compensated by the service provider for part of the net realised losses on their respective pension portfolio.

In the particular circumstances of this case, considering that the service provider held the last word on the investments and acted in its dual role of trustee and RSA, the Arbiter considered it to be fair, equitable and reasonable for the service provider to be held responsible for 70% of the net realised losses sustained by the complainants on their investment portfolio.

The service provider was accordingly directed to pay the respective complainants compensation equivalent to 70% of the sum of the net realised loss incurred within their respective portfolio of underlying investments constituted by the investment advisory firm and allowed by the service provider for each respective complainant.

The Arbiter also provided a detailed explanation as to how such compensation was to be calculated by the service provider.

He also directed the provider to submit a full and transparent breakdown of the compensation calculations to each complainant.

The decision has been appealed.

Annex 1 - Enquiries and minor cases' statistics

Figure 1 - Enquiries and minor cases (by sector)

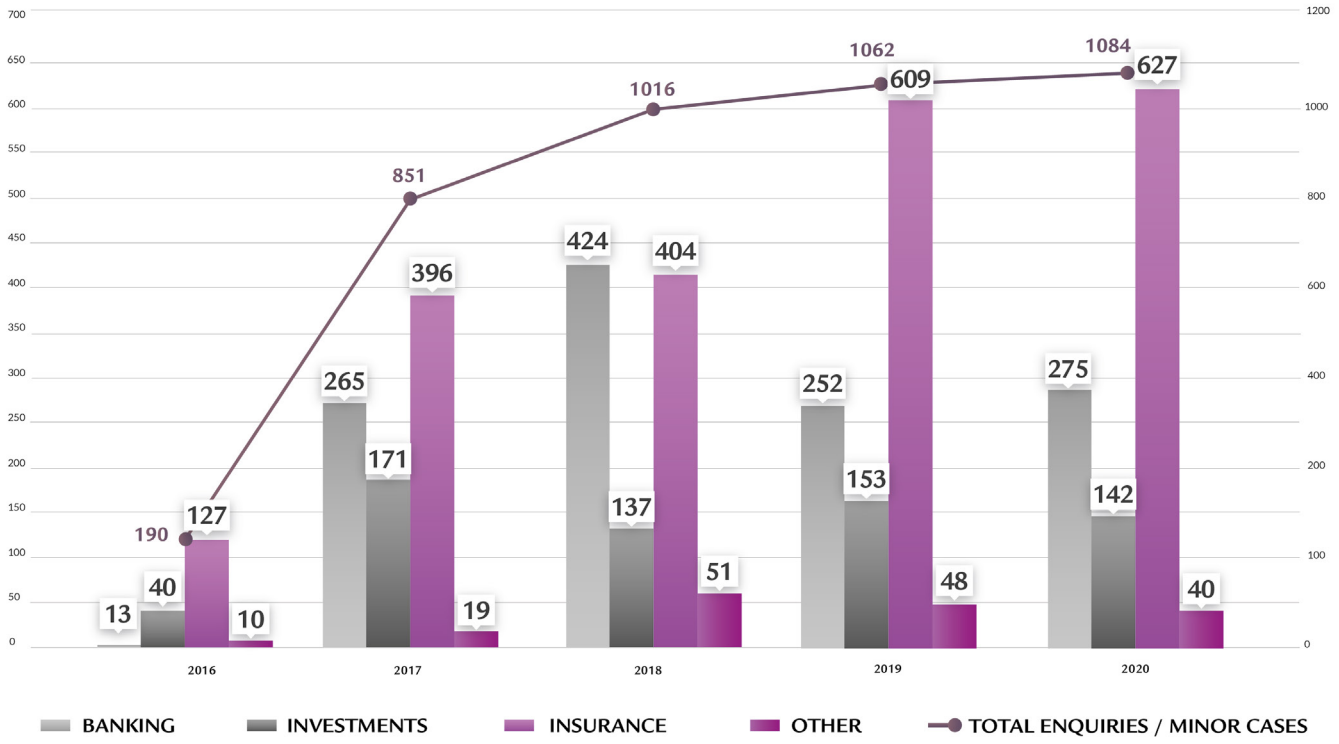


Figure 2 - Enquiries and minor cases in 2020 (by origination)

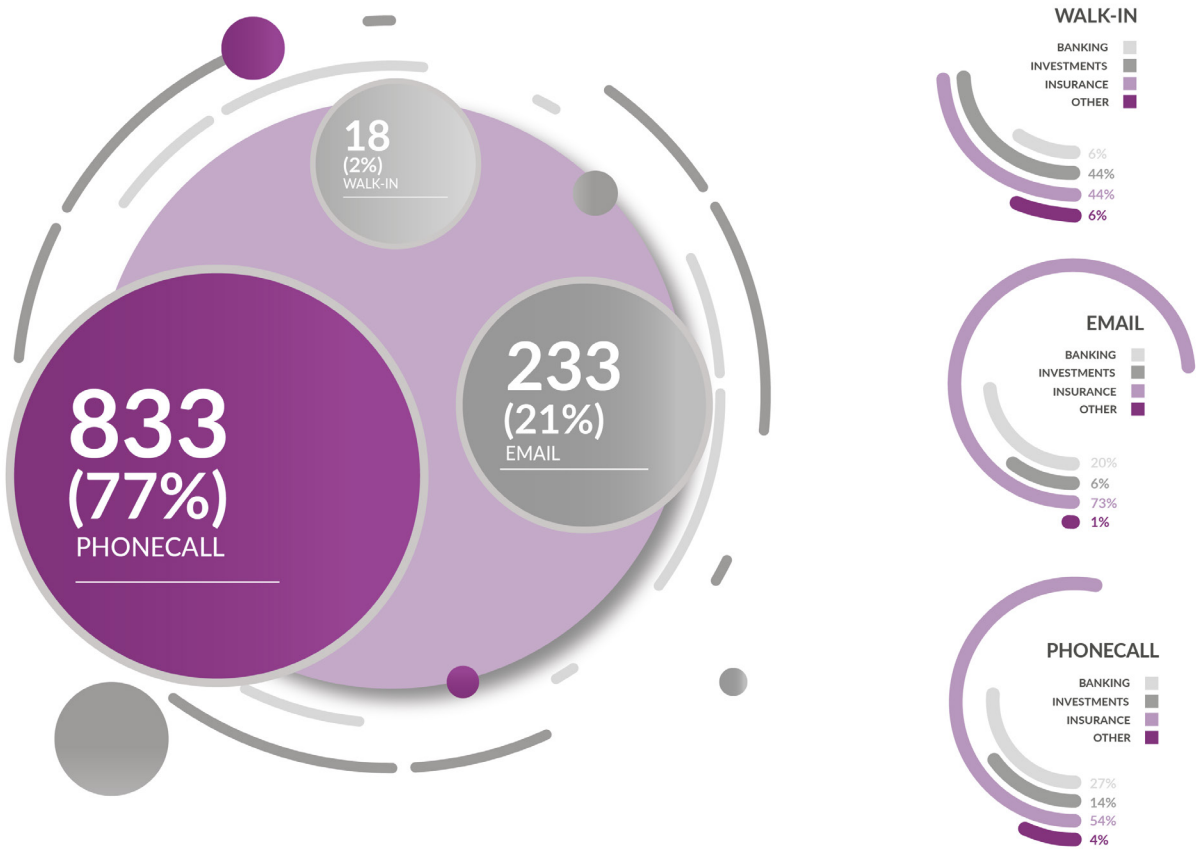


Figure 3 - Enquiries and minor cases in 2020 (by outcome)

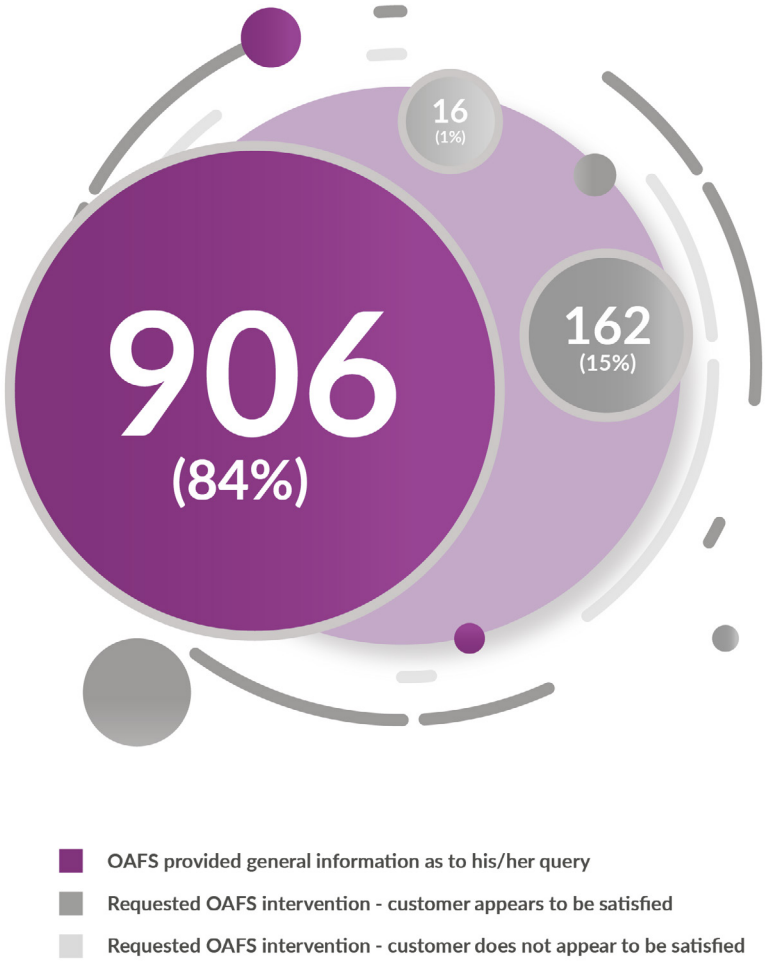


Figure 4 - Enquiries and minor cases in 2020 (by sector and outcome)

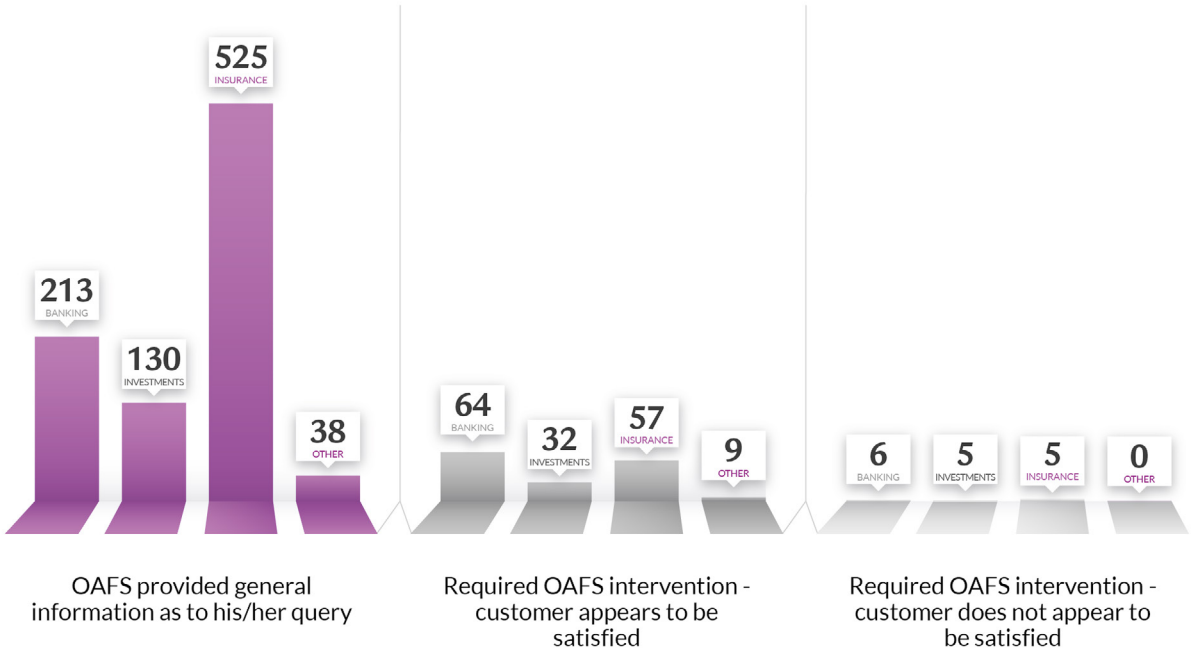
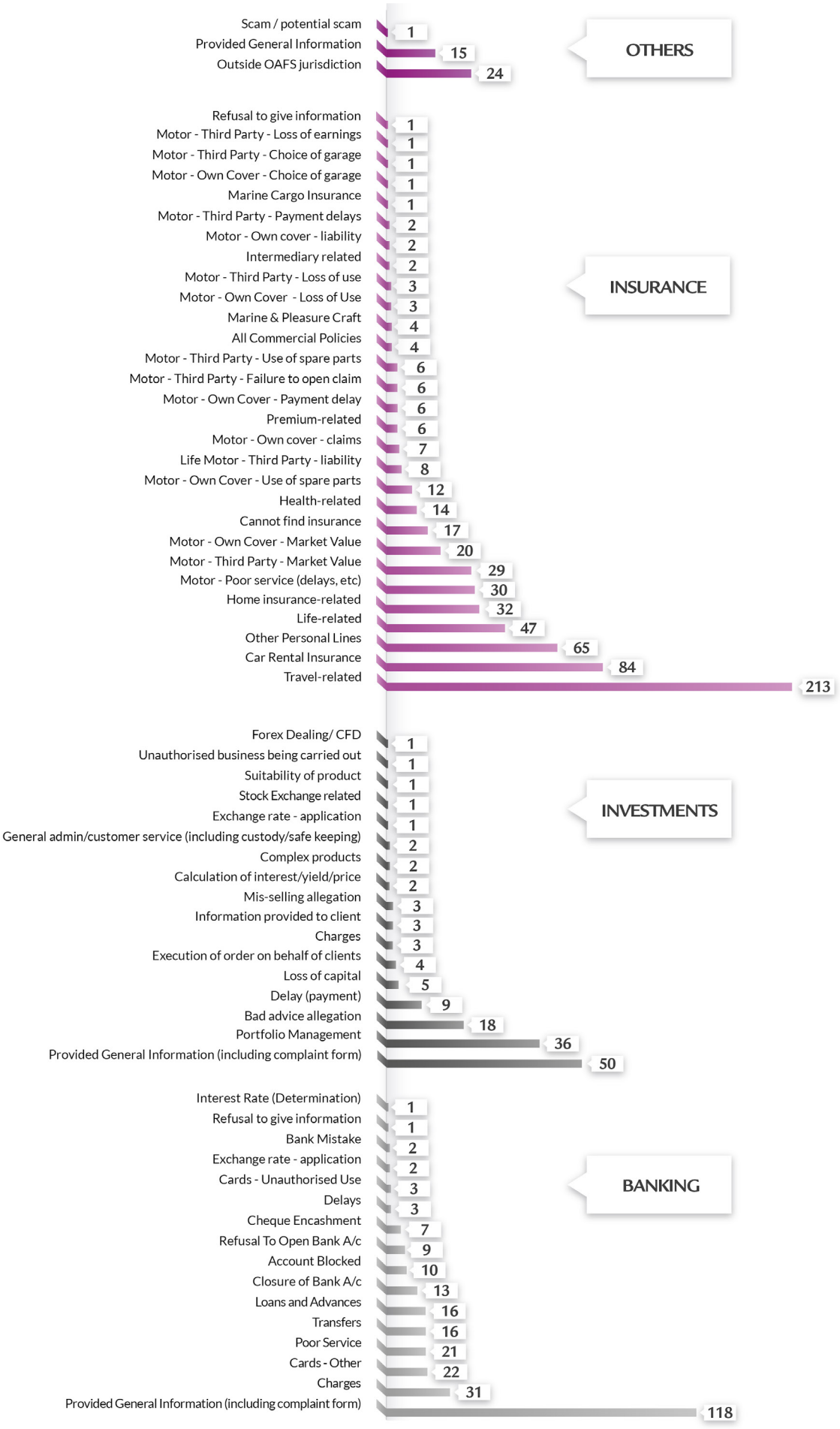


Figure 5 - Enquiries and minor cases in 2020 (by type)



Annex 2 - Formal complaints' statistics

Table 1 - Formal complaints (by sector)

	2020	2019	2018	2017	2016[1]
Banking	22	32	39	40	13
Investments	34	30[3]	134	112	138[2]
Insurance	89	48	19	23	21
Others	/	/	/	/	1
Total	**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 - Formal Complaints in 2020 (by sector and type)

BANKING	
Cards - Other	6
Transfers / Payment outwards	6
Closure of account	5
Cards - Unauthorised use	1
Deposit accounts	1
Other loans and advances	1
Interest Rate (Determination)	1
Refusal to open an account	1
Total	**22**

INVESTMENTS	
Pensions - related	13
Bad advice/Mis-selling	8
Calculation of interest/yield	6
Forex Trading/CFD	3
Delay (payment)	2
Failure to provide information	1
General admin/customer service	1
SUB-TOTAL	**34**

INSURANCE	
Life insurance	39
Pet - Insurance	17
Travel-related	7
Car Rental Insurance	7
All commercial policies	4
Health-related	4
Motor - own p'holder - claims	4
Home insurance-related	3
Motor - Poor service (delays etc)	2
Motor - own p'holder - Loss of use	1
Motor - own p'holder - Market Value	1
SUB-TOTAL	**89**

Table 3 - Formal complaints in 2020 (by provider)

Alphabetical list of financial services providers against whom complaints were lodged with the OAFS during 2020.

	SECTOR	TOTAL
Agon Asset Management Limited	Investments	1
AKFX Financial Service Limited	Investments	1
APS Bank plc	Banking	2
ArgoGlobal SE	Insurance	1
Atlas Insurance PCC Limited	Insurance	4
Axeria Insurance Limited	Insurance	1
Bank of Valletta plc	Banking	6
Building Block Insurance PCC Limited	Insurance	23
Calamatta Cuschieri Investments Services Limited	Investments	3
Citadel Insurance plc	Insurance	1
Eagle Star (Malta) Limited	Insurance	1
Elmo Insurance Limited	Insurance	1
EM@NEY plc	Banking	1
Fortegra Europe Insurance Company Limited	Insurance	2
FXDD Malta Limited	Investments	2
GasanMamo Insurance Limited	Insurance	3
GlobalCapital Financial Management Limited	Investments	4
GlobalCapital Life Insurance Limited	Insurance	1
GlobalCapital Life Insurance Limited & GlobalCapital plc	Insurance	1
HSBC Bank Malta plc	Banking	9
HSBC Bank Malta plc	Investments	1
HSBC Malta Funds SICAV plc	Investments	1
Insignia Cards Limited	Banking	1
Integrated-Capabilities (Malta) Limited	Investments	4
Island Insurance Brokers Limited / Gasan Mamo Insurance Limited	Insurance	1
Island Insurance Brokers Limited / Mapfre Middlesea plc	Insurance	2
KANE LPI Solutions (Malta) Limited	Investments	1
Laferla Insurance Agency Limited / Mapfre Middlesea plc	Insurance	2
Lawsons Equity Limited	Investments	1
Lombard Bank Malta plc	Banking	1
Mapfre Middlesea plc	Insurance	2
Mapfre Middlesea plc / Central Insurance Brokers Limited	Insurance	1
Mapfre MSV Life plc	Insurance	36
Medirect Bank (Malta) plc	Investments	2
Mediterranean Insurance Brokers (Malta) Limited / Citadel Insurance plc	Insurance	1
Mediterranean Insurance Brokers (Malta) Limited /MIB Insurance Agency Limited	Insurance	1
Michael Grech Financial Investment Services Limited	Investments	1
Momentum Pensions Malta Limited	Investments	4
MPM Capital Investments Limited	Investments	3
Propgen Insurance Limited	Insurance	1
QIC Europe Limited	Insurance	1
Sovereign Pension Services Limited	Investments	2
STM Malta Pension Services Limited	Investments	2
TMF International Pensions Limited	Investments	1
TravelJigsaw Insurance Limited	Insurance	2
Truevo Payments Limited	Banking	2
		145

Table 4 - Complaint outcomes in 2020

Agreement was reached at mediation	16
Complaints withdrawn following mediation	13
Parties agreed to settle prior to commencement of mediation	13
Withdrawn prior to mediation	20
Agreement reached by the parties during hearing before the Arbiter	4
Cases in respect of which a decision has been issued by the Arbiter for Financial Services *	125

* Comprises 39 individual cases lodged separately by complainants against the same financial services provider. Following review of each respective complaint file, the Arbiter determined that these cases were to be treated collectively as the cases' merits were intrinsically similar in nature (Case 028/2018). Refer to Table 5 below.

Table 5 - Decisions of the Arbiter (by sector)

		Banking	Investment Services	Insurance
Preliminary and follow-up	3	0	2	1
Upheld in full	29	3	13	13
Partially upheld	63	1	53	9
Rejected	30	4	12	14
Res judicata	64	6	23	35
Appealed	58	2	55	1

Table 6 - Decisions delivered by the Arbiter in 2020 (breakdown by financial services provider)

The table below provides a breakdown of the type and nature of decisions by financial services provider during 2020, and whether the final decision has been appealed.

Financial Services provider	Sector	Final Decisions	Preliminary & Follow Up		Complaint Upheld	Partially Upheld	Complaint Rejected		Appealed	Not Appealed	
All Invest Company Limited	Investment	6		6	6			6		6	6
ArgoGlobal SE	Insurance	1		1			1	1		1	1
Atlas Insurance PCC Limited	Insurance	1		1	1			1		1	1
Axeria Insurance Limited	Insurance	5		5	4		1	5		5	5
Bank of Valletta plc	Banking	2		2	1		1	2		2	2
BNF Bank plc	Banking	1		1	1			1	1		1
Building Block Insurance PCC Limited	Insurance	5		5	4		1	5		5	5
Curmi & Partners Limited	Investment	1		1	1			1	1		1
Eagle Star (Malta) Limited	Insurance	1		1			1	1		1	1
GasanMamo Insurance Limited	Insurance	4		4	1		3	4		4	4
Global Insurance Brokers Limited et	Insurance	2		2	2			2		2	2
GlobalCapital Financial Management Limited	Investment	4		4	3		1	4	1	3	4
Hollingsworth International Financial Management Limited	Investment	2		2	1		1	2		2	2
HSBC Bank Malta plc	Banking	4		4	1	1	2	1	1	3	4
HSBC Bank Malta plc	Insurance	1		1			1	1		1	1
Jesmond Mizzi Financial Advisors Limited	Investment	1		1			1	1	1		1
Mapfre MSV Life plc	Insurance	15		15	1	9	5	15	1	14	15
MEDirect Bank (Malta) plc	Investment	1		1			1	1	1		1
Michael Grech Financial Services Limited	Investment	1		1			1	1		1	1
Momentum Pensions Malta Limited	Investment	54		54		48	6	54	48	6	54
Propgen Insurance Limited	Insurance		1	1				-			-
Satabank plc	Banking	1		1			1	1		1	1
Sovereign Pension Services Limited	Investment	1		1		1		1		1	1
STM Malta Pension Services Limited	Investment	4		4		3	1	4	3	1	4
The Timeless Uranium Fund SICAV plc	Investment	1	1	2	1			1		1	1
TMF International Pensions Limited	Investment	1	1	2		1		1		1	1
TravelJigsaw Insurance Limited	Insurance	1		1			1	1		1	1
XNT Limited	Investment	1		1	1			1		1	1
		122	**3**	**125**	**29**	**63**	**30**	**122**	**58**	**64**	**122**

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.

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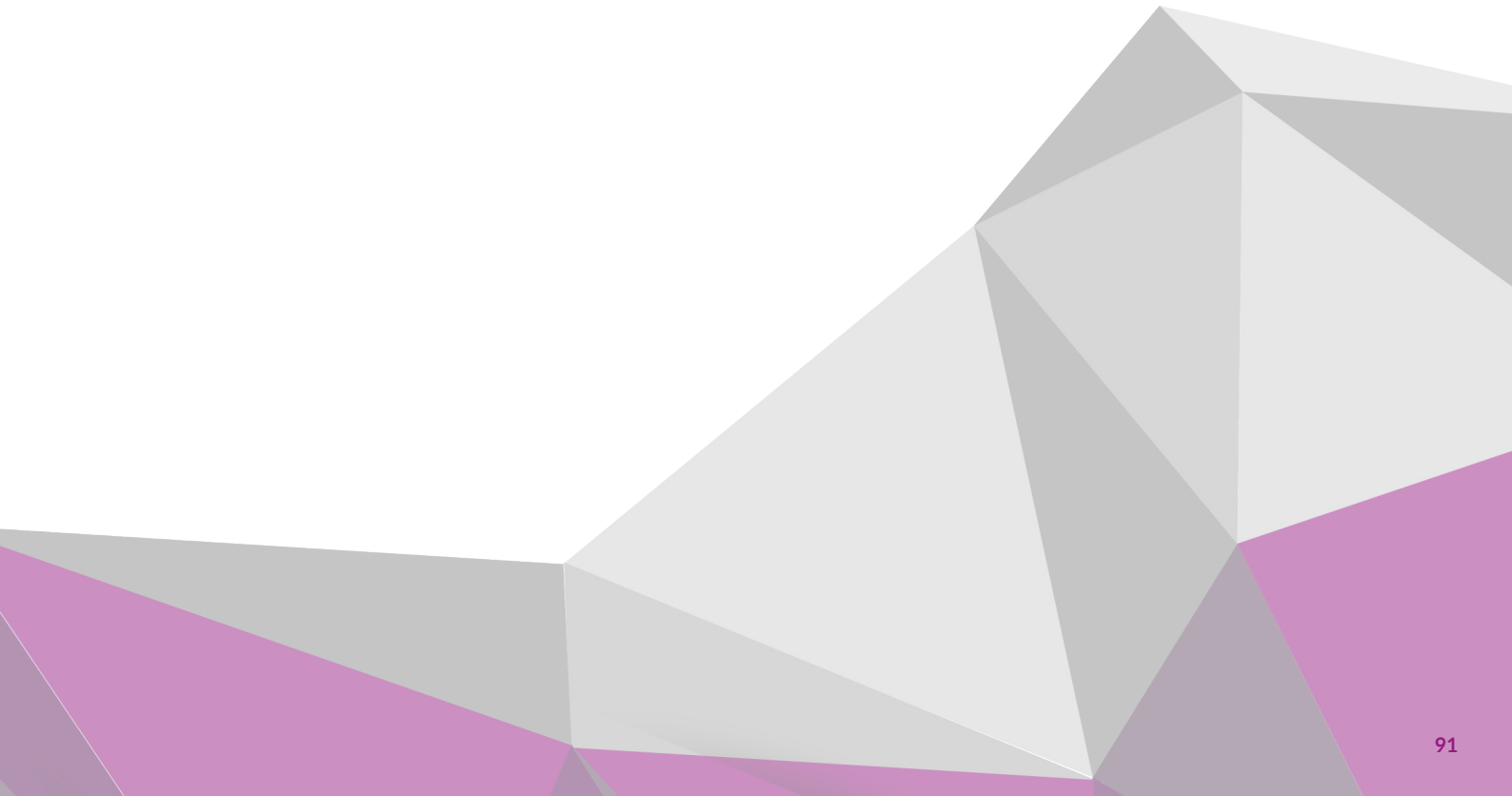
Office of the Arbiter for Financial Services

Audited Financial Statements as at 31 December 2020



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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 2020, 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 2020, 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 the Arbiter for Financial Services Act, 2016.

Auditor General
2 July 2021

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 2020.

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 €70,374 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	2020	2019
		€	€
ASSETS			
Property, Plant and Equipment	6	**22,083**	**25,102**
Intangible Asset	7	**39,825**	**-**
		61,908	**25,102**
Current assets			
Trade and other receivables	8	**2,706**	**2,582**
Cash and cash equivalents	9	**106,113**	**73,551**
		108,819	**76,133**
Total assets		**170,727**	**101,235**
EQUITY AND LIABILITIES			
Equity			
Accumulated Funds		**161,251**	**90,877**
		161,251	**90,877**
Current liabilities			
Trade and other payables	10	**9,476**	**10,358**
		9,476	**10,358**
Total liabilities		**9,476**	**10,358**
TOTAL EQUITY AND LIABILITIES		**170,727**	**101,235**

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: 1st July 2021

Mr Geoffrey Bezzina
Chairperson

Statement of comprehensive income

	Notes	2020	2019
		€	€
Income	3	**642,312**	**597,587**
Administrative expenses	4	**(571,592)**	**(569,972)**
Financial costs	5	**(346)**	**(214)**
Surplus for the year		**70,374**	**27,401**

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 2018	**72,223**	**72,223**
(Loss) for the year	(8,747)	(8,747)
Balance at 31 December 2018	**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

The accounting policies and explanatory notes on pages 6 to 9 are an integral part of these financial statements.

Statement of cash flows

	Note	2020	2019
		€	€
Operating activities			
Surplus for the year		**70,374**	**27,401**
Adjustments to reconcile profit before tax to net cash flows:			
Non-cash movements			
Depreciation of fixed assets		**20,142**	**8,329**
Working capital adjustments			
Increase in trade and other receivables		**(124)**	**(549)**
Increase in trade and other payables		**(882)**	**1,042**
Net cash generated from operating activities		**89,510**	**36,223**
Investing activities			
Purchase of property, plant and equipment		**(3,848)**	**(11,912)**
Purchase of Intangible Asset		**(53,100)**	**-**
Net cash used in investing activities		**(56,948)**	**(11,912)**
Cash and cash equivalents at 1 January		**73,551**	**49,240**
Net increase in cash and cash equivalents		**32,562**	**24,311**
Cash and cash equivalents at 31 December	9	**106,113**	**73,551**

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 2020 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.

	2020	2019
	€	€
Government Funding	**640,000**	**585,000**
Complaint Fees	**2,312**	**3,225**
EU Funding	**-**	**9,362**
Total Income	**642,312**	**597,587**

4. Expenses by nature

	2020	2019
	€	€
Staff Salaries	**479,284**	**468,814**
Office maintenance & Cleaning	**11,465**	**20,974**
Car & Fuel Expenses	**18,749**	**18,110**
Advertising (Recruitment costs)	**1,313**	**2,941**
Telecommunications	**5,666**	**6,998**
Professional Fees	**7,115**	**4,548**
Depreciation charge for the year	**20,142**	**8,329**
Other expenses	**27,858**	**39,258**
Total administrative costs	**571,592**	**569,972**

Notes to the financial statements (continued)

4. Expenses by nature (continued)

Average number of persons employed by the office during the year:	**2020**	**2019**
Total average number of employees	**13**	**14**

5. Financial costs

	2020	**2019**
	€	**€**
Bank and similar charges	**346**	**214**

6. Property, plant and equipment

	Furniture, Fixtures & Fittings	**Office Equipment**	**Computer Equipment**	**Total**
	€	€	**€**	**€**
Net book amount at 1 January 2019	14,412	2,329	4,778	21,519
Additions	8,391	590	2,931	11,912
Depreciation charge for the period	(2,819)	(1,283)	(4,227)	(8,329)
Net book amount at 31 December 2019	**19,984**	1,636	**3,482**	**25,102**
Additions	-	3,553	295	3,848
Depreciation charge for the year	(2,819)	(2,172)	(1,876)	(6,867)
Net book amount at 31 December 2020	**17,165**	**3,017**	**1,901**	**22,083**
As at 31 December 2020				
Total cost	28,194	8,687	17,204	54,085
Accumulated depreciation	(11,029)	(5,670)	(15,303)	(32,002)
Net book amount at 31 December 2020	**17,165**	3,017	**1,901**	**22,083**

Notes to the financial statements (continued)

7. Intangible Asset

	Website and Case and File e-Solution	Total
	€	€
Net book amount at 1 January 2020	-	-
Additions	53,100	53,100
Depreciation charge for the period	(13,275)	(13,275)
Net book amount at 31 December 2020	**39,825**	**39,825**

8. Trade and other receivables

	2020	2019
	€	€
Prepayments	**2,706**	**2,182**
Other receivables	**-**	**400**
	2,706	**2,582**

9. Cash and cash equivalents

For the purpose of the cash flow statement, cash and cash equivalents comprise the following:

	2020	2019
	€	€
Cash at bank and in hand	**106,113**	**73,551**

10. Trade and other payables

	2020	2019
	€	€
Other payables	**6,707**	**6,620**
Accruals	**2,769**	**3,738**
	9,476	**10,358**

Administrative expenses

	2020	2019
	€	€
Staff Salaries	**479,284**	**468,814**
Training	**300**	**3,615**
Office Consumables	**199**	**982**
Cleaning	**8,856**	**8,772**
Office Maintenance	**2,609**	**12,202**
Printing and Stationery	**2,889**	**3,459**
PC/Printer Consumables	**1,254**	**662**
Other Office Costs	**1,619**	**1,575**
Other Office Equipment	**518**	**110**
Telecommunications	**5,666**	**6,998**
Website Expenses	**1,226**	**671**
Postage, Delivery & Courier	**2,406**	**4,040**
Insurance - Health	**9,382**	**8,478**
Insurance - Travel	**51**	**280**
Insurance - Business	**1,690**	**1,197**
Memberships & Subscriptions	**1,691**	**1,025**
General Expenses	**289**	**672**
Vehicle, leasing and fuel expenses	**18,749**	**18,110**
Travelling Expenses	**285**	**7,650**
Advertising (Recruitment)	**1,313**	**2,941**
Legal Fees	**-**	**206**
Professional Fees	**7,115**	**4,548**
Payroll Fees	**308**	**118**
Accounting Fees	**3,751**	**4,518**
Depreciation Charge	**20,142**	**8,329**
	571,592	**569,972**

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