Before the Arbiter for Financial Services

Case ASF 138/2026

DM

('Complainant')

Vs

GasanMamo Insurance Limited

(Reg. No C 3143)

('Service Provider' or 'GM')

Sitting of 25 August 2026

The Complaint[1]

Having seen the complaint filed on 14 May 2026, whereby Complainant (age 19 years at the time of the event) challenges the Service Provider's decision to refuse settlement of her claim for €10,735.35 being:

a. Mater Dei Hospital (MDH) bill for €5,988.24 for emergency hospitalisation and in-patient treatment between 10 and 22 November 2025[2].

b. MDH bill for pre-operation bloods and assessment on 27 November 2025 €285.11[3].

c. MDH bill for surgery on Laparoscopic Cholecystectomy related to gallstone pancreatitis on 03 December 2025 for €4,462[4].

The Complainant argued:

[1] Page (p.) 1 – 7 and attached documents p. 8 - 82
[2] P. 23; 19 - 21
[3] P. 29
[4] P. 27 - 28; 81 - 83

“I am submitting this complaint regarding the rejection of my health insurance claim for acute pancreatitis.

My policy started on 1 July 2025. In November 2025, I was admitted to Mater Dei Hospital and was diagnosed for the first time with acute pancreatitis caused by gallstones. I had never previously been diagnosed with pancreatitis or gallstones, nor had I received medical advice or treatment for such a condition before the policy began.

The insurer is rejecting my claim on the basis that I had experienced abdominal discomfort before the policy started and therefore considers the condition to be pre-existing. However, prior to my hospital admission, I had only experienced occasional mild abdominal pain which I reasonably believed to be normal and not indicative of any serious medical condition. I never sought medical advice, received treatment, or had any diagnosis before the policy inception date.

I believe the insurer is applying an overly broad interpretation of “pre-existing symptoms,” especially since no diagnosis or medical investigation existed before the policy commenced. I also did not intentionally withhold any information when completing the proposal form, as I had no knowledge of an underlying medical condition at that time.

I respectfully request that this decision be reviewed and assessed independently.

The insurer has let me down by rejecting my claim based on an unreasonable and overly broad interpretation of what constitutes a pre-existing condition.

Although I experienced occasional mild abdominal discomfort prior to the policy start date, I had no diagnosis, no medical investigations, and no medical advice indicating pancreatitis or gallstones before the policy commenced on 1 July 2025. The condition was first diagnosed during my hospital admission in November 2025.

The policy wording states that pre-existing conditions include symptoms experienced prior to inception. However, interpreting any minor and non-specific discomfort as evidence of a pre-existing medical condition is

excessive and unfair, particularly when no medical professional had identified or investigated such symptoms before the policy began.

Furthermore, I did not intentionally fail to disclose any material information when completing the proposal form, as I had no knowledge or suspicion of an underlying medical condition at that time.

I believe the insurer's decision is disproportionate and does not reflect the principle of fairness and good faith in insurance practice. [5]*"*

The Reply

Having seen the reply[6] of 02 June 2026, where the Service Provider stated:

"History of Events – Health Claim Number W250XX2X80 (Postal Claim Temporary Number PW2500XXXX & PW2500XXXX)

Policy Number: IJ976W051

Policy Inception Date: 1 July 2025

Policyholder: DM

First Notification: 13 November 2025

1. Initial Notification

On 13 November 2025, the client informed us of admission at Mater Dei Hospital on 9 November 2025 due to abdominal pain and requested guidance on submitting a claim.

2. Claim Submission

The claim was received by post on 24 November 2025 and was assigned the temporary claim number PW2500XXXX, together with supporting documentation including the claim form, case summary, prescriptions, receipts and invoice.

[5] P. 3

[6] P. 89 - 93 and attachments p. 94 - 180

Further documentation was submitted on 25 November 2025, including a notice of upcoming surgery scheduled for 3 December 2025.

On 6 December 2025, the claim was integrated into the system, and a permanent claim number W250XX2X80 was created.

The total amount claimed for treatment received at Mater Dei Hospital is €5,988. Refer to Appendix J.

Note: When claims are submitted either by post or online, a temporary claim number is automatically generated for tracking purposes. Postal claim references begin with PW, whilst online claims begin with GW. Once the claim is integrated into the system, a permanent claim number is generated. This number begins with W, followed by the year in which the claim was opened, and becomes the sole reference for the claim going forward. If more than one claim is submitted relating to the same medical condition/symptoms, these are incorporated into one permanent claim.

3. Medical Evidence

A&E report (10 November 2025) recorded abdominal pain with vomiting and noted similar previous episodes. Refer to Appendix A.

4. Client Clarification

Client initially stated first symptoms occurred on 9 November 2025.

Since this was impossible due to the information noted on the A&E report dated the 10th November 2025, stating similar previous episodes in the past, we re-contacted the client to clarify the date of symptoms noticed first noticed for the symptoms noticed in the past as per the report. Refer to Appendix B.

On 18 December 2025, clients confirmed symptoms were experienced in mid and end of 2024, prior to policy inception which was of 1st July 2025. Refer to Appendix C.

5. Second Claim

A second postal claim, bearing temporary reference number PW2500XXXX, was received on 15 December 2025, relating to an elective

laparoscopic cholecystectomy, for which the client required admission from 3 to 4 December 2025.

Following the initial admission on 24 November 2025 related to severe pancreatitis, the client was referred for this elective procedure to remove the gallbladder.

The total amount claimed in respect of this treatment carried out at Mater Dei Hospital is €4,857.11[7]*. Refer to Appendix K*

6. Assessment Outcome

Based on the medical evidence and the client's own confirmation, the symptoms of abdominal pain pre-dated the inception of the policy and were not disclosed on the proposal form. Please refer to Appendices C and D.

Had the client disclosed these symptoms prior to policy inception, specifically in relation to abdominal pain, it is noted that although the client later explained that no medical advice had been sought, she was nevertheless required to declare any symptoms experienced under Question 9 of the proposal form, irrespective of whether medical attention had been obtained (refer to Appendix D).

Furthermore, the policy wording clearly stipulates under Page 19, Clause 30 – Pre-existing Medical Conditions that no cover is provided for any disease, illness or symptoms experienced prior to the inception date, whether or not medical advice or treatment had been sought.

Accordingly, had the symptoms of abdominal pain been disclosed at the application stage, the policy would have been underwritten with special terms, specifically the imposition of an exclusion relating to abdominal pain and any associated conditions prior to policy inception. As a result, any abdominal-related symptoms or treatment would not have been covered under the policy.

The client's initial admission was in relation to severe pancreatitis, which is not payable under the policy, as the condition presented with symptoms

[7] This figure includes two receipts for €55 each (p. 150 – 151) which were not included in the complaint.

of abdominal pain, which had already been experienced prior to the inception of the policy and remained undisclosed. The assessment is therefore based on the presence of pre-existing symptoms, irrespective of the eventual diagnosis.

For clarity, pancreatitis is defined as inflammation of the pancreas, which may be acute or chronic in nature. The condition commonly presents with symptoms including:

- *Severe upper abdominal pain radiating to the back*
- *Nausea and vomiting*
- *Fever and increased heart rate*
- *Abdominal tenderness*
- *In chronic cases, additional symptoms such as weight loss and digestive disturbances*

The most common causes of pancreatitis include:

- *Gallstones*
- *Alcohol use*
- *Elevated triglyceride levels*
- *Certain medications*
- *Genetic factors*
- *Abdominal trauma*

The hospital case summary dated 10 November 2025 confirms that the client required urgent surgical referral due to multiple gallbladder calculi, resulting in an elective laparoscopic cholecystectomy performed on 3 December 2025.

The abdominal pain exclusion extends to treatment relating to the abdominal area, which encompasses the major organs within the abdominal cavity, including the stomach, intestines, liver, spleen, kidneys,

ureters, pancreas, gallbladder, lymphatic system and major vascular structures.

Both the pancreas and gallbladder, which are directly implicated in the diagnoses of acute pancreatitis and gallstones, fall within this abdominal region and are intrinsically linked to the previously experienced symptoms of abdominal pain.

Conclusion

In view of the above, there is a clear and direct connection between:

• the pre-existing symptoms of abdominal pain,

• the subsequent diagnosis of gallstones,

• and the resulting acute pancreatitis and surgical intervention.

Had the abdominal pain been disclosed at inception, an abdominal pain exclusion would have been applied, which would have extended to both the pancreatitis and the gallbladder-related condition, including the surgery performed.

Therefore, the claim has been correctly rejected in accordance with the policy terms, on the basis that the condition arises from pre-existing, undisclosed symptoms, which would have been excluded from cover from the outset.

7. Underwriting

On 16 January 2026, underwriting applied exclusions for abdominal pain and pancreatitis. Refer to Appendix F – Exclusion letter C3 and C4.

For [Complainant's] benefit is not payable for the cost of any investigations/treatment for any condition, disorder or complication arising from or relating directly or indirectly to:

1) Contraceptive implant

2) Anaemia

3) Pancreatitis

4) Abdominal Pain.

8. Conclusion

Our position in response to this complaint remains that the claim is not payable. Had the client disclosed the symptoms experienced prior to policy inception, an abdominal pain exclusion would have been applied. This exclusion extends to treatment relating to the abdominal area, which encompasses the major organs within the abdominal cavity, including the stomach, small and large intestines, liver, spleen, kidneys, ureters, pancreas, gallbladder, lymph nodes and major vascular structures.

Both the pancreas and gallbladder, which are directly implicated in the diagnosis of acute pancreatitis and gallstones, fall within this abdominal region and would therefore have been subject to the abdominal pain exclusion had the symptoms been disclosed at inception.

Accordingly, the total amount of €10,450.24[8], comprising:

€5,988 relating to the initial admission on 24 November 2025; and

€4,857.11 relating to the elective laparoscopic cholecystectomy, has been rejected on the basis that the client had experienced similar episodes of abdominal pain prior to the inception of the policy. These symptoms are therefore considered pre-existing and would have resulted in the application of an exclusion effective from 1 July 2025.[9]*"*

Appendix C relates to email dated 18 December 2025 where Complainant, on being pressed to state when *'she had similar episodes in the past',*[10] informed '*between mid and end of the last year* (2024)'[11].

Appendix D is the Health Insurance proposal form of 17 June 2025 signed by Complainant where in the medical history panels, she reported three medical conditions, including annual check-ups, blood tests and glucose tests but she

[8] €5988.24 + €4857.11 = €10845.35 not €10450.24. Claim is for €10845.35 less 2x€55 = €10735.35
[9] P. 89 - 93
[10] P. 95 as declared in MDH Medical report of 10 November 2025
[11] P. 105

made no reference to any abdominal pain which she eventually admitted having, as reported above, in the latter half of 2024.

In reply to question 9 of the proposal form asking, "*Have you experienced any symptoms, medical conditions or injuries within the last year for which you did not consult a doctor?"* Complainant answered 'NO'[12].

The Hearings

A hearing was held on 30 July 2026.

In presenting her case, Complainant stated:

> ***"I purchased my health insurance last year. After four months, I had acute pancreatitis, for which I had to go to Mater Dei Hospital. I had to stay there around 20 days.***
>
> ***They discovered that the acute pancreatitis was due to gallstones. So, for this reason, I had to have an operation to remove the gallbladder. The cost of the procedure amounted to around €10,700.***
>
> ***The insurance company should not say that it was a pre-existing condition just because when I went to the hospital and they asked me if I had similar symptoms in the past, I answered yes. In the past, I had occasional abdominal pain, and they are taking these words to claim a pre-existing condition. For me, it does not make sense. So that's what I believe. I'm just asking to get my money back.***
>
> ***I purchased this health insurance policy in July 2025. I had arrived in Malta and one of the obligations was to have this insurance.***
>
> ***Four months after purchasing this insurance, I had this acute pain that made me go to the hospital.***[13]***"***

The Arbiter then made reference to MDH report where Complainant admitted having *'similar episodes in the past'*[14] and asked Complainant to elaborate.

[12] P. 111
[13] P. 181
[14] P. 19

"But there is one thing with that answer, with that form. Before, I answered those questions three times. I wrote that my first symptom was in November, the day that I went to the hospital. When I sent that answer, they sent me back the email asking for the exact date that I experienced the first symptom. I answered the same. They told me that they did not want to know when I went to the hospital. They wanted to know the specific date when I first felt something that was related with the pain that I had at that moment. I answered again that my first symptom was in November when I went to the hospital.

Then, one lady called me, after I sent the email, telling me that they were not interested about the day that I went to the hospital, but they just wanted to know the date when I first experienced pain related to my condition.

And that is why I finally sent the answer that it was between the middle and end of December 2024.

I say that, actually, it all started in 2024, after I ate a very spicy food. That was the first time that I experienced this abdominal pain. The pain only happened occasionally after I eat certain foods. So, I believed that it was related to the food and I never went to a doctor to complain about this pain.

I arrived in Malta on 28 November 2024. I say that from the end of December 2024 until I took out the health insurance policy in 2025, I did not have any pain. And I never went to a doctor in Malta to complain about the pain. I say that I do not have a doctor in Malta.

With regard to the acute pain which made me go to Mater Dei, I say that night, I had gone out with my friends. We were partying on the beach. When I went home, I decided to buy some spicy food. After I ate it, I started to feel a really severe pain. I tried to take some pills and drink some water. I vomited. Then I felt a little bit better and I went to sleep.

At midnight, around 1 a.m. or 2 a.m., the pain started to return. I went to the bathroom and vomited again. But the thing was, when I vomited, I vomited blood. I had to go to the hospital because the pain was

extremely, extremely, extremely severe. That is what happened. It had never happened before. That was the only time when I felt that severe pain and vomited blood and that is why I had to go to the hospital. The pain was so acute that I felt like I was dying on the floor. I could not move. It was very different from what I felt in the second half of 2024.[15]***"***

The Service Provider opted not to cross-examine and proceeded with their own evidence through Ms Micallef Briggs, who stated:

"I say that we have already passed on our evidence to the Office of the Arbiter and to the client including the report from Mater Dei, and her disclosure in writing that similar symptoms were experienced prior to policy inception.

Our argument here is that she had to disclose these symptoms when she applied for the insurance policy, which she did not. We have a question in the proposal that states that if you felt any symptoms, even if you did not consult a medical doctor in the previous year, you must disclose this information to us.

And that is our argument, that she should have presented this information to us because that would have affected the underwriting terms at the proposal stage, which we would have presented to Ms. Rivera, and she would have had the option whether to proceed or not with our underwriting terms, which would have included abdominal pain, because as she's saying, she did not have a formal diagnosis because she did not seek medical attention at the time.

So, in that case, with the exclusion on the policy of abdominal pain it would have captured the complaint for which she presented to Mater Dei hospital.

The Arbiter asks Ms Micallef Briggs to point out to him the hospital certificate which indicates that there were other events in the past which made the Service Provider think that this could be a case of a pre-existing condition.

[15] P. 182 - 183

Ms Micallef Briggs refers the Arbiter to Appendix A (page 095 of the process) attached to the Service Provider's reply to the complaint.

Ms Micallef Briggs points out to Area 1, the fifth bullet point which says:

- 'had similar episodes in the past'.

At this point, we spoke to [Complainant] to get more insight and asked her what these similar episodes in the past were and, finally, she said that she had those episodes in the second half of 2024.

Asked whether we declined [Complainant's] claim on the basis of this report and the declaration of [Complainant], I say, this is correct.

The Arbiter would like to understand better the issue of pre-existing conditions. And he gives a practical example of somebody who has a brain tumor but he does not know that he has a brain tumor, and then he takes out a health insurance policy. After three months, he is diagnosed with a brain tumor. And when he took the insurance, he never declared that he had a headache before. So, the fact that he had a headache, which everybody has headaches, should have been declared even though he did not know that he had a brain tumor?

Ms Micallef Briggs replies:

Correct. If someone has experienced symptoms, which in this case would have been the headache, he would have had to declare the headaches, in which case, the insurer has the right to impose an exclusion on the policy saying that any conditions which are related to the headache are excluded. So, if then one is diagnosed with the brain tumor 3 months down the line, and the headaches were the result of the brain tumor, we would not cover the claim.

The Arbiter asks whether this means that when one takes out a health insurance policy, and one is not aware that they have a brain tumor, they should declare the headache even though a headache is something very normal which everybody has.

Ms Micallef Briggs replies:

Yes, we expect that one declares the headaches; we do not go into details on the proposal if they are mild or severe symptoms. One has to declare any symptoms or medical conditions or recurring problems or chronic problems or injuries that they would have experienced depending on the question and the time frame to that question.

I say, yes, even if it is just a routine headache, you would expect somebody to declare it because that headache could potentially – I am not saying it is every case - be a result of something more serious. So, then the insurer would take a decision whether to proceed to offer cover without any exclusions or ask for more information. And then we decide if an exclusion is merited or not. But, at least, we have been given the opportunity to underwrite the proposal form with the information provided.

The Arbiter asks whether somebody who has a health insurance policy and, at some point in time, a brain tumor is diagnosed, the fact that before taking the policy he did not declare that he had a headache would this exclude the cover for the brain tumor.

Ms Micallef Briggs replies:

Yes, potentially, yes. If there is evidence, just as in this case, where there is a link to previous episodes, I say, yes, it is linked.

The Arbiter states that in this case, [Complainant] said that she had episodes practically 12 months before the actual event. And then she said she did not experience further episodes. So, she thought that these were normal. But, the fact that she did not declare what might be considered a normal event, for example, a headache or abdominal pain, would present an exclusion on the basis of pre-existing condition.

Ms Micallef Briggs replies:

I say that the way [Complainant] described her abdominal pain, it is a similar pain experienced by one who has gallstones. And with gallstones, one could live with gallstones for years and not even know that one has them, but he may also be experiencing similar episodes as she said, especially after eating certain foods, which she just confirmed she did.

This confirms that the abdominal pain she was experiencing relates to a gastrointestinal problem, in this case the gallbladder and the pancreas does fall within the gastrointestinal system. So, they are linked.

The Arbiter asks me whether the claim would have been honoured in full according to the policy were it not for the issue of a pre-existing condition, I say, yes, correct. [16]***"***

On conclusion of evidence, both parties opted to proceed to adjudication without offering final submissions.

Analysis and Considerations

The Arbiter will decide the Complaint by reference to what, in his opinion, is fair, equitable and reasonable in the particular circumstances and substantive merits of the case.[17]

The Arbiter has to decide whether abdominal pain Complainant felt 6 to 12 months before inception of the policy, for which she sought no medical advice and for which she was not prescribed any medicine, is considered as a pre-existing medical condition which should have been declared in the proposal form and, if failure to do so, provides sufficient reason for GM to refuse the claim.

If it is considered as a pre-existing medical condition which should have been reported at the underwriting stage, the policy cover denial would be justified by the policy condition which states:

30. Pre-existing medical conditions

"We do not pay for treatment/investigations for any disease, illness, symptoms, signs or injury for which you have received medical advice or treatment or of which you have experienced symptoms prior to the inception date of your policy, whether medical attention has been sought or not.[18]"

[16] P. 184 - 186
[17] Cap. 555, Art. 19(3)(b)
[18] P. 171

The Complainant argues that GM's position would be a broad interpretation of pre-existing medical conditions as:

- The abdominal pain she declared was minor without specific enduring discomfort which she associated with the intake of certain type of food.
- The last admitted such discomfort happened several months (at least 6) before inception of the policy, and she had no such episodes between the inception of the policy in July 2025 and the date she was admitted to MDH with acute pain in November 2025.
- She was not wilfully withholding information at the application stage, and she had no knowledge of any possible association of such abdominal pain to any underlying condition at the time.

The pre-existing medical condition as defined in the policy does not give a timeline for the history of declarations being limited to several months or years prior to inception of cover. It seems to expect declarations for all the period from birth to policy application.

On the contrary, the proposal form requests such disclosures to be limited to *'within the last year'*. Consequently, irrespective of the policy wording, the Arbiter would not find fault of non-disclosure for any episodes occurring beyond the period requested in the proposal form.

Contracts of insurance pre-suppose utmost good faith from the assured in making faithful and full declarations at the proposal stage to ensure that the insurance provider understands and prices correctly the risk it is willing to take on when issuing the policy. It is not meant as a blanket excuse to avoid claims even on the flimsiest good faith failure to declare a normal symptom which a reasonable person would not normally relate to any chronic condition and which passes away without need of any consultation or medical intervention.

In this particular case, there was no build-up following the minor symptoms of abdominal pain by the Complainant for at least six months prior to policy inception. There was no build-up of pain symptoms leading to the event of the

claim, and it is medically accepted[19] that abrupt and severe abdominal pain is quite typical of gallstone pancreatitis related events.

The case revolves on whether non-disclosure of symptoms or medical conditions in the year before policy inception, which the Complainant considered minor and transient so much so that no consultation with medical professionals was considered necessary, is strong enough to be considered as breaking the rule of utmost good faith on the part of the Complainant.

The Arbiter has searched for similar Arbitration decisions in comparable jurisdictions and found a particular decision taken by Ireland's Financial Ombudsman in a case with similar issues where the Ombudsman states:

> *"I must assess whether there was a full disclosure to the Company of the First Complainant's health history. In this regard, I am mindful of the decision in Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199 wherein the Supreme Court stated that the test for materiality is:*
>
> *'... a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective.'*
>
> *I am further mindful of the well accepted principle that a contract of insurance is a 'contract of utmost good faith on both sides' and I note the dicta of Mr Justice Barrett in Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536 in relation to this duty wherein he outlined that:*
>
> *'The duty of utmost good faith requires a genuine effort to achieve accuracy using all available sources; to require disclosure of all material facts which are known to an insured may well require an impossible level of performance.'*
>
> *With regard to this office's assessment of whether the fact that was not disclosed was a material fact, the High Court in Earls (cited above) decided that this office should not proceed on the basis that if a material fact was*

[19] Source: general online research conducted by the Arbiter

not disclosed then, ipso facto, there has been a breach of the duty of disclosure. Rather in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a 'genuine effort to achieve accuracy using all reasonably available sources' and on the facts of the case in Earls it was noted the proposer's 'memory and experience' in the characterisation of the event was relevant. Consequently, it is evident that the test for materiality is an objective one and the proposer is required to disclose every matter which a reasonable person would consider to be material to the risk against which indemnity is being sought."[20]

There is no doubt that the proposal form demanded disclosure of symptoms and medical conditions without limitation if they were experienced within the previous year, even if no consultations with a doctor were involved.

The Arbiter will consider whether Complainant's failure to disclose minor ailments was material enough to breach the principle of utmost good faith based on the disclosure that a reasonable person would have made in the circumstances.

> Would a reasonable person have declared even a simple normal headache or a mild abdominal pain genuinely assumed to be related to certain food intake?
>
> If such disclosure was made as expected, would the Insurer have denied or restricted cover?

The Arbiter considers that there is no binary answer to these questions, and the absence of such binary answers raises doubt on the appropriateness of GM's outright refusal of the claim.

The Arbiter is of the opinion that if the interpretation of pre-existing medical condition as expected by GM were to prevail, even a simple undisclosed

[20] https://fspo.ie/complaint-outcomes/investigation-services/legally-binding-decisions/documents/2018-0034.pdf?_gl=1*9xurcz*_gcl_au*NzE3OTE5OTIzLjE3ODU3NDg0NzQ.*_ga*NDc1OTg1MjcyLjE3ODU3NDgzNzM.*_ga_2NK1P017D7*czE3ODU4Mjg3MzEkbzMkZzEkdDE3ODU4Mjg3OTckajU5JGwwJGgxOTI4ODM1NzE.

headache experienced during the disclosure period would be enough to void claims, rendering such health policies extremely restrictive.

Decision

The Arbiter has no reason to doubt the Complainant's good faith in the application process and in the events leading to the acute medical interventions which gave rise to the claim.

The Complainant carries an element of fault for not disclosing symptoms and conditions when she was asked to disclose even if no medical consultation was involved.

However,

1. Reasonable persons may well have considered such ailments as minor and transient once in their mind such occasional ailments were the direct result of certain type of food intake for which they had limited tolerance.

2. Given that in the proposal form in reply to question 11, the Complainant declared she undergoes *"annual medical check-ups, blood tests, glucose for peace of mind"*[21] there is reasonable doubt that even if such ailments had been declared, the Service Provider would have refused or restricted cover.

For reasons above explained, the Arbiter considers the complaint as fair, reasonable and equitable, and is accordingly accepting it to the point that the costs of the medical intervention should be shared between the litigants.

In accordance with article 26(3)(c)(iv) of CAP. 555 of the Laws of Malta, the Arbiter orders GasanMamo Insurance Limited to pay the Complainant €5,367.67 (five thousand, three hundred and sixty-seven euro point six seven) in full and final settlement of the claim subject of this complaint.

[21] P. 111

With interest at the rate of 2.40% p.a.[22] from five working days after the date of this decision till the date of payment.[23]

The parties are to carry their own respective costs of these proceedings.

Alfred Mifsud
Arbiter for Financial Services

Information Note related to the Arbiter's decision

Right of Appeal

The Arbiter's Decision is legally binding on the parties, subject only to the right of an appeal regulated by article 27 of the Arbiter for Financial Services Act (Cap. 555) ('the Act') to the Court of Appeal (Inferior Jurisdiction), not later than twenty (20) days from the date of notification of the Decision or, in the event of a request for clarification or correction of the Decision requested in terms of article 26(4) of the Act, from the date of notification of such interpretation or clarification or correction as provided for under article 27(3) of the Act.

Any requests for clarification of the award or requests to correct any errors in computation or clerical or typographical or similar errors requested in terms of article 26(4) of the Act, are to be filed with the Arbiter, with a copy to the other party, within fifteen (15) days from notification of the Decision in terms of the said article.

In accordance with established practice, the Arbiter's Decision will be uploaded on the OAFS website. Personal details of the Complainant(s) will be anonymised in terms of article 11(1)(f) of the Act.

[22] Equivalent to the current Main Refinancing Operations (MRO) interest rate set by the European Central Bank.
[23] It is to be noted that in case this decision is appealed, should this decision be confirmed on appeal, the interest is to be calculated from the date of this decision.