MFSA

MALTA FINANCIAL SERVICES AUTHORITY

CONSUMER AFFAIRS UNIT

ANNUAL REPORT

2011

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CHAIRMAN'S STATEMENT

Consumer protection is considered as a core part of financial services policy, not only in the EU, but also worldwide. At EU level, despite the robust framework of rules and regulations that have been setup during the past years, it is evident that the imbalance of information between the service provider and the consumer requires urgent attention. This is particularly true in regard to complex financial products.

Despite the fact that the Malta Financial Services Authority has been very active in various educational campaigns, it simply cannot be assumed that consumer education is the panacea for less regulation.

Consumers are not, and cannot be, in a better position than their advisers to assess the characteristics and risks of an investment. Consumers have their responsibilities but so too do financial services providers.

Some firms may be inclined to push products because of the potential upfront rewards. The problem is that some of these products are poorly designed to the extent that when push comes to shove, all the risk (i.e. loss of capital and interest) is shifted onto the investor. This invariably leads to consumer dissatisfaction and naturally gives a bad reputation to the financial sector.

A balance therefore needs to be struck without losing sight of the main objective – that of ensuring that legitimate consumer expectations are preserved and upheld. In light of concerns that some financial products are likely to have been or continue to be mis-sold to consumers, the Authority will continue to take action on abusive behaviour by some firms which is a disservice to consumers and to the financial sector. The Authority will take regulatory action when it deems that there is non-compliance with the rules.

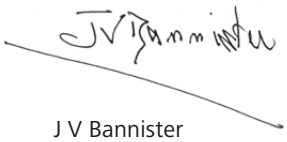
Financial firms have to be responsible for their actions and for the financial products they design, package or sell to the public. They have to face the consequences of stiff regulatory action if they allow their commercial priorities to overshadow the very basic tenets of consumer protection – to treat consumers fairly.

Consumers may expect a regulator to approve each and every product which is issued. Some consumers may also expect that a regulator can always bring their money back in the event of loss. This can breed moral hazard, which is undesirable. Heaping documentation onto consumers to make them decipher the multi-layered risks and complexities of some financial products is, on the other hand, unfair. The Authority believes that consumers' demands for simplified product documentation which effectively informs them at the outset of all key facts, conditions and restrictions needs to be addressed by the financial sector.

The Consumer Affairs Unit has encountered several cases of hardship during the course of its reviews into consumer complaints. It has also come across potential cases of hard-selling, bad advice and, most worrying, an increasing number of products which are ill-conceived. The Unit has to remain objective in its assessment of these cases and where it identifies that the consumer has not been treated fairly, it should expect full cooperation from the licence holder to shoulder responsibility. The mentality and sales culture of some licence holders needs to change as well.

The Authority understands that complainants are sometimes unhappy with delays for a number of cases to be solved where mis-selling is suspected. However, the process of reviewing complaint files and the parallel regulatory processes take time. Certain situations may pose a number of hurdles which the Authority has to overcome to ensure successful fruition of its detailed reviews. Consumers have to understand that due process at law must take place.

I thank the staff of the Consumer Affairs Unit for their perseverance in light of the rather large caseload of complaints received during the year under review.



J V Bannister

RESPONSIBILITIES OF THE CONSUMER AFFAIRS UNIT

The Consumer Complaints Manager appointed under the MFSA Act is empowered to investigate complaints from private individuals relating to any financial services transaction in a fair and impartial manner.

The Director of the Consumer Affairs Unit, who is also the Consumer Complaints Manager, heads the Unit which is responsible for investigating complaints and answering queries from the public on financial services and financial products.

The Unit has two core complementary functions – an "investigative" and an "educational" role. In this latter role, the Unit provides consumer education and information about financial services. The Unit also handles different queries from the public on various aspects relating to financial services.

The Unit also assists the Authority's Supervisory Units identify any new issues that require prompt attention as they may affect consumer confidence in financial services.

In addition, the Unit Director provides administrative support to and is also the secretary of the Compensation Schemes Management Committee – which administers the Depositor Compensation Scheme (established under the Banking Act) and the Investor Compensation Scheme (established under the Investment Services Act). He is also secretary of the Protection and Compensation Fund (established under the Insurance Business Act).

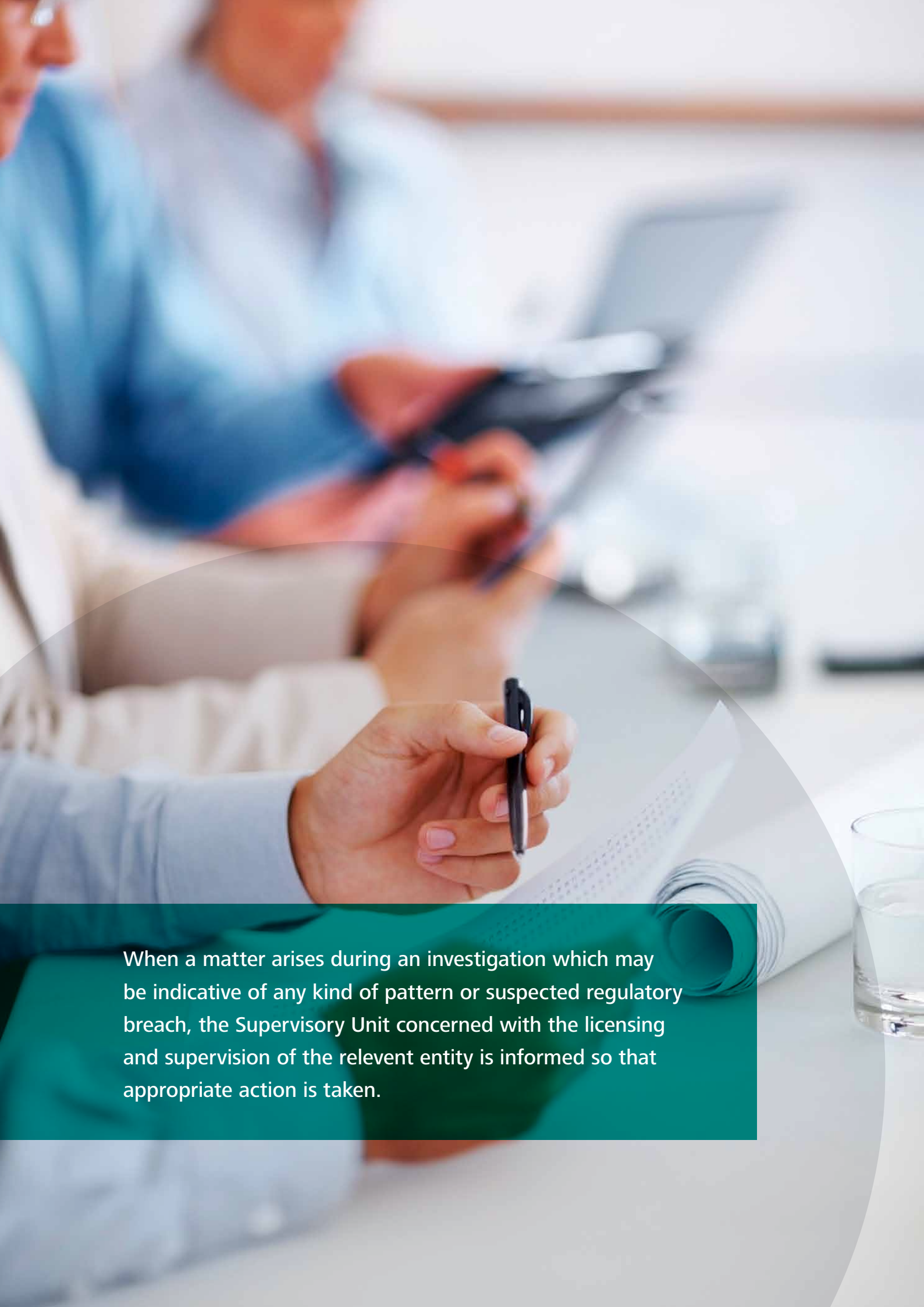
THE LEGAL FRAMEWORK

In terms of article 4 of the MFSA Act (the Act), the MFSA is tasked to promote the general interests and legitimate expectations of consumers of financial services and to promote fair competition practices and consumer choice in financial services.

The functions of the Consumer Complaints Manager are established in article 20 of the Act. The Manager investigates complaints from individual private consumers arising out of, or in connection with, any financial services transaction. Where required, cases may be referred for consideration to the Authority's Supervisory Council.

The legislation empowers the Consumer Complaints Manager to communicate with a consumer, whose complaint is being investigated, information concerning any matter which may have come to his cognisance in the course, or as a result of, an investigation into a complaint. However, the Manager is unable to give advice on any particular matter or to act on the complainant's behalf in any dispute with a licensed person, except where this is provided for by law.

The Manager can also encourage the parties to a dispute, to reach a settlement whenever circumstances so warrant. In addition, the Manager is required to the extent possible, to assist and cooperate with bodies of other EU and EEA States responsible for the resolution of consumer complaints to settle local and cross-border consumer disputes concerning financial services.



When a matter arises during an investigation which may be indicative of any kind of pattern or suspected regulatory breach, the Supervisory Unit concerned with the licensing and supervision of the relevent entity is informed so that appropriate action is taken.

Section 26 of the Financial Institutions Act empowers the Complaints Manager to investigate complaints from payment services users arising out of, or in connection with, any alleged infringement by a service provider authorised to provide payment services activities in terms of the said Act.

In addition to complaints relating to payment services activities from private consumers, the Complaints Manager's mandate has also been extended to include the handling of complaints from interested parties, as defined in the Payment Services Directive (2007/64/EC) as well as complaints from consumer associations.

The Complaints Manager is also required to inform the complainant of his/her right to seek independent professional advice, especially if he/she is not satisfied with the outcome of the complaint. For cases related to payment services, the Complaints Manager is required to inform the complainant of the possibility of having the dispute settled through arbitration proceedings (in terms of the Arbitration Act) without prejudice to the right of the consumer, as defined in the Consumer Affairs Act, to submit a claim to the Consumer Claims Tribunal or to exercise any other rights under that Act.

SHARING OF INFORMATION WITH REGULATORY UNITS

When a matter arises during an investigation which may be indicative of any kind of pattern or suspected regulatory breach, the Supervisory Unit concerned with the licensing and supervision of the relevent entity is informed so that appropriate action is taken.

CORE PRINCIPLES FOR OUT-OF-COURT SETTLEMENT OF CONSUMER DISPUTES IN PRACTICE

The Consumer Complaints Manager is an active member of FIN-NET and is required to comply with all the seven principles set out in Commission Recommendation (98/257/EC) on the principles applicable to the bodies responsible for out-of-court settlement of consumer disputes.

The Consumer Complaints Manager and analysts within the Consumer Affairs Unit follow these principles when reviewing complaints:

1. Independence:

The Unit considers each case impartially, on its own merits, after due discussion with the parties concerned, and does not automatically take the side of either the consumer or the financial entity.

2. Transparency:

The MFSA requires each financial entity to have its own internal complaints-handling procedure and to make this available to its clientele.

Generally speaking, an entity has to give the client a final response within a reasonable time of receiving the complaint. In normal circumstances, an entity should be in a position to respond within two months of receipt of the complaint.

In the event that the client does not accept the redress proposed by the financial entity or that his complaint has not been upheld, the entity is required to notify the complainant that he may lodge a complaint with the Authority's Consumer Complaints Manager. In their final response letter, financial entities must give all relevant details of the MFSA's redress mechanism.

The Unit will accept a complaint for formal consideration when it appears that the financial services entity has already sent the customer a final response to the complaint; or the entity has not settled the complaint within the two month timeframe; or the complainant's case is of utmost urgency and requires immediate consideration (in this instance, the Complaints Manager will decide whether the case is urgent or not).

The Unit generally investigates complaints based on the information supplied by the complainant and the financial services entity. The complainant is required to provide a declaration that the Unit may request a financial entity and/or a third party to provide copies of any documentation or information relating to his case. A signed copy of this declaration will be sent to the financial entity or third party as applicable.

3. Adversorial:

In many instances, a financial entity is able to sort out complaints satisfactorily without requiring the Unit's involvement. Essentially, the financial entity should engage with the complainant to resolve a complaint expeditiously and, preferably, meeting the complainant's legitimate expectations. The complainant is at liberty to take up any offer made by the financial entity, after being given the opportunity to review the offer and any conditions which may be imposed by the entity.

The Unit will not initiate an investigation before the financial entity has been given the opportunity by the consumer to solve the complaint. Neither can the Unit provide advice to a complainant on any settlement which may be offered.

4. Effectiveness:

The Unit generally investigates complaints based on the information received from the complainant and the financial services entity. The Unit may request meetings with the consumer and representatives of the entity, separately or jointly.

Complaints can be determined within a short timeframe. However, certain complaints may take longer to be concluded especially if the review process involves scrutiny of multiple documents and several exchanges of correspondence with the financial entity. In addition, regulatory issues may need to be investigated in parallel. These could prolong the review process.

5. Legality:

The Unit ensures that any recommendation does not deprive the complainant from exercising his/her rights under consumer protection legislation or bringing an action before the courts for settlement of a dispute.

As part of the complaint review process, the Unit requests clarifications, explanations and copies of documentation from those parties involved in the dispute. In the final report to the complainant, the Unit provides a detailed description of the review process and would normally provide a copy of any relevant documentation on which basis the Unit may have reached a conclusion. The Unit will also provide details regarding any recommendation made to the financial entity. Any information which is provided to the Unit on request of confidentiality is not disclosed or copied to a complainant.

6. Liberty:

A financial entity or a consumer may or may not accept a recommendation of the MFSA and the Authority cannot enforce a recommendation on either party. A complaint submitted to the MFSA does not have the effect of depriving the consumer or the financial entity of the right to bring an action before the Courts or any other entity established by law for the settlement of complaints, should either party refuse to accept the MFSA's recommendation.

A complainant is informed of the outcome of his complaint and is also advised of his right to seek independent professional advice if he is not satisfied with the outcome.

7. Representation:

Complainants would not usually need to seek professional, legal or financial advice to bring a complaint to the MFSA, but the Authority cannot preclude them from being assisted by an adviser when making representations on their complaint. The Authority does not charge fees to complainants. Fees payable to advisers are the complainant's responsibility.

COMPLAINTS' HANDLING - AN OVERVIEW

THE CONSUMER COMPLAINTS MANAGER

- Acts independently of the parties concerned;
- Reviews each case impartially and on its own merits;
- Does not charge fees for reviewing complaints;
- Considers during reviews any relevant legislative aspects, rules, industry practice and other previously reviewed cases;
- Can only make a recommendation, which consequently may be rejected by the complainant and/or the licence holder;
- Would not normally accept to review a case if the licence holder who has not been given the opportunity to first review the client's contentions;
- Would commence review of a complaint if the licence holder has issued a final letter to the complainant outlining its review or the licence holder fails to issue a final letter within two months from the date of the complainant's letter;
- Generally does not reject a complaint, even if a case appears to be time-barred;
- Would normally inform a complainant if, on the basis of an initial review, his/her case is unlikely to be upheld or any requests being demanded may not appear to be legitimate;
- Would always recommend parties to a dispute to reach an amicable solution. If a licence holder offers a settlement, the Unit would recommend the complainant to seek professional advice before signing any agreement to that effect. The Unit does not provide legal or financial advice and is not responsible for any decision taken by the complainant in this regard;
- Always informs the complainant of his rights at law so that s/he may pursue legal action if s/he remains dissatisfied with the outcome of the Unit's review into his/her complaint;
- Endeavours to finalise a review of a complaint within a short period of time. However, this may not always be possible, especially if the review involves several exchanges of correspondence with the licence holder for documentation and clarification, or when the issues brought up by the complainant are likely to result in regulatory breaches, in which case a parallel review by the supervisory unit concerned with the financial entity's activities may need to be carried out.

The complaint procedures of the Consumer Complaints Manager are available online at:
mymoneybox.mfsa.com.mt/procedures4mfsa.aspx

THE FINANCIAL ENTITY

- Must have in place a complaints handling mechanism which is communicated to all its staff;
- Is required to make its procedures readily accessible to its clientele in a language which is easily understood. These procedures should be available online and made available on request to a complainant;
- Is required to maintain an internal complaints register;
- Must inform complainants of their right to submit a complaint with the MFSA if their complaint is not to their satisfaction;
- Must handle complaints within two months of receipt of a complainant's request. If more time is required, the financial entity is required to inform the complainant that it requires more time to review the case;

- Should not allow cases to escalate unnecessarily and should attempt to arrive at an amicable resolution for the benefit of all parties concerned. Whenever a financial entity rejects a complaint, it should clearly explain why it has refused the client's contention;
- Is at liberty to reach a settlement during or following the conclusion of the Complaints Manager's investigations. The entity would be expected to make the terms of the settlement available to the complainant prior to concluding an agreement.

The complaint procedures issued by the Unit for financial entities is available online at:
mymoneybox.mfsa.com.mt/procedures4firms.aspx

THE COMPLAINANT

- May not necessarily have his/her complaint resolved by verbally communicating his/her dissent;
- In most cases, a client can only explain matters properly if s/he makes his contentions in writing;
- Should never use abusive or arrogant language when submitting a complaint in writing;
- Should express his/her views to the financial entity first – and not to the MFSA. S/He may submit a copy to the MFSA, however, this is not a requirement. S/He should provide all relevant details to the financial entity and express her/himself to the best of his/her abilities;
- The letter of the complainant should also include a request to the financial entity to acknowledge receipt thereof. The complainant should keep a copy of any correspondence sent to the financial entity. It is preferable if the complainant requests the name (and e-mail address) of the person to whom s/he should address his/her complaint prior to lodging a complaint to avoid unnecessary delays;
- May lodge a complaint with MFSA is s/he remains dissatisfied with the financial entity's response or two months have elapsed and the financial entity fails to respond;
- Should use the complaint form for this purpose. This is available online or on request. Complaint forms are available in both Maltese and English. Internet users may also lodge a complaint online;
- May seek assistance from a professional adviser to submit a complaint;
- Will be provided with a final letter outlining the Unit's review process into his/her case. S/He will be given a period of time to respond to the Unit's conclusions. If s/he remains dissatisfied with the outcome of his/her complaint, the complainant has a right to initiate legal action against the financial entity;
- At any time during or following conclusion of an investigation, the complainant may be approached by the financial entity with an offer to conclude the case. The complainant is free to discuss and accept the offer after taking professional independent advice. The complainant should be given the opportunity and allowed time to review any agreement which the firm may require the complainant to sign to settle the complaint. The Authority is unable to provide advice on the offer and is not responsible for any decision which the complainant may take in this regard;
- May also lodge a complaint with the Office of the Ombudsman if s/he feels aggrieved of the manner his/her complaint had been handled by the Unit.

More information about the role of the MFSA's role in handling complaints for consumers is available online at:
mymoneybox.mfsa.com.mt/info4consumers.aspx

INTERNATIONAL PARTICIPATION

FIN-NET PLENARY MEETING HELD IN MALTA

The Consumer Affairs Unit hosted the plenary meeting of FIN-NET, the European out-of-court network for the resolution of disputes between consumers and financial services providers on 21 October 2011. The Consumer Complaints Manager represents the Authority on FIN-NET.

FIN-NET is a network established by the European Commission in February 2001. It links 50 out-of-court Alternative Dispute Resolution (ADR) schemes that deal with complaints in the area of financial services and covers the European Union, Norway, Iceland and Liechtenstein (European Economic Area – EEA). Within this network, national ADR schemes assist consumers who have disputes with financial service providers based in another Member State in identifying and contacting the ADR scheme, which is competent to deal with their complaint.

FIN-NET represents an appropriate mechanism for member ADR schemes to share experiences and exchange information, which also has a positive effect on the complaints handling procedure. This is primarily based on the two semi-annual meetings that allow networking among FIN-NET members and facilitate the exchange of information on recent developments at European and national level. The first meeting, which is usually held during early spring, is held in Brussels. The second plenary, usually held in autumn, is hosted by a member of the network.

FIN-NET
financial dispute resolution network

At the meeting in Malta, officials from the European Commission gave FIN-NET members an update on developments in financial services and consumer protection at European level. During the meeting, an official from DG SANCO gave a presentation on a proposal which the EU Commission published in November in connection with ADR and Online Dispute Resolution (ODR). The proposal for a directive on ADR will address gaps in geographical and sectorial coverage of dispute resolution mechanisms, uneven quality of ADR bodies and enhance awareness for both traders and consumers.

The planned Regulation on ODR aims at increasing confidence in the digital Internal Market. It will envisage the creation of an online platform, which will provide a single entry point at EU level for cross-border disputes concerning e-commerce transactions. Disputes will be automatically routed to the appropriate ADR.

Delegates also discussed the findings of reports issued by the World Bank on financial ombudsmen and the situation of ADRs in Central/Eastern Europe. The two reports were drawn up by two of the founding members of FIN-NET, the French Insurance Ombudsman and the Principal Ombudsman of the UK Financial Services Ombudsman.

One of the most important aims of FIN-NET is the sharing of experiences. During the meeting in Malta, two FIN-NET members explained a number of cases which their respective schemes handled and explained how they reviewed them, the challenges posed by the circumstances of the cases, the arguments made by the financial entities in their defence and the eventual outcome.

The Plenary also discussed the relationship between regulators/authorities and ADRs. Members also had the opportunity to exchange experiences on dealing with cases which may involve attempts of fraud by the consumer and, in some instances, the financial services provider.

Finally, officials from the ICT Unit of the MFSA gave a short presentation to FIN-NET delegates regarding a new case management system which will be used by the Consumer Affairs Unit to manage its case workload more effectively. The new system incorporates tools to facilitate classification and reporting of consumer complaints in line with the EU Commission Recommendation on harmonised methodology for the harmonisation of consumer complaints. The new system, which will be implemented in 2012, will allow for specific complaints data to be sent to the EU Commission, obviously respecting the confidentiality of consumers and businesses.

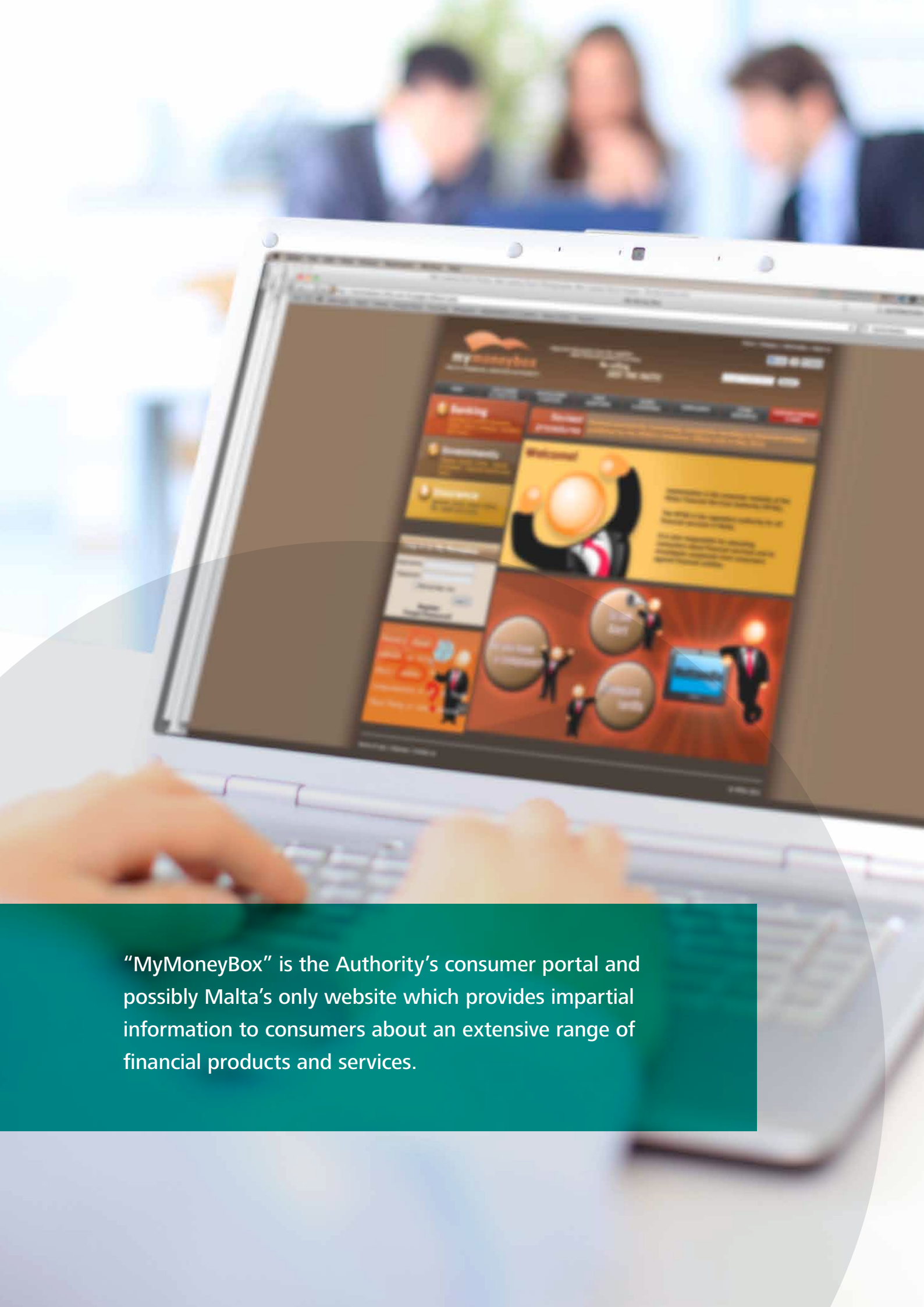
EIOPA - COMMITTEE ON CONSUMER PROTECTION AND FINANCIAL INNOVATION (CCPFI)

Officials from the Unit have actively participated at meetings of the Committee on Consumer Protection and Financial Innovation of the European Insurance and Occupational Pensions Authority (EIOPA).

EIOPA was established as a consequence of the reforms to the structure of supervision of the financial sector in the European Union. EIOPA, along with the European Banking Authority and the European Securities and Markets Authority, is required to take a leading role in promoting transparency, simplicity and fairness in the market for consumer financial products or services across the internal market. As an integral part of its structures, EIOPA is required to engage with all relevant competent national supervisory authorities with a view to achieving a co-ordinated approach to the regulatory and supervisory treatment of new or innovative financial activities. EIOPA is an independent advisory body to the European Parliament, the Council of the European Union and the European Commission. In this context, EIOPA established the Committee on Consumer Protection and Financial Innovation (CCPFI) in January 2011 which took over the work of the Committee on Consumer Protection set up in March 2008.

Amongst many initiatives taken by the CCPFI last year, the Committee endeavoured to collect, analyse and report on the various consumer trends identified in the insurance and occupational pensions markets across the EU. The CCPFI also performed a stock taking exercise with a view to evaluate and coordinate financial literacy and education initiatives taken by competent authorities in the respective Member States. In addition, the Committee launched a public consultation in relation to Good Practices for Disclosure and Selling of Variable Annuities.

In order to promote greater harmonisation within the EU Member States, the Committee published a Report setting out Best Practices for Complaints-Handling by Insurance Undertakings. Finally, at the end of 2011 the Committee organised a 'Consumer Strategy Day' aimed to provide professional stakeholders and consumer protection experts not only with the opportunity to hear about the work EIOPA has been carrying out to fulfil these objectives, but also to express their own views on these issues in the form of a dialogue between consumer representatives, industry and supervisors and other stakeholders.



"MyMoneyBox" is the Authority's consumer portal and possibly Malta's only website which provides impartial information to consumers about an extensive range of financial products and services.

CONSUMER EDUCATION

MYMONEYBOX – THE CONSUMER EDUCATION PORTAL

"MyMoneyBox" is the Authority's consumer portal and possibly Malta's only website which provides impartial information to consumers about an extensive range of financial products and services.

Information on the portal is divided in thematic pages under the three broad categories of banking, investment services and insurance. In addition, the portal contains sections relevant to specific life cycles and four calculators.

Some sections of the website have been extensively revamped (such as the one on motor insurance), while new subjects have also been added on money transfer services, boat insurance, payment protection insurance, contractors' all risks and business insurance. New and updated information about structured products, Exchange Traded Funds, hybrid securities and hedge funds have also been included under the appropriate sections. The sections on motor and travel insurance are available also in Maltese.

Every month, the Unit circulates an electronic newsletter to all subscribers of the portal.

In line with the Unit's ethos to reach as wide an audience as possible, an interactive page has also been created on Facebook to promote and disseminate MyMoneyBox (facebook.com/mymoneybox).

Complainants may also lodge a formal complaint online in a secure environment with the added benefit that documentation may be uploaded and attached to the complaint form. Eventually, complainants who lodge a complaint online would be able to see what action has been taken by the Unit during the review process of their case.

Statistically, the most accessed section of the portal is the on-line database of tariffs and charges relating to a number of financial products and services offered in Malta. Users can compare tariffs of any four financial entities in respect of the product/service selected. General information about the respective products or services which may be compared is also available.

The comparative database is in line with the Authority's remit to promote the general interests and legitimate expectations of consumers of financial services and to promote fair competition practices and consumer choice in financial services. The Authority will be widening the scope of the online database by including comparative features of a number of insurance products, initially those related to motor insurance. This additional service will be launched during the first semester of 2012.

RADIO AND TELEVISION PROGRAMMES

During the year under review, Unit staff participated in various television and radio programmes discussing a wide range of financial subjects and issues relevant to the rights of consumers when purchasing financial products. On average, the Unit participated in three live television programmes and two live radio programs every week during the year. During these programmes, viewers/listeners have the opportunity to ask questions on the topic being discussed. In addition, the Unit produces its own radio programme on one of the private radio stations.

The Consumer Affairs Unit distinguishes between ‘formal’ complaints, where the complainant submits a complaint in writing, and ‘verbal’ complaints which are normally received over the telephone.

COMPLAINTS' TRENDS

The Consumer Affairs Unit distinguishes between 'formal' complaints, where the complainant submits a complaint in writing, and 'verbal' complaints which are normally received over the telephone. If the issue raised verbally by the complainant requires contacting a licensed entity, the latter is contacted by e-mail or over the telephone for any comments. However, if the matter becomes complicated, the complainant is requested to submit a formal complaint in writing.

Throughout 2011, data was collected with regards to the number of queries received from consumers on a wide range of issues relating to financial services. Comments or replies on these queries were given immediately over the telephone without the need to contact the licensed entity concerned.

During the year, the Unit received 374 formal complaints and 320 verbal complaints. The Unit also received over 1500 telephone calls from consumers enquiring on various subjects. Statistically, a major number of enquiries were related to the coverage of the depositor compensation scheme for bank deposits and the state of play in relation to particular investment products and funds.

During 2011, a total of 140 cases were reviewed and concluded. These included a number of cases that were carried forward from the previous years.

Table 1: Analysis of complaints against licence holders and queries handled in 2010 and 2011

	FORMAL COMPLAINTS						VERBAL COMPLAINTS		QUERIES	
	Cases Received		Cases Closed*		Cases Pending					
Complaints related to:	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010
Banking	28	39	26	43	10	9	48	43	466	147
Insurance	63	87	74	87	17	28	105	88	471	258
Investments	277	41	30	21	344	97	116	53	493	168
Others	6	5	10	4	1	5	51	4	90	48
Total:	***374***	***172***	***140***	***155***	***372***	***139***	***320***	***188***	***1520***	***621***

**Includes cases carried forward from previous years*

Table 2: Formal cases closed in 2011 by classification

(A)	15	Outside MFSA jurisdiction (in such instances and following any investigation undertaken, the complainant is requested to seek redress with the appropriate authority or redress system as applicable).
(B)	3	Customer withdrew complaint.
(C)	4	Referred to entity or consumer – no feedback.
(D)(i)	26	Entity has not treated the customer's complaint fairly – complaint upheld by Consumer Complaints Manager. Entity accepts recommendation.
(D)(ii)	3	Entity has not treated the customer's complaint fairly – complaint upheld by Consumer Complaints Manager. Entity did not accept recommendation.
(E)	63	Entity has treated the customer's complaint fairly – complaint not upheld by Consumer Complaints Manager.
(F)	15	Entity has generally treated the customer's complaint fairly but it still agrees to a goodwill payment or improved settlement.
(G)	11	General query – provided information/clarification.

A substantial number of outstanding complaints are related to investments, most of which are cases which had been submitted to the Unit in 2008 and 2009. The complexity of the issues surrounding these cases, which allege mis-selling and bad advice, severely delayed the Unit's efforts to conclude its investigations by end of the reporting year.

The Unit is quite aware of its obligations to keep complainants informed of progress relating to its investigation into their complaints. While acknowledging the inconvenience these delays may cause to complainants, the Authority is also mindful of the fact that commenting or expressing an opinion on its findings would be inappropriate until the investigative process is concluded. A detailed breakdown of Tables 1 and 2 is available in Appendices 1 and 2.

GENERAL REVIEW OF QUERIES AND COMPLAINTS

The year under review can be considered as the most eventful year since the Unit was set up in 2002 purposely to handle consumer complaints and answer consumer queries. Not only has the Unit received the highest number of complaints in one year, but the volume of calls received from consumers is clear evidence that 2011 has been a rather busy and challenging year.

The Unit categorises complaints and queries under four broad terms: banking, investment services, insurance and other. The annual report enables the Unit to share aspects of its workload with all stakeholders and gives it the opportunity to discuss and bring to the fore issues of concern which merit addressing. A selection of important cases reviewed by the Unit during the year are included. Names and particular situations have been changed to preserve confidentiality.

INVESTMENT SERVICES

As at the end of the reporting year, over 340 of pending cases were related to investment services complaints. The majority of these cases allege that a financial entity had mis-sold them a financial product, provided bad advice and/or improperly disclosed key characteristics of the financial product they had been recommended to purchase. A number of complaints filed during the year focused on allegations of improper selling of a property fund and preferred securities.

A number of the outstanding complaints which have been pending since 2009 relate to investigations into selling practices related to the sale of units in a particular collective investment scheme. This investigation is taking much longer than anticipated. At this stage of the Authority's review, it would be premature to comment on any aspect of its findings so far. The Authority is mindful that many investors are anxious to learn about its investigations. On the other hand, investigations into allegations of mis-selling are far from straight forward and require careful assessment of any information elicited in the process.

Other than formal complaints that the Unit is actively reviewing, the Unit has also processed a substantial number of queries from investors whose investment has performed badly. Regrettably, during the year, a number of structured financial products – all with headline promises of lucrative returns – suspended payment of interest and capital. Until such time that these funds are in a position to honour redemption requests, it is natural for investors to be apprehensive of the value of their investment. Some investors may suffer partial or full capital losses, especially if recovery of any funds from the sale of any assets during liquidation is slim.

In both the 2008 and 2009 annual reports, the Unit had commented on the manner some financial products were being sold to investors. The reports expressed concern that investment products which had illiquid underlying assets, such as property or life insurance products, were being sold to retail investors. The Unit expressed the view that these investment products were complex and the advertised headline rates of return potentially unsustainable. Regrettably, many investors invested into such products, despite the Authority's constant warnings in the media about their risks.

Investors should reasonably be expected to shoulder part of the responsibility for their actions. However, the burden of responsibility on the financial planner is even greater.

Investors behave irrationally when confronted with financial products which depict substantial potential returns (compared to mainstream bank deposits, for example). These products are normally presented against a background of serene photography accompanying glossy brochures which give a false sense of security in that they tend to obscure the underlying risks and complexities of such products. Certain financial firms have exploited the low interest rates and highly volatile markets by increasing the supply of financial products whose performance is not correlated with other asset classes, such as bonds or equities. This environment tried to meet consumers' demand for higher return products which many investors believed to be of a lower risk than traditional investment products (when in fact these products involve risks which are not transparent). Although many collective investment schemes are approved by regulators, there are similar investments which are not regulated but have nevertheless been sold to retail investors. Prospective investors are unlikely to draw this distinction and may therefore believe that an investment product is always approved by the regulator, when in fact it is not.

It would be a dangerous precedent for a regulator to guarantee that it will always be in a position to recoup losses for investors each time an investment turns bad. Rules and regulations are in place to protect investors from predatory practices by over-eager financial planners. Some investors may not be prepared to lose their money – if that is so, they should not invest.

Investors should reasonably be expected to shoulder part of the responsibility for their actions. However, the burden of responsibility on the financial planner is even greater.

The Unit has come across many investors who invested into high risk products with scant knowledge of what they had actually purchased (except for the headline rate of return which lured them to make the investment in the first place). It is unlikely that these same investors took time to inform themselves about the investment before signing the dotted line. How could one possibly justify the veracity of a form signed by an investor who declares that he has read and understood a prospectus and the risks and characteristics of a product at the moment he was offered with such information at the first meeting? How could one justify the fairness of the process if the investor is asked to sign a declaration which states – in small print – that he did not require a copy of the very document he had been asked to sign?

Some investors are more vulnerable than others, and therefore require more assistance. Any assumption that investors assimilate characteristics and risk features of a complex product similarly to financial planners who promote such products is fallacious. Investors sometimes find it difficult to understand some of the risks of a traditional product. Expecting them to appreciate the underlying risks of more sophisticated investment products is plainly unfair. In much of the real world, investors do not second guess what their financial planners recommend that they purchase. At times, the problem is therefore not the investor's irrationality but that of the financial planner who may promote investments which could pile onto the investor substantial risk.

It is a fact that investments are sold, rather than bought. Although MiFID created the "appropriateness" and "suitability" tests purposely for the guidance of investors, it is important that the prime beneficiaries of these tests have to be in a position to appreciate the difference between and the importance of the two. Financial entities have an obligation to explain what type and level of service they are giving investors.

Consumers may not always understand the risks they need to take to achieve potentially higher yields. The Unit has encountered many instances where, during the course of receiving financial advice, investors ended up buying investments which were incompatible with their risk appetite or particular circumstances. This was clearly evident when, during analysis of documentation sourced by the Unit as part of case reviews, investors who were initially categorised as "cautious" ended up acquiring unsuitable investments in later years purely because their risk profile had been changed to a higher risk category without a clear justification.

Rightfully, MiFID aimed high. However, the problem with very detailed and intrusive rules is that some very basic but high level concepts - such as acting honestly, fairly and with integrity in the best interests of customers and of the market– seem to have become blurred. The suitability and appropriateness tests risk being used as formal tick-box exercises compiled to shield potential allegations of bad advice or mis-selling. This is considered unacceptable and the Unit is working closely with the Authority's regulatory and enforcement units to ensure that not only the word but also the spirit of the rules are observed by whoever is entrusted with managing people's savings.

The industry needs to focus on the market maker – the investor – and not its self-interest. The selling culture of some financial planners lured by initial upfront commissions and the pursuit of sales targets cannot be left unchecked.

There should be more effort and emphasis towards making the whole investment process less daunting for investors, especially those who are vulnerable and susceptible to being mis-sold a product.

The industry will not stop innovating. This is positive for all investors. However, not all financially innovative products may be suitable for investors; which goes without saying that anything which offers a substantial headline rate of return over and above an average rate of interest on a simple bank deposit should not only be an eye-opener for the investor, but also for the financial planner.

COMPLAINTS REGARDING PREFERRED SECURITIES UPHELD BY THE AUTHORITY

Since 2009, the Unit has been investigating a number of complaints lodged with the Authority's Consumer Complaints Manager requesting a review of the manner in which certain perpetual and other preferred securities issued by Lehman Brothers, Royal Bank of Scotland, HBOS and other banks that had been offered to investors. The complaints had been prompted following the collapse of Lehman Brothers in September 2008. However, during the course of its investigations, the Authority had also widened the scope of its review to other preferred securities which formed part of investment portfolios of a number of complainants.

The complexity of the issues surrounding these cases, which alleged mis-selling and bad advice, severely restrained the Unit from concluding these investigations in a short period of time. As part of the Unit's lengthy investigations into the various complaints, the Unit had requested information and copies of documentation relating to these complaints.

The Unit also carried out extensive research about the nature and risks relating to these securities, including the vetting of the official documentation issued at the time these securities had been offered to the general public. The Unit has, however, treated each case on its own merits. Given the complexity of the nature of the complaints, the Unit referred these cases to the Authority's Supervisory Council in terms of Article 20 of the MFSA Act for further regulatory action as required.

On the basis of the outcomes of each complaint reviewed, the Authority recommended compensation to the aggrieved investors. In some cases, the Authority's recommendations were accepted and a private settlement was reached with the investor. In regard to some other cases disagreement with the Authority's findings and recommendations continues. The Authority is, however, hopeful that all cases which merit reinstatement of the original capital invested are upheld as this is the only manner which ensures fairness and consistency for aggrieved investors.

In the case of a consumer complaint, the burden to prove that the necessary disclosure, in respect of the product features and risk characteristics has been made, lies with the licence holder. A consumer is not, and cannot be assumed to be, in a position to be more knowledgeable about a security's or product's characteristics than the person giving the advice. If the information given by an adviser to an investor was incorrect or incomplete, the investor could not have been in a position to make an informed decision about the investment and its inherent risks. In the cases reviewed, the Authority established that advisers failed to disclose the intrinsic characteristics of such securities. In some cases, the manner in which these securities had been described was also incorrect.

During the year, a number of new complaints, also in relation to the manner in which these securities had been sold, were filed with the Authority. The Unit is reviewing each case on its own merits but will continue to apply the same principles and methodology it has applied to review the "2009" case load to these recent complaints.

INSURANCE COMPLAINTS

In previous annual reports, the Unit highlighted a number of issues which were constantly being brought up by policyholders and consumers in regard to the manner their claims were being handled. In this report, the Unit would like to bring forward two particular issues which it feels merit particular and urgent attention.

A few years ago, the insurance industry brokered a code of practice to ensure that motor claims made by third parties are treated fairly by insurers. The idea, at the time, was laudable given the multiple complaints the Unit had received against insurers on the manner they were allegedly treating third parties. However, the Unit believes that an assessment of that code needs to be made in order to identify those aspects which require immediate amplification and clarification.

The 10-day letter is a formal procedure which the law makers had deemed fit to introduce in the legislation to address those situations where a policyholder – who is most likely to be at fault for an accident – fails to lodge a claim with his insurer.

A recurring issue which keeps cropping up relates to the delays which generally occur in relation to what is termed as the "ten-day letter". According to legislation, an insurer is obliged to formally inform a policyholder of its intention to settle a claim in the absence of the latter's failure to lodge a claim following a collision. The policyholder is given ten days to give a formal reply to the insurer from the date the letter is sent, failure of which would automatically allow for the claim to be settled. This is a formal procedure which the law makers had deemed fit to introduce in the legislation to address those situations where a policyholder – who is most likely to be at fault for an accident – fails to lodge a claim with his insurer. An insurer may prejudice the rights of its policyholder if payment is made for a claim which has not been formally notified. What the legislation might have overlooked is the fact that between the date of the accident and that date when the so-called "10-day letter" is issued considerable time may elapse to the detriment of the third party (especially if such person is not comprehensively insured). The Unit has encountered many legitimate claims by third parties requesting the Authority to intervene with insurers to speed up this process. It is simply unacceptable for an insurer to delay the issue of a 10-day letter by a month (sometimes even more). The Unit has also encountered cases where the insurer, rather than applying the law, informed the (innocent) third party to seek the services of a lawyer to initiate court proceedings against their client. Such procedures being adopted by certain insurers certainly do not constitute good market practice. The Unit believes that the insurance sector should agree on a maximum period of not more than two weeks from the date an insurer is notified that he is likely to be responsible for the payment of a claim to issue such "10-day letter".

During the year, the Unit has also been asked to intervene in cases where an innocent party suffered damages caused by a person who was likely to have been under the influence of alcohol.

In terms of law, an insurer cannot invoke drink-driving or driving under the influence of illegal substances to avoid paying damages and compensation to third party victims. However, many motor policies are likely to exclude cover in such situations. This is not a deliberate attempt to circumvent the law but rather an effort by insurers to convey a message which could otherwise be interpreted differently had such policies been silent on these aspects. The fact that there are such exclusions in a policy allow the insurer to claim a breach of policy conditions on the part of their insured and a legal right to claim back any funds which it was required to pay to injured parties. However, such right can only be legally executed if the insurer has in hand an arbitration or judicial award which attributes liability on its policyholder for the damages sustained to third parties.

This therefore explains why some insurers may be reluctant to speed up the process of payment to third parties even if they have sufficient grounds to believe that their policyholder breached such policy condition. In some respect, it is a matter of "when" rather than "if". Even if the process may eventually lead to payment to the innocent third party, it is this very process which is of inconvenience for an injured party who may have to initiate legal action against the errant party and his insurer to ascertain his rights.

If the damages sustained do not exceed €11,646 and there are no injuries or fatalities or damaged public property involved, the case has to be taken to arbitration. This process may be faster and less costly. If, however, the damages exceed this amount or there are injuries involved, then the case has to be referred to a court of law.

An insurer may not always wait for a court judgement or arbitration decision to compensate a third party and may decide to settle without requiring legal action. This is likely to happen where fault is clear or where the damages are not substantial and the person who caused the damages agrees to refund the insurer in full. It may also occur if the likelihood of recovery is slim.

The process might not be very different from any other collision claim. What makes this process more complicated is that, even if the insurer has sufficient grounds to suspect a breach of a policy condition, it would still hold payment to the third party in order to be able to make a recovery of damages paid from their insured.

Drink-driving convictions are taken very seriously by insurers. For innocent third parties, the inconvenience and hardship these situations may cause is unquantifiable. It would be unwise to propose short-cuts (in the claims' process) especially when injuries are sustained. However, in cases of property damage, stakeholders should identify measures to bring swift justice at the least inconvenience to innocent third parties. The priority, in such cases, should not be recovery of amounts paid but priority settlement of the claim to the innocent party.

Motor insurance – Mobile phone damaged during accident (complaint partially upheld)

Ms A was involved in a car accident with a truck. Due to the severity of the impact, her mobile phone, which was placed in a car phone holder, was damaged. Being in a state of panic when the wardens came to the scene of the accident, Ms A did not make any reference to her damaged phone when providing the warden with her version of events. The third party insurer accepted liability for the accident. Three weeks later Ms A sent a VAT receipt for the amount of €200 claiming reimbursement from the third party insurer in relation to a new mobile phone she had purchased. The insurer repudiated this part of the claim on the basis that it had not been informed of the damaged phone until the time she provided the fiscal receipt. The insurer also argued that Ms A would have needed her mobile immediately after the accident and not waited three weeks to replace her damaged phone. Furthermore, the insurer stated that Ms A never presented her broken mobile phone for inspection and she never informed them that she was buying a new phone.

In her defence, Ms A claimed that due to her long working hours she didn't have the time to shop around for another mobile phone and therefore she was temporarily using an old phone which she still had at home. Ms A also provided the insurer with the damaged phone for assessment as requested.

In the light of the Unit's investigations, it did not transpire that the third party insurance had acted unfairly in regard to Ms A. In the end, the insurer (after taking into account that Ms A had owned the damaged phone for a couple of years) offered to settle this complaint by offering Ms A the sum of €100 in full and final settlement. Ms A accepted the offer.

Motor insurance – Payment of hospital bill to an injured party (complaint upheld)

Mrs P lodged a complaint with the Unit in regards to a claim on her motor insurance policy. Mrs P, and her cousin Mrs Q, who was a passenger in Mrs P's car, were involved in a car accident. Mrs Q, who is not Maltese but resident in an EU Member State, was badly injured and was taken to the state hospital which in turn issued a bill for the medical services provided. Mrs Q did not have a travel insurance policy or a European Health Insurance Card (EHIC). It appeared that she was refused an EHIC from her home country on the basis that she was not paying national insurance contributions at the time.

The insurance company of the third party accepted to pay damages sustained by Mrs P's car but refused to pay the claim with respect to Mrs Q's hospital bill. The insurer maintained that Mrs Q was an EU citizen and, as she was medicated in a state hospital in Malta, she was able to recover the medical bill upon her return to her home country. Mrs P complained that the state hospital was persistently contacting her to settle the medical bill on the basis of a declaration she had signed to shoulder the cost of her cousin while in hospital. Mrs P stated that, rather than Mrs Q, the insurance company should have paid the bill.

The Unit contacted the government department in charge of issuing the EHIC cards to understand the procedure which is usually followed when foreign EU nationals avail themselves of local state medical facilities. The Unit learnt that whenever an EHIC is not produced, the individual may be required to pay for the medical services availed of but may be able to recoup the amount from the respective home authority. The Unit also contacted the European Commission Representation in Malta to confirm whether what the insurance company was saying was correct (i.e. that Mrs Q could recoup the expense from her own country, even if not in possession of an EHIC). The Commission representative stated that it might be the case that certain EU member states can decide not to provide social security benefits to those citizens who do not pay national insurance contributions. Indeed, it transpired that Mrs Q, who had been unemployed before she came to Malta, was not paying national insurance contributions and therefore, according to her country's rules, was not entitled to an EHIC.

The Unit argued that since Mrs Q was not able to claim the injury benefits from her home country and was not covered by any other insurance policy, the insurance company was bound to pay the hospital bill in terms of law.

The insurance company agreed to settle the hospital bill in full in favour of Mrs Q (besides the expenses incurred by Mrs P to repair her car).

Motor insurance – Loss of use/right to a rented vehicle and VAT payment on repairs of commercial vehicles (complaint upheld)

Mr G was driving a commercial vehicle and was involved in an accident. The fault of the accident was attributed to a third party and consequently the third party's insurer accepted liability. A surveyor of the third party insurer assessed the quantum of damages and Mr G was authorised to start repair works. Mr G was advised by the parts supplier that, although parts had been ordered, delivery was expected not before a further three weeks and repairs could only start thereafter.

Mr G used his vehicle to transport furniture and could not be deprived of his vehicle for such a long time. Mr G informed the insurer of his need to rent a commercial vehicle until his van was fully repaired. The insurance, however, was only willing to provide him with a replacement vehicle for the five days during which his van would be undergoing repair (as allocated by the surveyor). Mr G felt that this was grossly unfair as he thought he should not bear additional car rental expenses when it was the third party who had caused the accident. Discussions with the third party insurance were unsuccessful and Mr G referred his case to the Unit.

The Maltese Courts established that an injured party (i.e. the party whose vehicle has been damaged) should be reinstated in full and rightfully able to recover his losses and to restore his property to its pristine original state from the guilty party.

The Unit exchanged several e-mails and phone calls with the insurer, who seemed adamant. At one point, the insurer also claimed that the reluctance to offer a replacement vehicle to Mr G for the period until the parts arrived was attributed to the fact that the latter had an obligation to minimise losses. The insurer alleged that Mr G's vehicle was still roadworthy and could be driven without any problems. The Unit was of the opinion that the duty to determine whether a vehicle is road worthy or not lies with the insurance company and its appointed surveyor and therefore the insurer should have clarified this issue with Mr G at the time he informed them of his intention to rent the vehicle. In his defence, Mr G appointed an independent surveyor who confirmed that his vehicle could not be considered as roadworthy until it was fully repaired.

The Unit held the view that Mr G should not suffer car hire expenses. The Unit reminded the insurer that on various occasions, the Maltese Courts established that an injured party (i.e. the party whose vehicle has been damaged) should be reinstated in full and rightfully able to recover his losses and to restore his property to its pristine original state from the guilty party. On this basis, the Unit recommended that Mr G had to be refunded for the car hire expenses up to the limit allowed under the motor insurance policy. The insurer did not accept the Unit's recommendation in full but decided to increase the amount paid to Mr G in relation to the rented vehicle by another ten days.

Mr G also raised the issue that the insurer was going to settle his claim without paying the VAT element incurred on the repair expenses. The Unit explained to Mr G that an agreement existed between insurance companies and the VAT department whereby it was agreed that in regard of commercial vehicles, the insurance company should pay the parts suppliers and panel beaters the total cost of repairs less the VAT expense with the latter being borne by the policyholder. The policyholder could then claim back this VAT expense in his/her VAT declaration.

Motor insurance - Third party insurer did not open claim

Ms X had an accident with Mr Y following which a traffic warden report was compiled and forwarded to the respective insurers. Ms X duly went to file a claim with her insurers who told her that she was not at fault and that they will discuss the issue with the third party insurer to have their view and get their confirmation to start repairs.

When contacted, the third party insurer informed them that they were still waiting for the insured to file a claim. After around 40 days, Ms X went directly to the third party insurer who informed her that they were still waiting for confirmation from Mr Y to lodge a claim.

Exasperated, Ms X opened a complaint with the Unit which contacted the third party insurer and insisted that ample time had been given to Mr Y to lodge a claim. The Unit stated that the insurer's laissez-faire stance was unacceptable and reminded the insurer that in terms of law, there was a mechanism to ensure that claims by third parties are expeditiously handled without insurers being held hostage of their client's irresponsibility.

At the end of the week in which the Unit contacted the insurer, the third party insurer sent its client the statutory "ten-day letter" through a registered letter. However, the letter was not delivered as, after a couple of attempts, no one replied. Neither could the insurer contact Mr Y by phone.

It transpired that Mr Y was working abroad and his home was vacant. The insurers were told that he would be travelling to Malta about a week before Christmas and would be willing to open the claim then. The Unit informed the third party insurer that this delay (a further six weeks of waiting) was totally unfair for the third party.

A week before Christmas, Mr Y was served with the statutory "ten-day letter" and did not object. After weeks of tortuous waiting, the third party insurer confirmed approval for the repair works to commence.

Unit-linked policy - TII delays instructions to redeem a unit-linked policy (complaint upheld)

Mr Z had a unit-linked policy. Following an increase in its value, he decided to surrender the policy and transfer proceeds to a single premium policy with the same insurer. Mr Z contacted a Tied Insurance Intermediary (TII) who immediately provided him with the necessary paper work for completion and advised that he would be receiving confirmation of the transfer the following week.

Mr Z received confirmation of the transfer two weeks from the date of his instructions and noted from the paper work that the transaction was processed five working days from the date of his instructions to the TII. He also noted that due to this delay, the value of his unit-linked policy decreased in value leading to a loss of €2,500 in the process.

Mr Z complained about this delay to the insurance company which in turn advised that, although it processes applications for surrender within two days of receipt of the application, it could not be held responsible for any delays caused by a TII if he failed to deliver the necessary paperwork in a timely manner. In addition, the insurer stated that it could not process applications unless provided in original.

Mr Z lodged a complaint with the Unit. As part of the investigation, the prices for the week when the insured placed his instructions were sourced. The Unit confirmed that, due to an exceptional deterioration in market conditions, the underlying assets of the unit-linked policy had decreased in value during those five working days. Had the provider acted on its client's instructions the next day, the loss would have been much less as opposed to the loss of € 2,500 suffered by Mr Z.

The Unit upheld the complaint noting that the insurer is ultimately responsible for the actions of its TII and could not absolve from its responsibility if he failed to follow internal procedures. Given the nature of the product, which is linked to market prices, it was of utmost importance that there were no delays in executing instructions. The insurer agreed with the Unit's recommendations and applied the prices of the underlying assets of Mr Z's policy as were applicable on the day of his instructions.

Medical insurance – Portability of insurance cover (insufficient evidence)

Mrs X was employed with a local company, Company A. She was covered under a basic group health insurance scheme paid for by the company but opted to upgrade her policy to a better scheme covering her and other members of her family for an additional annual premium.

Mrs X left the company and started work with Company B. Mrs X, however, wanted to retain the same level of coverage she enjoyed when working with Company A and was prepared to pay an additional premium as long as continuity from the previous cover was preserved. To this end, she asked the same insurance company to extend the level of coverage and benefit for her and her family on a "stand-alone" basis.

The insurer, however, rejected Mrs X's request on the grounds that continuity of coverage could not apply. Mrs X and her family were required to compile a proposal form as the arrangement to insure on a stand-alone basis necessarily required new underwriting. The stance was considered by Mrs X as punitive. She was aware that over the preceding year, her partner was diagnosed with a terminal illness and new underwriting would not only increase premium but also exclude any pre-conditions. Mrs X claimed that the insurer's refusal was tantamount to restrict job mobility.

The Unit established that the group medical policy was a contract between the company and the insurers. The employees of the company and dependants were beneficiaries. Hence the contractual relationship of the insurer was directly with Company A. Employees who left the company could opt for private medical insurance cover with the same company but not on the same underwriting arrangements as different risk scenarios would have had to be taken into consideration. The insurer also confirmed that the insurance contract with the company did not cater for scenarios of continuity or portability from group to stand-alone policies.

The claimant felt that her preceding employer, Company A, was acting as an "intermediary" who with her approval and authorisation deducted the cost of the premium from her salary. Hence, she believed that the upgrade to a better scheme was between her and the insurance entity. However, any arrangement which allowed an employee to upgrade and extend the benefits under a group scheme would be terminated as soon as that employee left the company.

It was established that group policies are always weighed as one risk with the premium charged commensurate to the risk of the group. Therefore, for those groups whose members had lodged higher levels of claims, then such claim history would be loaded into the total cost, justifying the levying of higher premiums than that of another group that had not registered such levels and nature of claims.

The Unit could not concur with Mrs X that the upgrade to her policy (for which she paid additional premium) had to be treated differently from the group insurance arrangements made by the "previous" employer with the insurers. The Unit also confirmed that the group insurance contract did not include any continuity provisions in regard to those employees who resign from the company.

Prima facie, the insurer's decision appeared to be austere especially in regard to the "portability" of a claims history which not only led to a loading in premium but also excluded medical conditions for

which treatment had already been sought. In effect – and reviewing the argument purely from a potential policyholder's perspective - insurers were dissuading (rather than encouraging) prospective policyholders to take up stand-alone private medical cover at a reasonable price without the additional burden of "portability". On the other hand, insurers were technically correct to require new underwriting as the contractual arrangements were different.

The Unit sought informal opinions from two other jurisdictions on this issue. It was evident that a group policy differs in terms of risk from an individual contract and it is opportune for an insurer to reassess the risk pertaining to the individual if the latter leaves the group. In a specific jurisdiction (and this might also imply similar arrangements in other jurisdictions), specific legislation provides for claims submitted following sickness, maternity and accident to be met despite the employee becoming unemployed or if he/she retires subject to specific timeframes. In the case of the death of the insured, coverage is also continued up to a specific time frame and following demand for such cover to apply within six (6) months after death. Tariffs applicable on new policies following departure from a group are also set by legislation and may not exceed set percentages on the salaries applicable at the time.

The Unit informed Mrs X that, in regard to her case, there was not enough evidence to suggest that the insurer was negligent or insensitive in her regard.

Medical insurance – Mistake rectified after five years (complaint upheld)

Mrs X had been employed with a company for a number of years. She enjoyed free medical insurance as part of a group medical policy arranged between her employer and an insurer. A few years back, the employer sought the services of another medical insurance provider and discontinued the policy with the previous insurer. Employees were given the opportunity to upgrade the insurance arrangement from basic cover to a better plan at an additional premium.

Some months earlier, Mrs X had to undergo an operation on her left knee. When she contacted the insurers before the intervention, Mrs X was told that they would not reimburse her claim for MRI and other relative costs because any medical intervention on any of the two knees were excluded from cover given that she had already been operated on either of the two knees. Mrs X was perplexed by this decision and requested the Unit's intervention.

During the course of the Unit's review of the case, it transpired that some years back, Mrs X had been operated on one of her knees but was not exactly sure whether it was the left or right knee. When the "second" insurer took over from the "first" insurer, the latter failed to specify exactly which knee Mrs X had been operated on. Although Mrs X had received a copy of the exclusions, she did not understand what was written ("internal derangement and conditions arising therefrom or associated therewith"). The second insurer checked its records for any information which the first insurer might have provided and confirmed that the "first" insurer simply excluded both knees.

The Unit was made aware that the switch from the first to the second insurer was made on a "no worse" terms basis, meaning that where a change of insurer (or change in policy) is under consideration, members are covered with an alternative insurer using the previous medical underwriting status

applicable to their original policy with no worse medical underwriting terms applying to the new policy. The second insurer also opined that when exclusions do not specify a particular knee, then the exclusion will refer to both, adding that a prudent underwriter would impose an exclusion on both knees if he knows that a proposer suffers (or suffered) from a medical condition on one knee which is likely to repeat itself on the other knee in the future.

The Unit disagreed with this opinion because it was unfair to rely on "probabilities". The Unit also found it objectionable that the insurer refused to take into consideration a medical test Mrs X was proposing to carry out in order to establish with certainty whether she had already been operated on her left knee. The second insurer did not consider the medical tests as relevant given that the exclusion applied to both knees.

The Unit asked the first insurer to review Mrs X's file and, rather than putting the onus on Mrs X to establish whether it was the right or left knee on which she was originally operated, sought to establish whether her doctor at the time provided any detail in this regard. On the basis of documentation held on file, the first insurer confirmed that the exclusion should have read "internal derangement right knee". In addition, the second insurer also agreed that its assumption that a problem with a right knee might also lead to problems in the other knee did not justify the exclusion of both knees. The second insurer subsequently accepted to reword the exclusion to read "internal derangement right knee" and settled Mrs X's claim for the left knee in full. The Unit also observed that it was unfair for an insurer to continue to indefinitely exclude cover for medical conditions which existed (and successfully treated) without any time lapse.

Motor insurance – Transportation of LPG cylinders in one's own vehicle

Mr O wrote to MFSA asking for an opinion as to whether his motor insurance policy would cover damages to his vehicle and third parties in the likelihood that something happens to an LPG gas cylinder while transporting it in his private vehicle following purchase from a fixed point of sale.

A private motor vehicle insurance policy would generally be restricted for the "use solely for social, domestic and pleasure purposes". If a policyholder uses his own vehicle to transport an LPG cylinder purchased for own consumption, then such carriage would appear to fit in the 'domestic' definition should anything happen during carriage. Some policies, however, had a clause under "General Exclusions" which specifically excluded cover if any "hazardous or combustible material" is transported. Some policies went beyond this term and were more specific in their exclusions.

The Authority does not approve insurance policy terms and conditions. EU Insurance directives prohibit member states from adopting provisions requiring prior approval or systematic notification of general policy conditions or of scale of premium.

Although gas cylinders may explode if subjected to extensive heat, the Authority did not have the competence to establish whether gas cylinders fit into the description of combustible material. Whilst it is certainly beneficial for an insurance policy to be unequivocal as to whether the transposition of such cylinders for domestic purposes would be covered, one should always act as a prudent uninsured and determine with his insurers whether the policy extends to cover these types of transits.

Mr O made the Unit aware that he had contacted other relevant organisations with his query. It was confirmed that transporting gas cylinders in a private car was – as such – not illegal and that the carriage of maximum two gas cylinders for own use is allowed. Obviously, safety precautions need to be observed, typically that the gas cylinders are safely secured in the luggage booth. It also transpired that, some time ago, a campaign to increase safety awareness as to the purchasing and transporting of empty and full gas cylinders had been embarked upon.

Exchanges were also made with the Malta Insurance Association (MIA) regarding the issue of the carriage and transportation of gas cylinders. The Unit became aware that the MIA had guided the market on this aspect after discussing this matter with motor insurers. The MIA referred to the restriction as to use which is generally defined as "…use solely for social, domestic and pleasure purposes and for [the policyholder's] business, that of the spouse or that of the [policyholder's] employers or spouse's employers …" According to this wording, the MIA was of the opinion that cover would not be prejudiced if a policyholder uses his own vehicle to transport an LPG cylinder purchased for own consumption from a fixed point of sale.

However, a policyholder should always check his policy for any specific exclusion and if in doubt seek advice.

Long-term insurance – Valuation of a matured unit-linked insurance policy (complaint upheld)

Mrs Y's unit-linked policy matured on a Sunday. Some days prior to maturity date, Mrs Y visited a bank's branch to sign the necessary documentation for the proceeds to be routed to a particular account. Mrs Y also requested the official to give an estimate of the value of the policy. The official taking the instructions duly informed Mrs Y that the actual amount of proceeds might differ from that quoted as the value depended on market conditions prevailing at the time.

Mrs Y received the proceeds into her account eight days after maturity. However, the proceeds fell quite short of the amount estimated by the branch.

Mrs Y complained that she was not satisfied with the outcome and asked the Unit to intervene. During review, it transpired that the insurer did not value policies on a daily basis but rather on a weekly basis and on a particular day. This meant that, although the policy matured on a Sunday, the insurer computed the valuation on the basis of prices occurring on the next valuation day which was a Thursday. It so happened that between Monday (the next available working day) and Thursday (the insurer's valuation day), financial markets were in chaos and Mrs Y's suffered a 15% loss when compared to Monday's valuation.

The insurer held the view that its practice of valuing prices on a weekly basis was in line with policy conditions as well as standard market practice.

The Unit held the view that if standard market practice in Malta was truly based on weekly pricing of unit-linked policies, then the whole market was failing investors. The Unit held the view that daily pricing should be "the" standard as the policyholder should not be subjected to any market fluctuations purely on the basis of inadequate accounting procedures of the insurer.

Furthermore the policy document did not specify "weekly valuations". Indeed, the policy wording stated that assets will be valued at intervals of no greater than one month and that on the maturity date, the maturity value will be the bid value allocated to the Policy at the maturity date.

The insurer felt that it was going beyond its commitment to the client and pointed out that its decision to value policies once a week had been taken to reduce any element of speculation especially in regard to policyholders who surrender their policies prematurely.

The Unit rejected the insurer's views. It stated that Mrs Y was not speculating and was not surrendering her policy prematurely. It stated that while a weekly valuation might have been a reasonable expectation at the time when Mrs Y started the policy over 15 years ago, it was reasonably expected of an insurer to adjourn its accounting procedures to daily valuations.

Given that Mrs Y's plan matured on a Sunday, the Unit was of the firm view that the valuation of her policy should be computed on the values of the next available working day.

The insurer complied with the Unit's request and duly refunded the claimant with the difference.

Travel insurance – Exclusion from cover (upheld but rejected by the insurer)

Mr P booked a tour with a group for the summer but a few weeks before departure he suffered from an anxiety attack and decided not to travel. He had paid a deposit for his partner and himself at the time he purchased the policy. Mr P sought the services of a psychiatrist. Mr P insisted that he had never suffered from any mental conditions and that he never had to refer to a psychiatrist for any reason. The psychiatrist prescribed the necessary therapy however, no progress was registered. Following another attack in the month when Mr P intended to travel, he was medically declared unfit for travel. The claimant formally informed the touring company about his intention to cancel the tour because of the medical conditions prevailing. Subsequently he was referred to the insurance agency supplying the latter with a certificate issued by the psychiatrist.

It further transpired that Mr P was aware that one of the conditions prevailing in the insurance policy involved "injury, illness or death of yourself or any person with whom you have arranged to travel or stay." However, no reference was made as to whether illness constituted physical or mental illness.

Unfortunately, Mr P did not attend the meeting convened by the travel agency for the whole group which had been scheduled around three weeks before departure.

The insurer rejected Mr P's claim on the basis that "emotional, mental or depressive illness of any type and/or anxiety state and/or similar conditions" were not covered by the policy. Mr A claimed that he was not aware of this exclusion because he had not been given a copy of the insurance policy at the time he paid the deposit and the premium to join the group travel policy. Mr P stated – and the Unit believed him – that he was only provided with a summary of the benefits. The summary of benefits was not comprehensive as to exclusions.

Consumers should be encouraged to ask questions about the depositor compensation scheme and bank staff should remain factual in the manner they explain it to consumers.

To add insult to injury, the summary of benefits referred to the possibility that the insured may download a copy of the policy from the insurer's website. Mr P was computer illiterate.

The Unit opined very strongly in favour of Mr P. It stated that the summary of cover is not correct in disclosing that 'a specimen may be examined on application' and further felt that it is in breach of an Authority's rule in that the full policy document should have been furnished to the insured from the outset. The Unit however pointed out that the condition that was diagnosed to the claimant prior to departure is a condition that is invoked in exclusions inherent in travel insurance policies and is prevalent in the majority of policies available locally.

The Unit felt that as an insured Mr P was not made aware of the policy conditions at point of sale.

The insurer remarked that the tours brochure from which Mr P chose his tour contained a full page description of its travel policy sold by its intermediary (the travel agent). The Unit rejected the insurer's argument as a full page on travel insurance on the tours brochure could not substitute the conditions inherent in the policy document.

The Unit recommended payment equivalent to the amount that Mr P had paid in deposit. The entity, however, rejected the Authority's recommendation. It also refused to reach a compromise. Mr P was informed of the insurer's decision and the Unit informed Mr P of his right to seek other means of redress.

BANKING

Competition for deposits and home loans appears to be quite evident. This may be welcoming news for some consumers.

The Unit is, however, concerned to note that moral hazard may have seeped into depositors' minds: if something happens to the bank, there is "someone" who guarantees return of my money. Factually, this is correct. Depositors are not – and never will – be in a position to gauge a bank's level of risk. They are more likely to understand that, in the event of a problem, their money will be paid back because a mechanism is in place for such an eventuality. It may also be true that some banks might have used such mechanism as a marketing tool to dispel any doubts or questions about a bank's standing, or why it offers better rates than the bank just round the corner. The Unit has received a substantial number of calls (in proportion to the overall number of calls processed) from consumers enquiring about the depositor compensation scheme. Consumers ask about the level of coverage or whether the bank is a participant of the depositor compensation scheme. Some others go beyond the basic questions and seek more information about the scheme's workings. Consumers should be encouraged to ask questions about the scheme and be given factual information. Bank staff should remain factual in the manner they present information to depositors about the scheme and should not use it as a marketing tool.

During the year, a number of revisions were made to the home loan regulations. Although the rules are aimed towards ensuring adequate levels of consumer protection, there is ample room for improvement such that home loan consumers should be able to switch their loan to other banks without having

to spend a fortune on processing and legal fees (which inhibit consumers' appetite to shop around between banks). In addition, a consumer should not be burdened with processing fees purely to obtain a quote from a bank for a home loan or termination fees when early payment is made. In this sense, proper research should be conducted to assess whether competition between banks in this sector is working in favour of consumers.

If competition appears to be working in some areas, one cannot make the same inference for the wide array of tariffs charged by banks, where it is clear that market forces are not functioning. One has yet to see downward revisions of some charges such as, for example, in relation to electronic processing of payments. Although banks have invested heavily in systems to ensure speedier processes for both outgoing and incoming payments, the increasing number of payments processed electronically should have by now paid back the initial investment costs. Consumers therefore rightfully expect banks to revise their charges to promote more efficient means of payment transactions (such as direct debits).

Cross-selling is an important tool for banks which allows them to exploit their relationship with their customers in an attempt to offer them other services. Banks are depositories of substantial information about their depositors and some banks have used such information to offer alternative products or services. In itself, the practice is not wrong if the customer gave his explicit consent for the bank to use the information for cross-selling purposes. Worryingly, the local situation is perverse in that banks simply assume that they can use such information for cross-selling unless the customer explicitly disallows them from doing so. This has led to allegations of bank staff selling investment products to an unassuming client base. It may be true that a customer is not obliged to take up any of the bank's offers. However, anecdotal evidence seems to suggest that consumers may not necessarily make a link between the sales pitch that may be used and the suitability of the product they most likely end up acquiring

The Unit has come across a few unfortunate cases involving unauthorised withdrawals following card theft. Most of the cases that were evaluated involved theft of wallets and/or handbags in a foreign country. Bank cards were often targeted by fraudsters affecting withdrawals to extinguish the maximum limit accessible on the card. An evaluation on the basis of audit trails received from the respective banks elicited the fact that the cards were used with the PIN and hence the onus is on the cardholder to inhibit the incidence of keeping the PIN written down anywhere. Some banks have implemented a free notification service to cardholders whereby a text message is sent to the cardholder's mobile number whenever a transaction which may appear "not ordinary" for the bank's system occurs. Cash withdrawals may also trigger such automated text messaging warnings. The Unit believes that banks should promote this service more as it is likely that many cardholders are not aware of it or are reluctant to divulge their mobile number to their bank.

Banking – Cancellation of loan and processing fees (Insufficient evidence)

Ms T always used the services of Bank XYZ to manage her finances. She in fact also applied for a home loan with her bank when she wanted to purchase her first residence. She did not bother to shop around to check if other banks provided better terms on the substantial amount she wanted to borrow. Indeed, her loan application was approved by the bank and a sanction letter explaining the terms and conditions of the loan was issued. As is customary, the legal and processing fees were charged to the account of Ms T on the same day she signed the sanction letter.

Some days later, Ms T appears to have had a change of mind and decided to approach Bank ABC for a home loan quotation. Consequently, Ms T cancelled her sanction letter with Bank XYZ and applied for the loan with Bank ABC. Ms T asked Bank XYZ to reimburse her with the processing and legal fees which were already taken from her account as she declined to avail herself from the loan offered by this same bank. Bank XYZ, however, refused to refund these charges on the basis that details of such charges were clearly indicated on the proposal form. Customer had agreed to all clauses by signing this form. The loan application form unambiguously specified that when a customer does not utilise the loan, the bank would still charge the full amount of fees due without any discount.

The Unit explained to Ms T that this practice was not unique to Bank XYZ but is a common banking practice as the bank would have still incurred legal and administrative expenses in order to carry out the necessary formalities for the loan to be issued. The Unit also urged Ms T to ask Bank ABC for a copy of the loan application form she had just signed and check for herself that this Bank also included the same clause in its application for finance. Ms T confirmed the Unit's submissions.

On this basis, the Unit was unable to determine that Bank XYZ could be found at fault or that it acted wrongly in Ms T's regard.

Banking – refusal to effect direct credit of dividends to a new bank (complaint upheld)

Mr S submitted a complaint to the Unit after a company listed on the Malta Stock Exchange refused to process a direct credit of dividend to Bank A - one of the banks that had started business in Malta some years ago.

The Unit raised the matter to the company's financial controller to establish the root of the problem. The company claimed that the company's bankers (Bank B) and Mr S's bank did not have an automatic payment transmission arrangement between them and that accordingly, a dividend payment could not be generated by Bank B to Bank A. This was resulting in an inconvenience for Mr S as he was being deprived from opening an account with the bank of his choice. In the Unit's view, this was an anti-competitive and unacceptable attitude.

There might be some situations where the Unit, during the course of its investigation into a complaint, may have to refer to other authorities or organisations which have competence over the subject matter. Clearance of payments between banks is in fact overseen by the Central Bank of Malta (CBM) and therefore the Unit had to seek its assistance. After various discussions with the CBM and the company, the latter confirmed that the problem had been solved and that future dividend payments made by the company will be credited directly to Mr S's chosen bank.

Banking – Dormant account in an Australian bank

Mr Y received a letter, addressed to his deceased uncle who used to live with him, notifying him of a sum of money his late uncle had in an account with an Australian bank. The letter was sent by a firm in Australia which described itself as a leading firm specialising in recovering money from dormant accounts held with Aussie banks. Mr Y suspected the letter was a fraud although he was aware that

his uncle had been in Australia for a number of years and might have opened an account in Australia during that time. He approached the Unit to verify the veracity of the letter's contents.

The Unit contacted the Australian financial regulator to check on the veracity of information contained in this letter. The Unit was advised that the Australian financial regulator had an online database of all the persons who hold inactive (i.e. no transactions over a span of two years) banks accounts with Australian banks. The information on the financial regulator's website listed the name and address of the account holder, the name of the bank and the balance held in the account. Upon verification, it transpired that Mr Y's uncle did actually have an account with an Australian bank which had been inactive for quite some time. Mr Y was the only heir to his uncle.

As the information was freely available, money search companies send mailshots addressed to account owners of dormant accounts. For a fee, these companies offer to assist rightful owners to claim balances held in these accounts.

The Unit advised Mr Y that the letter was not a scam and he should therefore write to the bank and ask for instructions on how to claim the money. Mr Y could by-pass the private money search company but should seek assistance from a local notary as all documentation submitted to the bank had to be certified.

The bank replied soon after it was contacted by Mr Y and requested several documents including a death certificate and copy of the will together with a form which needed to be completed. In addition Mr Y had to provide his bank account details in order to transfer the funds. Mr Y was advised to open an account specific for this particular transaction in Australian dollars to counter any risks involved in the transaction. A few weeks later the money was transferred in his Australian Dollars account with the local bank.

APPENDICES

APPENDIX I

FORMAL COMPLAINTS BY CLASSIFICATION

	A	B	C	Di	Dii	E	F	G	TOTAL
Banking complaints									
Any financial insitituion	1			1		2			4
Bank commercial decision							1		1
Mistake	1			1		1			3
Charges				1		1			2
Cheque encashment						1			1
Delays	1							1	2
Loans and advances				1		2			3
Refusal to give information						1		1	2
Transfers							1		1
Unauthorised card transactions						8			8
Use of exchange rate				1		1			2
Insurance complaints									
Health-related					1	2	1	1	5
Home-insurance related		1					1		2
Motor - Third Party - Delay in claim/payment	1					1	1		3
Life-related	1			3		4		1	9
Local company passporting in the EU	3	1	2	1		6	1	1	15
Motor - Own policyholder - Claims			1			1			2
Motor - Own policyholder - Market Value	1							1	2
Motor - Own policyholder - Liability								1	1
Motor - Own policyholder - No Claims Discount				1					1
Motor - Third party - Property damage				1		1			2
Motor - Third party - Failure to open claim	3			3			1		7
Motor - Third party - Liability	1			1		1			3
Motor - Third party - Loss of use				1					1

FORMAL COMPLAINTS BY CLASSIFICATION - *continued*

	A	B	C	Di	Dii	E	F	G	TOTAL
Motor - Third party - Market value				1		1	2		4
Motor - Third party - Use of spare parts		1					1		2
Motor - Own policyholder - Use of spare parts				1					1
Personal accident insurance				1					1
Providede information						1			1
Travel-related				1	1	12	4	1	19
Investment complaints									
Calculation of interest/yield/price				1		1	1		3
Capital-guaranteed related						1			1
Charges						1			1
Intermediary mistake						2			2
mis-selling allegation	1			3	1	7		2	14
Other						2			2
Suitability of product	1			2		1			4
Other complaints									
Listed company on the Malta Stock Exchange								1	1
Trusts-related			1			1			2
	15	3	4	26	3	63	15	11	140

CLASSIFICATION

(A)	15	Outside MFSA jurisdiction (in such instances and following any investigation undertaken, the complainant is requested to seek redress with the appropriate authority or redress system as applicable).
(B)	3	Customer withdrew complaint.
(C)	4	Referred to entity or consumer – no feedback.
(D)(i)	26	Entity has not treated the customer's complaint fairly – complaint upheld by Consumer Complaints Manager. Entity accepts recommendation.
(D)(ii)	3	Entity has not treated the customer's complaint fairly – complaint upheld by Consumer Complaints Manager. Entity did not accept recommendation.
(E)	63	Entity has treated the customer's complaint fairly – complaint not upheld by Consumer Complaints Manager.
(F)	15	Entity has generally treated the customer's complaint fairly but it still agrees to a goodwill payment or improved settlement.
(G)	11	General query – provided information/clarification.

APPENDIX II

QUERIES AND VERBAL COMPLAINTS

	Queries	Verbal Complaints
BANKING		
Charges	6	39
Cheque encashment	2	13
Delays	1	5
Bank Mistake	8	-
Refusal to give information	3	-
Unauthorised card transactions	4	15
Bank Commercial Decision	5	-
Provided info or General query	19	71
Information relating to the Depositor Compensation Scheme	-	323
INVESTMENTS		
Bad advice allegation	6	5
Calculation of interest/yield/price	4	4
Capital guaranteed-related	1	8
Charges	4	19
Intermediary mistake	-	5
Mis-selling allegation	31	333
Suitability of product	25	20
Refusal to give information	25	-
Other	10	-
Delays (payments and other documents)	2	-
Provided information or general query	8	99
INSURANCE		
Cannot find insurance	2	7
Health-related	2	21
Home insurance- related	6	26
Increase in premium	2	5
Life-related	7	57

QUERIES AND VERBAL COMPLAINTS - *continued*

	Queries	Verbal Complaints
Motor - Own policy - NCD	3	6
Motor - Own policy - Claims	5	68
Motor - Own policy - Liability	1	17
Motor - Own policy - Loss of use	1	41
Motor - Own policy - Market Value	6	21
Motor - Own policy - Use of spare parts	3	9
Motor - Third-party – Failure to open claim	10	25
Motor - Third-party – Liability	12	31
Motor - Third-party – Loss of use	4	15
Motor - Third-party – Market Value	5	21
Motor - Third-party - Use of spare parts	3	8
Refusal to give information	-	-
Intermediary-related	1	-
Motor - Third-party – Loss of Profit	2	-
Motor - Third-party – Delay in handling claim/payment	7	14
All Commercial Policies	1	-
Provided information or general query	5	29
Local company passporting in EU	10	13
Provided info or General query	35	6
OTHERS		
Scam	14	23
Outside MFSA competence	37	67
	320	1520

APPENDIX III

ABBREVIATIONS

ADR	Alternative Dispute Resolution
CBM	Central Bank of Malta
CCPFI	Committee on Consumer Protection and Financial Innovation
EEA	European Economic Area
EHIC	European Health Insurance Card
EIOPA	European Insurance and Occupational Pensions Authority
EU	European Union
ICT	Information and Communication Technologies Unit
MFSA	Malta Financial Services Authority
MIA	Malta Insurance Association
MIFID	Markets in Financial Instruments Directive
ODR	Online Dispute Resolution
SMSU	Securities and Markets Supervision Unit
TII	Tied Insurance Intermediary

EU AND MALTESE LEGISLATION

Banking Act (Cap. 371)

Commission Recommendation on the principles applicable to the bodies responsible for out-of-court settlement of consumer disputes - (98/257/EC)

Commission Recommendation on the use of a harmonised methodology for classifying and reporting consumer complaints and enquiries - C(2010)3021 final

Consumer Affairs Act (Cap. 378)

Directive on Payment Services in the Internal Market – (2007/64/EC)

Financial Institutions Act (Cap. 376)

Insurance Business Act (Cap. 403)

Investment Services Act (Cap. 370)

Malta Arbitration Act (Cap. 387)

Malta Financial Services Authority Act (Cap. 330)

Markets in Financial Instruments Directive (2004/39/EC)

NOTES

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