Alternative Dispute Resolution Systems Regarding Private Insurance

SİGORTA HUKUKU TÜRK DERNEĞİ
TURKISH CHAPTER OF AIDA

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SİGORTA HUKUKU TÜRK DERNEĞİ
(AIDA TURKEY)

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Foreword

Due to various reasons, unavoidably disputes arise between insurers and policyholders. In spite of the fact that a popular means - and in any case the ultimate weapon - to resolve such disputes is via the resort to state court litigation, nevertheless another means of resolution of such disputes is the so-called ADR (Alternative Dispute Resolution) schemes and methods, which are frequent and often lead to successful results.

This booklet contains articles written by experts of different jurisdictions. The aim is to give the reader a comparative idea about existing ADR methods in the field of private insurance.

I would like to express my warm thanks to the authors (all linked to AIDA) for their most valuable contributions.

Samim Ünan
Chairman
AIDA Consumer Protection and Dispute Resolution
Working Party

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The German Insurance Ombudsman System

Prof. Dr. Jens Gal, *Maître en droit*

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I. Introduction

For many years the proliferation of new ombudsman systems in Germany has been met with almost universal acclaim by political and economic actors and the public at large. The development of the ombudsman idea took place in two very distinct spheres: On the one hand, ombudsmen were instituted in the political, public law sector.[1] Here the ombudsman is usually a state official appointed and entrusted with the task of serving as an advocate for the citizens' interests vis-à-vis political or administrative activities. On the other hand, ombudsman systems have also flourished in the private economic sector.[2] Here, ombudsmen are intended to remediate a disequilibrium that exists between an economic actor and its contractual partner – which is usually a consumer – by providing the latter with an efficient, yet inexpensive dispute resolution mechanism for complaints against the former.

1 For an overview on some public sector ombudsmen, cp. *i.a.* Haas, Der Ombudsmann als Institution des Europäischen Verwaltungsrechts – Zur Neubestimmung der Rolle des Ombudsmanns als Organ der Verwaltungskontrolle auf der Grundlage europäischer Ombudsmann-Einrichtungen, Tübingen 2012.

2 An overview on ombudsmen in the financial sector may be found in Brömmelmeyer, Der Ombudsmann im Finanzsektor, in: WM - Zeitschrift für Wirtschafts- und Bankenrecht 2012, pp. 337–342 at 337; for further sectors providing an ombudsman system cp. e.g http://www.galli-institut.de/vr_om.htm.

One of the most successful ombudsman procedures in Germany is the one provided by the German insurance undertakings, the *Versicherungsombudsmann*, which since its inception in 2001 has attracted an annual average of about 17,000 complaints[3] reaching a new peak in 2013 when almost 19,000 complaints were lodged.[4] At first sight one might be mystified as to how this institution managed to garner equal support from insurers and policyholders alike. One of the reasons can certainly be seen in the fact that unlike many other ombudsmen the *Versicherungsombudsmann* is not limited to making recommendations to the parties (in the sense of a reconciliation procedure) but in disputes up to an amount of € 10,000 is empowered to take decisions binding on the insurer (but not the complainant). This is, however, but one facet of the attractiveness of the German insurance ombudsman and to understand its success one needs to take a more detailed look at its structure.

II. Historical Development

Whilst the creation of an insurance ombudsman had been under occasional discussion since the 1970s,[5] the foundation of the *Versicherungsombudsmann e.V.* by the German insurance industry in 2001 was rather belated[6] in comparison to the insurance sector of many neighbouring countries[7],

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3 Only during the first three years did the complaints average amount to a "mere" 10,000. Since then, the average has constantly remained between 17,000 and 19,000 complaints *per annum*; for the numbers in the first few years cp. e.g. Ombudsmann für Versicherungen, Jahresbericht 2007, p. 56.

4 To compare, the German Private Banking Ombudsman – which, however, is only competent for disputes with private banks – has even in his most successful years never attracted even half the amount of complaints; cp. Ombudsmann der privaten Banken, Tätigkeitsbericht 2012, p. 40.

5 Apel, Die Bedeutung staatlicher Politik für die moderne Privatversicherung, in: Versicherungswirtschaft 1977, pp. 1486–1491 at 1488; Büchner, Brauchen wir einen Ombudsmann?, in: Versicherungswirtschaft 1978, p. 1485–1490; Surminski, Versicherungswirtschaft und Verbraucherschutz, in: Zeitschrift für Versicherungswesen 1979, pp. 4–11; Hoeren, Der englische Versicherungs-Ombudsman – ein Modell auch für die deutsche Versicherungswirtschaft, in: Zeitschrift für die gesamte Versicherungswissenschaft 1992, pp. 487–498; Hohlfeld, Überlegungen zur Einführung eines Ombudsmanns im Versicherungsbereich, in: Basedow *et al.* (eds.), Anleger- und objektgerechte Beratung – Private Krankenversicherung – Ein Ombudsmann für Versicherungen: Beiträge der siebenten Wissenschaftstagung des Bundes der Versicherten, Baden-Baden 1999, pp. 223–230.

6 Jürgen Basedow, the long-time chairman of the supervisory board, is of the opinion that Germany was not late but rather came to the adoption of the ombudsman procedure at the appropriate moment, see: Basedow, in: Versicherungsombudsmann e.V. (ed.), 10 Jahre Versicherungsombudsmann: 2001–2011, Berlin 2011, pp. 21 et seq.

7 See e.g. Reichert-Facilides, The Insurance Ombudsman Abroad: A Comparative Survey, in: Basedow *et al.* (eds.), Anleger- und objektgerechte Beratung – Private Krankenversicherung

most notably in comparison to Switzerland, where the Swiss Insurance Association instituted the *Ombudsman der Privatversicherung* as early as 1972[8]. The reasons for this delay were manifold. Chiefly amongst them was the German insurance industry's rejection of an ombudsman as superfluous in light that at the time the German insurance supervisory authority – other than in many other countries – acted as a complaint point.[9] Catalyst for the development of an ombudsman procedure in the German insurance sector was the development of such a mechanism in the banking sector at the debut of the 1990s.[10] After the European Commission recommended to all Member States the establishment of a dispute resolution system, such as especially an ombudsman system, in 1990,[11] the German banking industry in 1992 – presumably also in an attempt to pre-empt any government movement on this point[12] – established the *Ombudmann der privaten Banken*.[13] Owing to the (albeit mixed) support that this institution garnered in the ensuing years,[14] the German insurance industry felt the time to

– Ein Ombudsmann für Versicherungen: Beiträge der siebenten Wissenschaftstagung des Bundes der Versicherten, Baden-Baden 1999, pp. 193–211.

8 Cp. Maurer, Ombudsmann der Privatversicherung, in: Faculté de droit et des sciences économiques et sociales de l'Université de Fribourg (ed.), Mélanges en l'honneur de Henri Deschenaux à l'occasion de son soixante-dixième anniversaire, Fribourg 1977, pp. 511–528; v. Hippel, Der Ombudsmann im Bank- und Versicherungswesen – Eine rechtsdogmatische und -vergleichende Untersuchung, Tübingen 2000, pp. 184 et seq.

9 Michaels, Die Unabhängigkeit des Ombudsmanns ist oberster Grundsatz, in: Versicherungswirtschaft 2000, p. 396; Lorenz, Der Versicherungsombudsmann – eine neue Institution im deutschen Versicherungswesen, in: Versicherungsrecht 2004, pp. 541–549 at 541; for a thorough historical overview v. Hippel (fn. 8), pp. 20 et seqq.

10 Scherpe, Der deutsche Versicherungsombudsmann, in: Neue Zeitschrift für Versicherungsrecht 2002, pp. 97–102 at 97; a major source of inspiration was also the pre-FOS British Insurance Ombudsman Bureau, cf. Römer, Der Ombudsmann im deutschen Privatversicherungsrecht, in: Basedow *et al.* (eds.), Lebensversicherung – Altersvorsorge – Private Krankenversicherung – Versicherung als Geschäftsbesorgung – Gentest – Der Ombudsmann im Privatversicherungsrecht – Beiträge zur 12. Wissenschaftstagung des Bundes der Versicherten, Baden-Baden 2004, pp. 199–208 at 202; Benkel/Hirschberg, in: *idem* (eds.), Lebens- und Berufsunfähigkeitsversicherung, 2nd ed., Munich 2011, part G para. 33.

11 Commission, Recommendation of 14 February 1990 on the transparency of banking conditions relating to cross-border financial transactions (90/109/EEC), in: OJ/EC nº L 67/39 (cf. esp. sixth principle in the annex).

12 There had in fact been some pressure by the Federal Government on the banking sector to establish such a dispute resolution mechanism, cp. Gude, Der Ombudsmann der privaten Banken in Deutschland, Großbritannien und der Schweiz, Bonn 1999, pp. 24 et seq.; Höche, in: Schimansky/Bunte/Lwowski, Bankrechts-Handbuch, 4th ed., Munich 2011, sec. 3 para. 22.

13 Scherpe, Der Bankenombudsmann – Zu den Änderungen der Verfahrensordnung seit 1992, in: WM – Zeitschrift für Wirtschafts- und Bankenrecht 2001, pp. 2321–2325 at 2321; Hoeren, Das neue Verfahren für die Schlichtung von Kundenbeschwerden im deutschen Bankgewerbe – Grundzüge und Rechtsprobleme, in: Neue Juristische Wochenschrift 1992, pp. 2727–2732 at 2727 et seq.

14 Cf. e.g. v. Hippel (fn. 8), pp. 15 et seqq.

be ripe and in February 2000 the *German Insurance Association (GDV)* decided that an ombudsman system was to be established.[15]

In April 2001 the *German Insurance Association (GDV)* founded the *Versicherungsombudsmann e.V.* in the form of a German registered association (*eingetragener Verein*) whilst establishing the articles of association and the ombudsman's rules of procedure.[16] Subsequently the members of the executive board of the association were commissioned and *Wolfgang Römer*, the former president of the insurance senate of the German *Bundesgerichtshof*, was elected to be the first *Versicherungsombudsmann*.[17] In October of the same year the Ombudsman took up his work. In parallel to this development under the aegis of the *German Insurance Association (GDV)*, the other German association of insurers – the *Association of [German] Private Healthcare Insurers (PKV)* – also set up an ombudsman system which equally took up its work on 1 October 2001.[18]

Both ombudsman systems are mutually exclusive, with the latter only dealing with disputes arising out of private health or long-term care insurance contracts. For the sake of clarity the present article will subsequently focus almost exclusively on the (practically more important) *Versicherungsombudsmann* while only sporadically mentioning the *Ombudsmann Private Kranken- und Pflegeversicherung* (hereinafter referred to as the *PKV-Ombudsmann*).

III. Membership and Funding

Pursuant to sec. 3 of the articles of association both the *German Insurance Association (GDV)* and all its member undertakings may become member of

[15] Labes, Der Ombudsmann der Versicherungswirtschaft: Sachstand – Erwartungen – Perspektiven, in: Bähr/Labes/Pataki (eds.), Liber discipulorum für Gerrit Winter, Karlsruhe 2002, pp. 149–174 at 157; Knauth, Der Versicherungsombudsmann e.V. – Die Erwartungen der Versicherungswirtschaft, in: Kollhosser (ed.), Der Versicherungsombudsmann e.V., Karlsruhe 2002, pp. 7–18 at 9 et seq.; Michaels (fn. 9), p. 396. Michaels, the then president of the *German Insurance Association (GDV)* and first chairman of the executive board, however claims that the Ombudsman was in its precise form not inspired by any other institution, cp. Michaels, in: Versicherungsombudsmann e.V. (ed.) (fn. 6), p. 21.

[16] Brömmelmeyer (fn. 2), p. 337. Registration of the association occured in May, cf. Bultmann, Der Versicherungsombudsmann e.V. – Die Organisation, in: Kollhosser (ed.), Der Versicherungsombudsmann e.V., Karlsruhe 2002, pp. 1–6 at 2.

[17] Bultmann (fn. 16), p. 2. The association's supervisory board (*Beirat*) was constituted in February 2002.

[18] Cf. Kalis, Der Ombudsmann in der privaten Krankenversicherung (PKV), in: Versicherungsrecht 2002, pp. 292–294; v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.), Versicherungsrechts-Handbuch, 2nd ed., Munich 2009, § 23 paras. 438 et seqq.

the *Versicherungsombudsmann e.V.* by unilateral declaration of accession.[19] By becoming a member of the association the insurance undertakings accept to be bound to the rules of procedure and as such agree that their insured may petition the Ombudsman.[20] Currently the GDV and over 95 % of all insurance undertakings established in Germany are members.[21] Other than e.g. in the UK[22] membership at the *Versicherungsombudsmann e.V.* (and at the *PKV-Ombudsmann*) is completely voluntary.

Since the procedure before the Ombudsman is offered free of charge to the complainant (i.e. the policyholder, co-insured, beneficiary or other applicant, who all usually need to be consumers),[23] the Ombudsman and its supporting association need to be financed by other methods than the ones applicable to court procedures. The association, and as such the dispute resolution mechanism, is financed in a twofold manner. Firstly, all member undertakings of the association are required to pay an annual contribution based on the financial needs of the association (sec. 16 articles of association). The individual contribution of each undertaking is based on its gross premium income in comparison to that of the other members.[24] Secondly, every admissible complaint triggers a case-based lump sum which the insurance undertaking needs to pay irrespective if the complaint is later found to be justified.[25] Currently the lump sum is set to be € 111.75 if the procedure is concluded by decision or (non-binding) recommendation and € 74.50 if the procedure is concluded by any other means.[26]

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[19] Pursuant to sec. 3 subsec. 3 of the articles of association the membership of an association ends firstly *de iure* if the undertaking loses its membership of the *German Insurance Association (GDV)* or secondly if the undertaking declares its resignation.

[20] Sec. 5 of the articles of association. Pursuant to subsec. 3 of the aforementioned provision, the undertakings, moreover, promise to inform their customers at the moment of contract conclusion or with the sending of the policy about the existence of the dispute resolution mechanism.

[21] Cf. v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), § 23 para. 390; cf. also Ombudsmann für Versicherungen, Jahresbericht 2012, p. 68; for a comprehensive list of the member undertakings see *ibidem*, pp. 110 et. seqq.

[22] Cf. e.g. Rühl, Außergerichtliche Streitbeilegung in Versicherungssachen im Vereinigten Königreich – Der Financial Ombudsman Service (FOS), in: Neue Zeitschrift für Versicherungsrecht 2002, pp. 245–251 at 246.

[23] Sec. 14 subsec. 1 Rules of Procedure. Only in the case of a complaint directed against an insurance intermediary (not against its employing insurance undertaking) which is manifestly abusive, may the complainant be charged a fee, cp. sec. 7 subsec. 2 phrase 2 rules of procedure for complaints in connection with the mediation of insurance.

[24] Hirsch, The German Insurance Ombudsman, in: Zeitschrift für die gesamte Versicherungswissenschaft 2011, pp. 561–569 at 564. The minimum contribution is set to be € 500, cf. Ombudsmann für Versicherungen (fn. 21), p. 76.

[25] Hirsch (fn. 24), p. 564.

[26] Ombudsmann für Versicherungen (fn. 21), p. 76.

IV. Organisation

As already stated above, the German insurance ombudsman system was established in the form of a private law association.[27] While the most important function in connection with the legal person is held by the Ombudsman himself – since the whole association's reason for being is to enable the Ombudsman to do his work –, the organs, bodies and employees of the supporting organisation play vital roles as well.

1. General Meeting

As within every German registered association (*eingetragener Verein*) the *Versicherungsombudsmann e.V.*'s central organ is its general meeting. The general meeting is made up of all members, which all have – irrespective of seize or premium income – a single vote within the general meeting (sec. 10 subsec. 2 phrase 1 Articles of Association [subsequently referred to as AoA]).

The general meeting's particular competences include altering and adjusting the articles of association and the rules of procedure, electing the members of the executive board, electing certain members of the supervisory board and appointing the Ombudsman, receiving and consulting the reports of the Ombudsman and of the executive board, approving the annual budget and discharging the members of the executive board and the managing directors, appointing an auditor, setting up the business plan and fixing the annual contribution.[28]

The general meeting will usually make use of its powers in the course of the annual general meeting (sec. 8 AoA). Where the interests of the association are at stake or one fifth of the members so requests the executive board may, however, also convene an extraordinary general meeting (sec. 9 AoA). The articles of association do not stipulate a specific quorum.[29] For the most part decisions require a mere majority of the members present at the meeting, while some decisions – i.e. alteration of the articles of association or the rules of procedure, appointment of the Ombudsman and expulsion of members (sec. 10 subsec. 3 AoA) – require a majority of three quarters of the members present.

While it is only natural for any legal person that the owners ultimately decide

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[27] See supra ch. II.

[28] Cp. in more detail sec. 11 AoA; see also Bultmann (fn. 16), p. 4.

[29] German law – other than for other legal persons – does not (in general) require the general meeting of a registered association to meet a statutory quorum, cp. sec. 32 German Civil Code. Insofar it is hypothetically possible for a general meeting composed of one member to pass binding resolutions, cp. Reuter, in: Münchener Kommentar zum Bürgerlichen Gesetzbuch, 6th ed., Munich 2012, sec. 32 para. 46.

the course of the undertaking, it would appear – in theory – problematic if the members, i.e. the insurance undertakings, were to have the power to elect the Ombudsman, alter the articles of association and, even worse, alter the rules of procedure, since such could call into question the independence of the ombudsman procedure.[30] In an attempt to limit the insurance industry's sway over the Ombudsman and the procedure and as such create more trust in the procedure, the general meeting's powers were limited by requiring the approval of certain other actors or creating co-decision powers (which will be discussed at a later point). The general meeting's powers are insofar far less encompassing than they might first appear.

2. Executive Board and Management

While the general meeting is the support organisation's central organ, its other organ,[31] the executive board, is no less important, since it assumes all powers and duties which are not explicitly assigned to the general meeting, the supervisory board or the managing directors (sec. 7 subsec. 4 AoA).

The executive board consists of at least five and at most 11 members (sec. 7 subsec. 1 AoA). Currently the executive board comprises eight members.[32] The members are elected by the general meeting for a term of four years, with re-election being possible (sec. 7 subsec. 5 AoA). It is important to note that the articles of association do not allow for so-called *Fremdorganschaft* (literally translated "external organship"), meaning that only physical persons that at the time of the election are members of an organ of one of the member undertakings are eligible (sec. 7 subsec. 5 phrase 2 AoA). The executive board elects its chairman from its midst (sec. 7 subsec. 2 AoA).

The executive board's *catchall competence* is complemented by certain duties and powers that are explicitly stated. Most importantly, the executive board – which is itself represented by two members acting co-jointly – represents the association to the outside.[33] The executive board is also competent to recommend the person to be elected as Ombudsman, define

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[30] Very critical on these points Tiffe, Eineinhalb Jahre Versicherungsombudsmann e.V., in: Verbraucher und Recht 2003, pp. 260–264 at 260 et seq.

[31] Interestingly enough, these two are pursuant to sec. 6 AoA the only organs of the *Versicherungsombudsmann e.V.* Insofar neither the Ombudsman nor, more surprisingly, the board of supervisors are regarded as organs.

[32] Ombudsmann für Versicherungen (fn. 21), pp. 69, 109.

[33] Cp. sec. 7 subsec. 4 lit. a AoA in connection with sec. 7 subsec. 2 AoA. All current members save two are chairmen of the executive boards of eminent German insurers. The two exceptions are *Frank von Fürstenwerth*, the chairman of the *German Insurance Association (GDV)*, and *Gutberlet*, who is a member – and not the chairman – of the executive board of Allianz.

the scope of competence of the Ombudsman (as long as such task is not reserved for the general meeting and the supervisory board), recall an Ombudsman (where such was agreed by the supervisory board), prepare and convoke general meetings, implement the decisions of the general meeting, prepare a business plan and finally appoint, supervise and recall managing directors (sec. 7 subsec. 4 AoA).

The current operations of the association are assumed by the managing director. As mentioned before, it is for the executive board to appoint one (or several) managing directors. This managing director is bound by the statutes for managing directors established by the executive board (sec. 7 subsec. 6 AoA). Currently – since 2003 – this office is assumed by *Horst Hiort*.[34] It is usually he who pre-prepares the preparation of general meetings, implementation of decisions of the general meeting and preparation of a business plan. He is, moreover, responsible for hiring and supervising[35] the employees and for organising the whole day-to-day operations of the association.[36]

3. Supervisory Board

One of the most dazzling features of the Ombudsman's supporting organisation is its supervisory board. Though not an organ proper of the association,[37] the supervisory board serves an important role in making certain that the Ombudsman can serve his function unharassed by the insurance industry and that the procedure remains fair and balanced. The supervisory board is, insofar, the guarantor of the Ombudsman's independence and as such the guarantor of the procedure's success with the general public.[38]

The supervisory board consists of 27 members: seven representatives of the member undertakings (amongst which the chairman of the executive board), seven representatives of consumer protection organisations, two representatives of the German Insurance Supervisor BaFin, two representatives of insurance mediator organisations, three representatives of the scientific world and six representatives of the parliamentary fractions. Amongst these only the representatives of the member undertakings are

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[34] Ombudsmann für Versicherungen (fn. 21), pp. 67, 109.

[35] Staff members who are charged with tasks relating to the complaints handling are, however, under the technical supervision (including a power to give instructions) of the Ombudsman; see sec. 15 subsec. 3 AoA.

[36] Cp. sec. 7 subsec. 6 AoA; see also Ombudsmann für Versicherungen (fn. 21), p. 67; Hirsch (fn. 24), p. 564.

[37] See sec. 6 AoA, cp. also supra fn. 30.

[38] With a comparable interpretation Hirsch (fn. 24), p. 564; very critical of this assessment Tiffe (fn. 30), p. 261 who claims the supervisory board to be little more than a fig leave.

elected by the general meeting, while the representatives of the scholastic world are elected with a two-third majority of all members of the current supervisory board and all other representatives are delegated by the respective institution. What is obvious from this composition is that the insurance undertakings' influence over the supervisory board and its decisions is everything but commanding.

The tasks entrusted to the supervisory board include as follows: co-responsibility in the appointment and recalling of the Ombudsman, co-responsibility for the alteration of the procedural rules, right to a say on the nomination of the managing director, right to receive and consult the reports of the Ombudsman, right to make recommendations to improve the Ombudsman's work and the procedural rules, right to make recommendations for the agenda of general meetings and right to counsel and aid the Ombudsman concerning questions of public relation (sec. 12 subsec. 5 AoA). Decisions are taken, unless otherwise provided, with a majority of votes of the members present (sec. 12 subsec. 6 phrase 2 AoA).

In discharging of its duties the supervisory board makes a large contribution in keeping the Ombudsman independent and the procedure effective and fair.[39] One should insofar note that the powers (and the composition) of the supervisory board are for the most part intended to keep in check the influence of the insurance undertakings (and as such that of their main representative organ, the general meeting). This equilibrating effect of the supervisory board can be seen for example in its co-responsibility in nominating the Ombudsman. If such a power were not provided by the articles of association nothing would procedurally keep the general meeting (i.e. the insurance undertakings) from nominating a person as Ombudsman whom they know to be excessively insurer-friendly and thus turning the whole procedure into a farce. The same applies for the co-responsibility in modifying the procedural rules. If such power was exclusively entrusted to the general meeting – as it would be in the case of an ordinary registered association – the insurance undertakings would be able to manipulate the procedural rules to favour them unduly. The co-decision power of the supervisory board is insofar an eternal guarantee for the procedural rules to at least remain as fair as they were drafted at the time of the formation of the ombudsman office.

4. Ombudsman

The central institution within the *Versicherungsombudsmann e.V.* – and its sole *raison d'être* – is the Ombudsman, i.e. the person entrusted with

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[39] Ombudsmann für Versicherungen (fn. 21), p. 64 regards the supervisory board – and its composition (especially the fact that it contains representatives of consumer protection organisations) – as one of the most distinguishing features of the *Versicherungsombudsmann*.

the power to adjudicate disputes between the member undertakings and its customers.[40]

In order to create trust with the public, which might be understandably suspicious of a dispute resolution mechanism financed by the opposing party, the success of the procedure turns on the quality of the person nominated as Ombudsman.[41] In his person and actions he should, if such is possible, be a manifestation of Lord Hewart's dictum that "justice should not only be done, but should manifestly and undoubtedly be seen to be done".[42] Other than this outer appearance of independence (and actual independence) the articles of association require the Ombudsman to meet several person-related criteria. He is required to possess the necessary abilities, qualifications and experience for his tasks (sec. 14 subsec. 1 phrase 1 AoA). In particular he should be qualified to exercise the functions of a judge (which in Germany means, he must not only have obtained a university degree in law but also successfully performed the *Referendariat* [form of clerkship] and the second state's exam) and possess special experience in insurance matters (sec. 14 subsec. 1 phrase 2 AoA).[43] He, furthermore, should have his legal residence in Germany.[44] More importantly, the Ombudsman may not have worked on a full-time basis for an insurance undertaking or an insurance lobbying organisation or as an insurance intermediary or insurance adviser during the three years that precede his accession to the office (sec. 14 subsec. 1 phrase 3 AoA).[45]

The *Versicherungsombudsmann e.V.* was lucky enough to find just the man

[40] Concerning the relationship between the Ombudsman and the supporting organization it seems feasible to regard the former as the special representative (regarding adjudication of disputes) in the sense of sec. 31 German Civil Code of the latter; in this sense Lorenz, Der Versicherungsombudsmann – eine neue Institution im deutschen Versicherungswesen, in: Versicherungsrecht 2004, pp. 541–549 at 545.

[41] Römer is of course correct in stating that the personality of the Ombudsman can never be sufficient to make up for institutional deficits; cited in Brömmelmeyer, Bericht über die Diskussion zum Vortrag von Fritz Reichert-Facilides, in: Basedow *et al.* (eds.), Anleger- und objektgerechte Beratung – Private Krankenversicherung – Ein Ombudsmann für Versicherungen: Beiträge der siebenten Wissenschaftstagung des Bundes der Versicherten, Baden-Baden 1999, pp. 188–191 at 189.

[42] *H.C. (King's Bench)*, Rex v. Sussex Justices, [1924] 1 K.B. 256 at 259 per Lord Hewart CJ.

[43] From the wording of the provision it is not completely clear if this requirement is compulsory, since the phrase applies the German word "*soll*" (depending on the context this may mean *shall* or *ought*) instead of the less ambiguous word "*muss*" (German for shall or must) in the first phrase of this section.

[44] Again it is unclear if this is compulsory or if the nominating actors are allowed to make an exception; cp. supra fn. 43.

[45] While these criteria regard only qualities before the assumption of the duties of the Ombudsman, sec. 14 subsec. 2 AoA sets out certain duties during the term: The Ombudsman must refrain from taking on any of the jobs enumerated above and must also refrain from any activity that might call into question his independence.

to fit this profile and in 2001 elected *Wolfgang Römer*, the former president of the insurance senate of the German *Bundesgerichtshof*, as its first Ombudsman.[46] Disapproving the proverb that lightning never strikes twice, the *Versicherungsombudsmann e.V.* was able to replace Prof. Römer – when he vacated the office in 2008 – with an equally distinguished insurance law expert: Prof. Günther Hirsch. Hirsch, a former judge of the European Court of Justice and the former president of the German *Bundesgerichtshof*, was elected in 2008 and is still acting as Ombudsman.[47] The extraordinary level of legal expertise and reputation of these personalities has been paramount in establishing the ombudsman procedure in the eyes of policyholders as a viable alternative for the resolution of disputes with their insurers.

Besides the individual office holder's willingness to act independently, other safeguards are necessary to guarantee the Ombudsman's independence. One of the most important procedural safeguards is enshrined in the nomination procedure. The Ombudsman is not single-handedly elected by a specific organ of the supporting association but through a co-decision process. The right of initiative is vested in the executive board whose duty it is to recommend a person to be elected as Ombudsman (secc. 7 subsec. 4 lit. b, 13 subsec. 1 AoA). It is then for the supervisory board to take a decision – with a majority of the votes of the members present – on whether or not to elect the person recommended (secc. 12 subsec. 5 lit. b, 13 subsec. 1 AoA). Finally the general meeting may appoint – with a three-quarter (!) majority of all members present (sec. 10 subsec. 3 AoA) – the person in question to the office (secc. 11 lit. b, 13 subsec. 1 AoA). Through this procedure it is made certain that only a person garnering support from all interested circles may be elected Ombudsman.[48]

Once the Ombudsman takes up his office he is bound by a duty and granted a guarantee of independence. This guarantee of independence encompasses his decisions, his directions of the proceedings and his administration of the office as a whole (sec. 15 subsec. 1 phrase 1 AoA). More precisely, he is under no duty to comply with any instructions (and no organ or body of the supporting association may give such instructions).

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[46] Bultmann (fn. 16), p. 2. If anything, Römer was regarded by some insurers as policyholder-biased, but certainly no one would have thought him to be partial towards the insurer's interest; cp. Michaels, in: Versicherungsombudsmann e.V. (ed.) (fn. 6), p. 23.

[47] Prof. Hirsch was re-elected in 2012 and his second (and last) term has commenced in April 2013.

[48] That such an institutional safeguard for independence is necessary can be seen by the criticism attracted by former German Bank Ombudsman, Leo Parsch. Due to the fact of having been nominated solely by the industry – as was provided for by the articles of association – he was often decried as a "home referee" who adjudicated by fiat ("*nach Gutsherrenart*"), cp. v. Hippel (fn. 8), pp. 18, 240 with further references.

The independence of the Ombudsman is also safeguarded by the fact that the Ombudsman may only under very strict conditions be dismissed from office. Firstly, only flagrant and gross breaches of the Ombudsman's statutory or contractual[49] duties may serve as grounds for dismissal (sec. 13 subsec. 3 phrase 1 AoA). Secondly, in order for the Ombudsman to be dismissed there needs to be a decision to this end not only by the executive board but also by the (neutral) supervisory board and the latter's decision needs to be carried by a two-thirds majority of all members (sec. 13 subsec. 3 phrase 2 in connection with sec. 12 subsec. 5 lit. a AoA). Interestingly enough another safeguard for the Ombudsman's independence was previously provided by the articles of association[50] but was abandoned in 2005: Up until that time the term of office was – and still is – for (up to) five years but re-election was disallowed (sec. 16 subsec. 1 AoA 2002-version). The exclusion of a possibility to be re-elected was intended to avoid the appearance that the Ombudsman might be swayed to alter his decisions in a way to make his re-election more likely.[51] In 2005, however, the general meeting voted in a modification of the articles of association, obviously in an attempt to be able to keep the then Ombudsman, Prof. Römer, on for an additional period of time,[52] allowing for a one-time re-election (sec. 13 subsec. 2 phrase 2 AoA). In light of the fact that the Ombudsman – if he were to try to influence his re-election decision – would have to pander to the interests of the insurers and to that of the policy holders at the same time (since he needs to be re-elected by all bodies of the association) one can see why this safeguard was seen as superfluous. The Ombudsman's independence is amply protected by other means.

5. Other Employees

With an annual case load of over 17,000 complaints and being but one person – since the articles of association allow only for the election of a single person to act as Ombudsman[53] – the Ombudsman must heavily rely on the assistance of auxiliary staff. Other than the Ombudsman and the

[49] Regarding the service contract which the Ombudsman concludes with the association.

[50] For the old version of the articles of association see e.g. Neue Zeitschrift für Versicherungsrecht 2002, pp. 293–296.

[51] Bultmann (fn. 16), pp. 5 et seq. That this is not a merely hypothetical problem may be highlighted by the fact that the former Ombudsman of the English Insurance Ombudsman Bureau, Julian Ferrand, complained that some insurers had allegedly tried to influence the IOB Council to not re-elect him in view of his overly consumer-friendly decisions, cp. v. Hippel (fn. 8), pp. 138, 241 with further references.

[52] Versicherungsombudsmann e.V. (ed.) (fn. 6), p. 46.

[53] This was differently under the first version of the articles of association, where sec. 13 subsec. 2 AoA 2002 allowed for the election of several ombudsmen; cp. AoA 2002 reprinted in Neue Zeitschrift für Versicherungsrecht 2002, pp. 293–296 at 295.

managing director the supporting association currently employs another 39 persons.[54] Of these people 12 staff members are trained in the insurance business (*Versicherungskaufmann*) and are the integral part of the so-called service centre. Their tasks[55] consist in registering the complaints, creating the case file, helping the complainants in concretising their claims and, in general, making the case ready for legal scrutiny before turning the case over to the legal centre (or deciding on its inadmissibility).

The legal centre employs 19 persons who are lawyers (*Volljuristen*, i.e. people qualified to exercise the functions of a judge). These people correspond (with an emphasis on legal matters) with all parties in an attempt to make the case ready for decision, they sound out the possibility of an amicable arrangement and they often – the Ombudsman could not personally adjudicate 17,000 cases – take the decisions on behalf of the Ombudsman. Cases of greater importance or with more problematic bearing are, however, often decided by the Ombudsman in person.[56]

The rest of the staff of the support organisation is employed for secretarial or administrative work.

V. Jurisdiction

The Ombudsman has jurisdiction over a vast array of disputes though not over all disputes that may arise between a policyholder (or insured or beneficiary) and his insurer (and insurance intermediaries). It is important to note that the term jurisdiction should not be understood to mean exclusive competence, since the presumably aggrieved party is at any stage free to bring its claim before the competent state court (or arbitral tribunal, where such applies).[57] It is the Ombudsman's duty to establish at the moment at which the complaint is lodged (and continuously throughout the course of the proceedings) if it is competent to hear the claim (sec. 5 subsec. 1 Rules of Procedure).

In doing so, the Ombudsman must establish if the complainant fulfils the person-related requirements to have standing to lodge a complaint, if the respondent has the standing to be made such, if the subject matter of the

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[54] Ombudsmann für Versicherungen (fn. 21), p. 67.

[55] See in more detail infra ch. VI 1. and 2.

[56] In all other cases the Ombudsman has a power to instruct the lawyers, furthermore the lawyers will be obligated to render certain decisions for approval before being rendered and will in more general terms be under the constant supervision of the Ombudsman; cp. Ombudsmann für Versicherungen (fn. 21), pp. 66 et seq.

[57] *Argumentum e contrario* sec. 2 subsec. 3 lit. e RoP which declares the ombudsman procedure not to take place if the complainant petitions the courts during the ombudsman proceedings.

dispute enters into the competence of the Ombudsman, if the complainant has complied with the procedural requirements, if an exception to the jurisdiction of the Ombudsman might apply and finally if the Ombudsman should reject the complaint on grounds of it being unsuitable for adjudication within the ombudsman procedure.

1. Person-Related Requirements

The ombudsman procedure is only available where both complainant and respondent fulfil the person-related criteria required to have standing before the Ombudsman.

a) Complainant

Pursuant to sec. 2 subsecc. 1 and 2 AoA it is the support organisation's corporate purpose "to advance the alternative resolution of disputes between insurance undertakings and consumers (policyholders)". It is insofar no surprise that the procedure is (in principle) only made available where the complainant is a consumer (sec. 2 subsec. 1 phrase 1 Rules of Procedure [subsequently referred to as RoP]). The latter provision defines a consumer to be a natural person who enters into a legal transaction for a purpose that is outside his trade, business or profession.[58]

While the bearing of this provision is clear in that only complaints by natural persons[59] having the status of consumer are admissible, it creates some uncertainty if only policyholders may lodge a complaint.[60] Under the application of the old rules of procedure one could make a strong argument to this effect since its preamble declared that „[t]he Versicherungsombudsmann is an independent institution of the German insurance industry for the reconciliation of disputes between insurance undertakings and consumers (policyholders) […]".[61] A strict reading of this provision would have hence excluded the co-insured and the beneficiary from making use of the ombudsman procedure. This was, however, not

[58] This definition is a direct transformation of the general definition of consumers in sec. 13 German Civil Code.

[59] The German civil law association (*Gesellschaft bürgerlichen Rechts* [*GBR*]) – though it may sue in its proper name – is not a legal person but a union of (natural) persons. Insofar there is a good argument to be made that if its associates are natural persons and the *GbR*'s purpose for entering into the transaction is outside its trade, business or profession it is a suitable complainant; cp. Hövel, in: Halm/Engelbrecht/Krahe (eds.), Handbuch des Fachanwalts Versicherungsrecht, 4th ed., Cologne 2011, ch. 3 para. 27.

[60] This problem of interpretation becomes more pressing, since sec. 2 subsec. 3 lit. d RoP explicitly declares as inadmissible any complaint regarding the claim of a "third party" to the insurance benefits; see infra ch. V. 4. d).

[61] RoP 2002 reprinted in Neue Zeitschrift für Versicherungsrecht 2002, pp. 296–298 at 296.

a reading favoured – even at that time – by the majority of scholars.[62] Since the preamble was subsequently altered – to now read that "„[t]he Versicherungsombudsmann is an independent institution of the German insurance industry for the reconciliation of disputes in connection with insurance contracts" – there now seems to be a universal understanding that the co-insured, beneficiaries and legal successors (resp. assignees) are also in principle permitted as complainants.[63] The admissibility of complaints lodged by these people is, however, contingent on their ability to individually demand performance under the insurance contract. In case of a complaint by a co-insured, for example, this requires that the co-insured is either in possession of the insurance policy or is acting with the policyholder's approval (sec. 44 subsec. 2 German Insurance Contract Act).[64]

The full-exclusion of all non-consumers from the procedure was regarded by many as a mistake. These scholars have continuously advocated the inclusion of such persons that may be regarded as consumer-like.[65] In reaction to this criticism, the rules of procedure were amended in 2007. They now explicitly provide in sec. 2 subsec. 1 phrase 2 that the Ombudsman "*may* handle complaints by tradesmen, if their trade is pursuant to its type, size and infrastructure to be considered a small trade [*Kleingewerbe*]" [emphasis added]. Insofar small traders – which are considered consumer-like – may now petition the Ombudsman. Their position as admissible complainants seems to be a little bit weaker, however, since the utilization of the verb "may" in the above provision implies that the Ombudsman enjoys a certain amount of discretion in admitting or rejecting one of their claims. All other tradesmen and professionals may not petition the Ombudsman.[66] In this context it is important to correctly assess if a specific insurance contract was taken out for business or for private purposes (e.g. car insurance for a vehicle used both for private and business purposes).[67]

62 Cp. e.g. Hövel/Leissner, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 paras. 46 et seqq.

63 Römer, Offene und beantwortete Fragen zum Verfahren vor dem Ombudsmann, in: Neue Zeitschrift für Versicherungsrecht 2002, pp. 289–293 at 290 (regarding beneficiaries); Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 paras. 46 et seqq.

64 Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 50. For more detail see infra ch. V. 2.

65 Cf. v. Hippel (fn. 8), p. 214; Scherpe (fn. 10), p. 99; Lorenz (fn. 40), p. 546; Römer, Der Ombudsmann für private Versicherungen, in: Neue Juristische Wochenschrift 2005, pp. 1251–1255 at 1253.

66 For an unpublished decision of the Ombudsman see Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 26.

67 The first Ombudsman pointed to the decision BGHZ 119, 252 concerning the demarcation between private and business related activities; see Römer (fn. 63), p. 289.

b) Respondent

The complaint must be directed against an insurance undertaking which is a member of the *Versicherungsombudsmann e.V*.[68] Complaints against non-member undertakings are impermissible. The utilisation of the term "insurance undertaking" is not intended to exclude complaints against occupational pension funds. As long as they are members of the support organisation – which only very few are[69] – they have the standing to be a respondent in the procedure.[70]

Since 2007 the Ombudsman is also competent to hear complaints against insurance intermediaries (i.e. insurance agents and insurance brokers) and insurance consultants.[71] The support organisation was entrusted with this task by the Federal Ministry of Justice[72] and it altered its articles of association and enacted distinct rules of procedure to deal with such disputes[73]. The procedure is distinct to the one applied to complaints against insurance undertakings, described here, in that the insurance mediator does not need to be (in fact cannot be) a member of the support organisation and in that the Ombudsman's adjudication may never take on the form of a binding decision[74] but will always be a mere recommendation.[75] In light of the rather reduced practical significance of complaints against insurance mediators – in 2012 they made up roughly two percent of all complaints[76] – the present treaty will henceforth focus exclusively on complaints against insurance undertakings.

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68 For a list of the member undertakings see Ombudsmann für Versicherungen, Jahresbericht 2012, pp. 110 et seqq.

69 Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 34 also correctly points out that the membership of an insurer at which the pension funds might have been instituted is insufficient. The pension funds itself needs to be a member.

70 In general, uncertainty as to the membership of an undertaking may arise where not it but the concern to which it belongs has declared its accession to the support association. Here one has to interpret the declaration of accession whether or not it includes all daughter companies, cp. Römer (fn. 63), p. 290.

71 See Hirsch (fn. 24), p. 564; Brömmelmeyer (fn. 2), p. 338 (fn. 11).

72 Anonymus, in: FD-VersR 2007, [n°] 237433.

73 See http://www.versicherungsombudsmann.de/Navigationsbaum/VermVo.jsp.

74 Since there is never any binding effect, it was seen fit not to limit the amount in dispute up until which the Ombudsman may hear a claim; see Hirsch (fn. 24), p. 564. In this respect also, the procedure is distinct from the one regarding claims against insurers, see infra ch. V. 4. a).

75 The reason for this can be seen in the fact that regarding insurance intermediaries the ombudsman procedure is not voluntary but rather prescribed by statute; a statutory ombudsman procedure which forces (at least) one of the parties to participate and renders binding decisions is, however, in Germany regarded as a violation of the constitutional right to the lawful judge; cp. v. Hippel (fn. 8), pp. 23, 203 et seq.

76 Ombudsmann für Versicherungen, Jahresbericht 2012, p. 85.

2. Subject Matter within the Ombudsman's Jurisdiction

The Ombudsman is only competent to hear disputes that regard an own contractual claim of the complainant arising out of an insurance contract or another contract which displays an intricate economic connection with an insurance contract (sec. 2 subsec. 1 phrase 1 lit. a RoP). From this it follows that such persons invoking a claim for damages or having a so-called direct claim (cp. sec. 115 German Insurance Contract Act), which is a derivative of the policyholder's claim out of the insurance contract, may not petition the Ombudsman. This – in particular – excludes such claims raised by the injured party in a car accident from being adjudicated within the ombudsman system.[77]

There still remains some doubt whether the criterion "own claim" has some further limitative bearing.[78] While it seems evident that a beneficiary and a co-insured would not be excluded by this phrase, doubt may arise concerning a person to which the policyholder has contractually assigned his claim. Even more importantly, it raises the question whether the policyholder himself is excluded from bringing a claim before the Ombudsman where such claim is subject to an insurance for the account of another. While such a claim is in the strict sense not his own, to disallow the policyholder to bring the claim would seem inequitable. Under many general terms and conditions the insured is excluded from directly raising a claim against the insurer. Even if no such contractual exclusion exists, the insured is only allowed to make a direct claim when in possession of the insurance policy or acting with the approval of the policyholder.[79] In general it is for the policyholder to dispose of the claim in his proper name (sec. 45 subsec. 1 German Insurance Contract Act). It would thus be most reasonable – and such appears to be the practice[80] – to allow claims of the co-insured to be mutually exclusively brought either by the co-insured (if he is in possession of the policy or acting with approval) or by the policyholder.

Prima facia it might surprise that the Ombudsman is equally competent to hear claims arising from other contracts than insurance contracts. Such contracts must, however, exhibit a close economic connection to an insurance contract. It must firstly be noted that this extension is not meant to bring third party respondents into the fold – the claim out of the

[77] Some scholars have forwarded the idea to include such claims, see e.g. Scherpe (fn. 10), p. 99. However, since the ombudsman system is widely regarded by the industry as a special service for their customers (see e.g. Knauth, Versicherungsombudsmann – private Streitbeilegung für Verbraucher, in: WM – Zeitschrift für Wirtschafts- und Bankenrecht 2001, pp. 2325–2329 at 2328 [fn. 21]) such is rather unlikely to occur in the near future.

[78] See already the doubts of the first Ombudsman in Römer (fn. 63), p. 290.

[79] See supra ch. V. 1. a).

[80] Römer (fn. 63), p. 290.

connected contract must be against a member undertaking[81]. Otherwise it remains difficult to assess which kind of contract displays the necessary interconnectedness to an insurance contract to be encompassed by sec. 2 subsec. 1 phrase 1 lit. a RoP. Such a contract might for example be an independent consultancy agreement concluded at the time of the conclusion of the insurance contract.[82] Not encompassed would be a loan agreement even if the loan is intended to be paid off by a life insurance contract since this connection is not regarded as close enough.[83]

Pursuant to sec. 2 subsec. 1 phrase 1 lit. b RoP the complaint may, furthermore, regard claims arising against an insurance undertaking in connection with the mediation or pre-contractual negotiation of such contracts as encompassed by sec. 2 subsec. 1 phrase 1 lit. a RoP.[84]

3. Compliance with Procedural Requirements

Under the old rules of procedure a complaint was only permissible if the complainant lodged his complaint within eight weeks after having received the insurer's final declaration.[85] This rule of sec. 2 subsec. 3 lit. a RoP 2002 – which was akin to a special period of limitation – was, however, with good reason abdicated in 2004.[86]

The only procedural requirement that needs to be fulfilled in advance for a claim to be heard is provided by sec. 2 subsec. 2 RoP. Pursuant to said provision the Ombudsman may only hear a complaint after a complainant has raised such complaint against the undertaking in question and given the insurer six weeks time to take a final decision. This requirement is intended to give the insurer ample time and opportunity to resolve any dispute itself before being dragged before the Ombudsman.[87] Insofar

[81] This does in contrast not mean that all contracts concluded with member undertakings meet the threshold – in an unpublished decision the Ombudsman declined his jurisdiction to hear a claim out of a loan agreement concluded between the complainant and an insurance undertaking since there was no connection to an insurance contract; see Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 31.

[82] Römer (fn. 63), p. 290.

[83] Römer (fn. 63), p. 290; the assessment might be different for a so-called policy loan (*Policendarlehen*) which is fully financed out of a life insurance contract, see Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 31.

[84] This is not be confused with claims directed against the insurance intermediaries which are adjudicated under different procedural rules, see supra fn. 72. Insurance agents and insurance undertakings will often be jointly and severally liable under German law; cp. sec. 69 German Insurance Contract Act.

[85] There was an exception to this rule where the belated lodging of the claim was not caused by the policyholder's fault, see sec. 2 subsec. 3 lit. a RoP 2002, reprinted in Neue Zeitschrift für Versicherungsrecht 2002, pp. 296–298 at 296.

[86] For some difficult questions that this rule raised, see Römer (fn. 63), pp. 290 et seq.

[87] See v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 411; Hövel, in:

the complaint may regard two distinct variants: either the complainant is unhappy with the decision taken by the insurer or it wishes to have a decision which the insurer has not issued within the six weeks time period. Both kinds of complaint are admissible.[88]

4. Exclusions from Jurisdiction

For various reasons some claims are excluded from the jurisdiction of the Ombudsman. Such exclusions may be found in sec. 2 subsec. 3 RoP and will be addressed subsequently.

a) Amount in Dispute (lit. a)

In an apparent attempt to limit the Ombudsman's caseload and to reserve financially more important disputes to the courts[89] the rules of procedure have since their enactment provided for an excess amount in dispute. Any complaint in which this amount is exceeded is inadmissible.[90] In 2002 this amount was set at € 50,000, was elevated to € 80,000 in 2007 and finally to € 100,000 in 2010.[91] While this current amount may appear generous enough in comparison to some other ombudsman procedures,[92] it certainly causes some problems, i.e. especially that (certain if not the totality of) claims pertaining to professional disability insurance and accident insurance are systematically removed from the authority of the Ombudsman. Considering that any "decision" by the Ombudsman regarding an amount in excess of € 10,000 would take the form of a non-binding recommendation, one could take the position that it would not cause the insurer any harm to submit all cases no matter what the amount in dispute to the Ombudsman's jurisdiction. On the contrary, it seems quite reasonable that the insurance undertakings only render such disputes (regarding the amount in dispute) to the jurisdiction of the Ombudsman with which they feel confident to be able to adhere to the recommendation in the majority of cases. There might be an amount in dispute where some insurers would as a general

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Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 31.

88 Cp. v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 412.

89 Scherpe (fn. 10), p. 99 views this as an illustration that the insurance industry had too little faith in its "own" dispute resolution organization.

90 v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 449 is correct in ascertaining that this excess amount in dispute is binding and that the parties may not agree as to its inapplicability. It is the exclusive prerogative of the Ombudsman to assess *ex officio* if the excess amount in dispute is exceeded.

91 Cp. Versicherungsombudsmann e.V. (ed.) (fn. 6), pp. 46 et seq.

92 Though it should be noted that in the rules of procedure for claims against insurance intermediaries no such excess amount in dispute exists; the statutes (which incorporate the rules of procedure) of the *PKV-Ombudsmann* do equally not provide for such a limitation, see v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 449.

rule be unwilling to settle the claim (amicably) if not forced by a court of law. Here the ombudsman procedure would become moot since it would only postpone the inevitable. In this light, the excess amount in dispute of € 100,000 appears to be not fully unreasonable.

It is more difficult to assess how this amount in dispute is to be calculated. In this context the rules of procedure explain that the Ombudsman is to apply the principles of the German Code of Civil Procedure regarding the amount in dispute. *In concreto* this would for example mean that a complaint regarding a claim for the payments of benefits (e.g. € 80,000) would have an amount in dispute equal to the amount of the claimed benefits (i.e. € 80,000). If the complaint regards the right to an annuity, the amount in dispute is pursuant to sec. 9 phrase 1 German Code of Civil Procedure the amount of the annuity multiplied by three and a half.[93] While the general rules of procedure concerning the calculation of the amount in disputes insofar apply – unless they need to be adapted due to the specific nature of the ombudsman procedure – there is one manifest exception. Sec. 2 subsec. 3 lit. a RoP explicitly provides that the amount in dispute of a complaint which reveals that it regards only a part of the full claim (*offengelegte Teilbeschwerde*) is equal to the amount in dispute of the full claim.[94] This rule was included into the rules of procedure in order to prevent policyholders from limiting their complaint to an amount still admissible for adjudication by the Ombudsman (while safeguarding their right to raise the remaining part of the claim subsequently) in order to artificially create jurisdiction of the Ombudsman.[95]

b) Health, Long-Term Care and Credit Insurance Contracts (lit. b)

Disputes concerning health and long-term care insurance contracts had to be excluded from the jurisdiction of the Ombudsman since the more specialised *Association of [German] Private Healthcare Insurers (PKV)* has established its own ombudsman procedure, the *PKV-Ombudsman*.[96] A complaint which regards the aforementioned contract types is not transmitted by the

[93] For a very thorough assessment of these matters see Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 paras. 37 et seqq.

[94] These aspects of when a *offengelegte Teilbeschwerde* is given are extensively treated by Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 40.

[95] Römer (fn. 63), p. 292.

[96] See supra ch. II. The first Ombudsman laments (since the existence of two ombudsmen is due to cause some confusion with policyholders) the fact that health insurers could not see fit to become members of the *Versicherungsombudsmann e.V.*, see Römer (fn. 10), p. 203. Such a confusion of the policyholders is still a reality with 12 % of all dismissals being caused by the fact that the complaint regards a health insurer, cp. Ombudsmann für Versicherungen (fn. 21), p. 88; for the reasons of this unilateralist approach of the health insurers see Labes (fn. 15), pp. 166 et seq.

Ombudsman to the PKV-Ombudsman.[97] It is, however, the Ombudsman's practice to inform a complainant about the existence of the alternative dispute resolution procedure and provide it with the address.[98]

Since credit insurance is usually not taken by consumers (or consumer-like tradesmen) the exclusion of claims pertaining to such contracts has little practical importance but is almost exclusively declaratory in nature.

c) Actuarial Methods or Formulae (lit. c)

Are moreover inadmissible such complaints which turn on the question if an actuarial method or formula is correct or lawful. This exclusion was presumably included since the Ombudsman would on the one hand be overburdened to decide such cases and on the other hand appear to be not the right venue[99] since such a complaint would be of overarching interest not limited to the complainant in question. Whilst the complaint may not turn on the correctness or lawfulness of actuarial methods and formulae, it may, however, regard the correct application of these methods and formulae to the complainant in question.[100]

d) Third Party Claims (lit. d)

A rather important exception from jurisdiction is provided by sec. 2 subsec. 3 lit. d RoP. According to this provision the Ombudsman may not hear any third party's claim regarding the insurance benefits. In some respects this exception might be regarded as only declaratory, since pursuant to sec. 2 subsec. 1 lit. a RoP the Ombudsman is only competent to hear complaints regarding *own* contractual claims out of an insurance contract.[101] Insofar third party claims would not enter into the jurisdiction of the Ombudsman in the first place and would thus not have to be excluded.[102] This notwithstanding it seems favourable to have included the exception if only for the sake of clarity. Furthermore there is good reason to believe this rule to have some constitutive effect as well.[103] It should, however, be clear that third party should not be understood to mean anybody but the policyholder. As was demonstrated above, co-insured persons and beneficiaries may not *per se*

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[97] According to Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 44, on the one hand, one cannot assume the consent of the complainant for such a transmission to occur. Scherpe (fn. 10), p. 100, on the other hand, advocates an inclusion of a duty to remit into the procedural rules.

[98] Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 44.

[99] Scherpe (fn. 10), p. 100.

[100] Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 46.

[101] See supra ch. V 2.

[102] In this sense Scherpe (fn. 10), p. 101 who thinks this exception to be superfluous.

[103] For a list of such persons that might be encompassed by this exclusion see Labes (fn. 15), p. 170.

be excluded from the ombudsman procedure,[104] and should thus not be regarded as a third party (it is a different question altogether if they have an *own* claim in the case in question).

e) Lis pendens (lit. e)

The complaint is, furthermore, (at least temporarily) inadmissible if a case with the same subject matter is pending before a court, arbitral tribunal, dispute resolution institution or the insurance supervisory authority. In this respect the ombudsman procedure is not intended to take precedent as it is to leave the complainant the full autonomy as to where to lodge his claim. If, however, the complainant chooses to lodge the claim at any of the enumerated venues even after the complaint was registered at the ombudsman office the complaint becomes inadmissible. As soon as the case is no longer pending before one of the aforementioned venues – and if the matter was not decided (otherwise sec. 2 subsec. 3 lit. f RoP applies) – the complaint becomes admissible again.[105] It should be highlighted that the complaint is also inadmissible if the insurance undertaking has instigated court proceedings (e.g. in order to claim the payment of the premium) before the complaint (about the policyholder's perception that such a claim is inexistent) was lodged. The grounds for inadmissibility of sec. 2 subsec. 3 lit. e RoP do, however, not apply if the insurer were to lodge a claim at a later stage: a once admissible complaint of the consumer will not be turned into an inadmissible one. Otherwise the insurer could randomly deprive the consumer of his right of complaint before the Ombudsman. The insurer is rather regarded of having agreed to a *pactum de non petendo*[106] which would make its court claim inadmissible for the time being.

While most venues (i.e. state court, arbitral tribunal and other dispute resolution institution) are pretty self-explanatory, some words need to be said about the insurance supervisory authority, i.e. the *Bundesanstalt für Finanzdienstleistungsaufsicht* (BaFin). Pursuant to sec. 4b of the Act on the Financial Supervisory Authority (*Finanzdienstleistungsaufsichtsgesetz [FinDAG*])[107] the customers[108] of financial institutions (such as *inter alia* insurance undertakings) may address a complaint to the BaFin. This

[104] See supra ch. V. 1. a) and 2.

[105] This is a positive difference to other ombudsman procedures in which pendency of a case will often result in permanent inadmissibility, cp. e.g. sec. 2 subsec. 2 lit. a Verfahrensordnung für die Schlichtung von Kundenbeschwerden im deutschen Bankgewerbe.

[106] Cp. e.g. v. Hippel (fn. 8), pp. 93 et seq.

[107] This section was introduced in 2012 by the Law on the Reinforcement of Financial Supervision (*Gesetz zur Stärkung der deutschen Finanzaufsicht*), in: BGBl. I-2012, pp. 2369. However the possibility to petition the BaFin has existed for a long time (cp. recently BaFin circular 1/2006) before.

[108] The complaint is also open to certain consumer protection organisations.

complaint is, however, not to be mistaken with a complaint in the sense of the ombudsman procedure but is more akin to a petition.[109] The procedure before the BaFin is restricted to supervisory aspects and is not intended to afford the complainant individual protection.[110] While the Ombudsman will not admit a complaint while the matter is pending before the BaFin – in order to avoid parallel work (and to avoid contradictory decisions) – the complainant may address the complaint to him after the proceedings before BaFin are concluded. In this respect the decision of BaFin, since it does not regard the individual position of the complainant, has no *res iudicata*-effect.

One finally needs to point out that the initiation of an order for payment procedure (*Mahnverfahren*) regarding the payment of the premium is not to be considered to have a *lis pendens*-effect. This procedure is a purely automated procedure in which the court order is issued without an evaluation of the underlying claim. The order, however, only becomes binding if the respondent (in this case the policyholder) does not object to the order in due time.[111] Insofar this procedure is not contradictory in the strict sense and it would be problematic if the insurer could render a complaint by the policyholder inadmissible by applying for an order for payment to be issued.[112]

f) Res Iudicata (lit. f)

Certain decisions and agreements are afforded a *res iudicata*-effect and make a complaint permanently inadmissible within the ombudsman procedure. The Ombudsman may not hear a complaint if the same subject matter has already been conclusively addressed by the decision of a state court, arbitral tribunal or dispute resolution institution. The same applies where the parties have reached a formal out-of-court settlement and where an application for legal aid (*Prozesskostenhilfe*) is denied on the grounds of insufficient prospect of success.[113]

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[109] Cp. Laars, Finanzdienstleistungsaufsichtsgesetz, 2nd ed., Munich 2013, sec. 4b para. 1.

[110] Laars (fn. 109), sec. 4b para. 1.

[111] To be clear, once the order has become binding (due to non-objection), it has a *res iudicata*-effect and the complaint becomes inadmissible pursuant to sec. 2 subsec. 3 lit. f RoP, and if the policyholder objects and the matter is transferred to the competent trial court, the complaint becomes inadmissible pursuant to sec. 2 subsec. 3 lit. e RoP. In practice the Ombudsman will request the undertaking to effect a stay of the order for payment proceedings (according to sec. 12 subsec. 2 RoP the undertaking has a duty to conform with this request).

[112] Cp. on the whole Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 57.

[113] See in more detail Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 58.

g) Criminal Proceedings (lit. g)

A complaint is equally inadmissible if the complainant has pressed criminal charges (or presses criminal charges after the complaint has been lodged) regarding the occurrences that are also the subject of the complaint. Though this is not a *lis pendens*-matter, since the Ombudsman decides only civil law aspects of a complaint, he will nevertheless not admit the complaint. The rationale behind this rule is that the Ombudsman is intended to have a pacifying effect which is no longer possible once the law enforcement agencies are involved.[114] One exception is, however, made where the complainant has pressed only such criminal charges as he was required to do in order not to endanger his insurance cover. Here, the complainant's willingness to be reconciled is not called into question by his pressing of charges and the insurer is expected to understand such actions (which are caused by [its proper] contractual conditions).

h) Manifestly Unfounded Claim (lit. h)

The rules of procedure, moreover, include an exception from jurisdiction of such claims which are manifestly without any prospect of success. This exclusion could have had a very severe effect if the ombudsman procedure would provide for an entry-stage instance without the Ombudsman's control as is the case in some ombudsman procedures.[115] Such an instance could overemphasis its role and be quick in assessing a complaint to be manifestly unfounded and in this way circumvent the particular ombudsman's authority. This problem is inexistent for the *Versicherungsombudsmann*. Though it is the employees of the so-called service centre[116] who receive the complaints and also make a first evaluation of whether or not the Ombudsman is competent and may dismiss a claim as inadmissible, they fulfil their task fully subordinated to the Ombudsman. For this and other reasons this exception has not gained any practical importance[117] but has been reserved to deal with the complaints of inveterate querulous persons.[118] In most other cases, instead of telling complainants that their complaint was inadmissible, the Ombudsman has regarded it as good

[114] Scherpe (fn. 10), p. 100 apparently mistakes the rationale behind this exception, when demanding that the ombudsman procedure should become available again after conclusion of the criminal proceedings.

[115] Pointed out by v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 395 (fn. 2). This was notably the case for the complaint center of the German Banking Ombudsman (cp. sec. 3 of its procedural rules until 1995).

[116] See supra ch. IV. 5 and infra ch. VI 1. and 2.

[117] The number of cases dismissed on these grounds is apparently so low that it does not even figure individually in the Ombudsman's statistics on inadmissible claims, cp. Ombudsmann für Versicherungen (fn. 21), p. 88.

[118] Cp. already Römer (fn. 63), p. 291.

policy (in order to re-establish good relations between the policyholder and his insurer) to explain to the complainants in a reasoned decision why their claim is unfounded.[119]

i) Prescribed Claim (lit. i)

Are finally inadmissible such complaints which regard a prescribed claim if the respondent raises the objection of prescription. This exception is systematically in contradiction to German law[120] since prescription is not regarded as a procedural question (as in common law jurisdictions) but as regarding the merits. If a respondent raises the objection of prescription the case is not turned inadmissible but rather becomes unfounded (since the claim is not enforceable). In case of the ombudsman procedure – which does not provide for a decision binding on the complainant and is free of charge for him – the differences between these two approaches will, however, be rather negligible.

5. Unsuitability

Even if a complaint is admissible, the Ombudsman may nevertheless decline jurisdiction if the complaint appears unsuitable for adjudication within the ombudsman procedure. The grounds on which such unsuitability may be based are enumerated in sec. 8 RoP.

It is to be stressed that all grounds for unsuitability – except for the one under subsec. 2 – by applying the term "may" (*kann*) grant the Ombudsman some leeway in deciding whether or not to decline jurisdiction. It is to be assumed that the Ombudsman when in doubt will rather assume jurisdiction than decline it. Concerning the possibility to decline jurisdiction because the relevant questions are controversial and have not been decided by the highest courts, matters appear differently. Here the rules of procedure apply the term "shall" (*soll*) indicating that the Ombudsman is to mandatorily decline jurisdiction.

a) Scope of Proceedings (Subsec. 1)

Jurisdiction may be declined during any stage of the proceedings if it becomes apparent that the taking of the documentary evidence (the only evidence admitted in the procedure) will attain such a scope as to unduly overburden the capacities of the Ombudsman and his staff. Such a complaint would be unsuitable to the Ombudsman procedure which is intended to be a swift and unbureaucratic assistance in insurance related disputes.[121] It is difficult to see how these grounds for dismissal would ever

[119] Römer (fn. 63), p. 291.

[120] Cp. v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 407; Römer (fn. 63), p. 291.

[121] Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 16.

become applicable in practice, since the procedure only allows for claims by consumers or consumer-like tradesmen.[122]

b) Controversial Legal Questions (Subsec. 2)

Much more important are the subsequent grounds for dismissal. According to sec. 8 subsec. 1 RoP the Ombudsman shall (!) decline jurisdiction, if the complaint raises a legal question which is decision-relevant, controversial and has not been decided by the highest courts. Even though these grounds for dismissal have been criticised by some,[123] they cannot be described as exorbitant. The exception is intended to reserve legal questions whose importance go far beyond the individual case to the courts.[124] Considering the simplified procedure before the Ombudsman, his possibility to publish decisions and the finality of his decisions up to the amount of € 10,000, one may understand the reluctance of the insurance industry to have controversial questions settled in this procedure and a possible "precedent" created. It seems rather understandable that such cases should be left to the courts and in the end the *Bundesgerichtshof* should not be deprived of finally settling such controversial questions.[125]

According to the present Ombudsman's account he "routinely refrains from dealing with complaints which raise questions the importance of which goes far beyond the individual case, as is usually the case with questions concerning the effectiveness or ineffectiveness of a clause in general policy conditions".[126] Insofar there are a not-insignificant number of cases that the Ombudsman may (if not shall) dismiss on these grounds.[127]

c) Remote Fields of Law (Subsec. 3)

Moreover the Ombudsman may decline jurisdiction if the complaint hinges on decision-relevant legal questions which regard the application of foreign law or special legal regimes (e.g. tax law). Again, the ombudsman procedure is intended to be a swift and unbureaucratic assistance in disputes with German insurers. As such, the Ombudsman and his staff are specialised in swiftly and correctly applying German insurance law. Dealing with cases under the application of foreign law or where untypical fields of law are

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[122] In this sense already Scherpe (fn. 10), p. 100.

[123] Scherpe (fn. 10), p. 100.

[124] Hirsch (fn. 24), p. 565.

[125] The same result, one might add, would have been reached if one had disallowed the Ombudsman to publish decisions relating to such questions and prescribed them to be only passed in the form of a non-binding recommendation.

[126] Hirsch (fn. 24), p. 565.

[127] Overall, dismissal (on any of the given grounds) is not completely irrelevant in practice since about 4 % of the admissible complaints are terminated in this way, cp. Ombudsmann für Versicherungen (fn. 21), p. 89.

relevant would require outside assistance or very extensive occupation, for both of which the procedure is not equipped.[128]

d) Model Case (Subsec. 4)

Very unusual grounds for dismissal are provided for by sec. 8 subsec. 4 RoP. Pursuant to this provision the respondent (i.e. the insurance undertaking) may request that a complaint be dismissed without decision on the grounds that it is a model case.[129] The Ombudsman is to grant this request as long as the undertaking makes plausible that the complaint touches on a legal question of fundamental significance. The Ombudsman, however, only grants the request if the undertaking takes on the obligation to refund the court and lawyer fees borne by the complainant in relation to the first instance of court proceedings. It is to be noted that German civil procedure law is based on the rule that the party which did not prevail has to bear all costs of the legal dispute (i.e. also the costs of opposing party, though there are some limits) to the extent to which it did not prevail, sec. 91 Code of Civil Procedure. The significance of the obligation of the insurer is insofar that it has to refund any costs borne by the complainant even if the latter did not prevail with his lawsuit.

e) Other Dispute Resolution Mechanism Available (Subsec. 5)

Lastly, may be dismissed complaints for which the underlying (insurance) contract provides an appropriate dispute resolution mechanism which has not yet been made use of. The Ombudsman will for example dismiss a complaint concerning an insurance of property for which the general terms and conditions of insurance provide for an expert procedure. Where the dispute regards the amount of the benefits due or the existence of a specific cause of damage such an expert procedure seems more apt in dealing with the dispute than the ombudsman procedure which is mostly intended for the resolution of disputes over legal (and not factual) questions.[130]

VI. Procedure

The procedure before the Ombudsman may be roughly divided into three stages: the entry stage, the remedial stage and the procedural (decision) stage.

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[128] Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 18.

[129] It has been implied that these grounds for dismissal were modeled after the English pre-FOS insurance ombudsman procedure; cp. v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 429 (fn. 18). In any case, it is not easy to assess which cases – which are not to be dismissed under subsec. 2 (questions which are decision-relevant, controversial and have not been decided by the highest courts) – might benefit from these grounds for dismissal.

[130] See in more detail and with other examples Hövel, in: Halm/Engelbrecht/Krahe (eds.) (fn. 59), ch. 3 para. 18.

1. Entry Stage

The procedure before the Ombudsman is incepted with the receipt of the complaint by the Ombudsman (sec. 3 subsec. 1 phrase 1 RoP) who is to confirm receipt and inform the complainant about the ensuing procedural process (sec. 3 subsec. 2 RoP).[131] To avoid any unclarity it should be mentioned that the Ombudsman will be represented at this stage by the service centre staffed with people trained in the insurance business (*Versicherungskaufmann*).[132] In order to allow an easy excess to the procedure and to make certain that complaints must not be dismissed for purely formal reasons, the complaint may be transmitted by all prevalent means of communication, i.e. via phone, letter, fax or email (sec. 3 subsec. 1 phrase 2 RoP). In his complaint the complainant is expected to formulate a clear and unambiguous claim, to convey all essential facts and transmit all necessary documents (sec. 3 subsec. 3 phrase 1 RoP). Where the complaint is lacking in this respect, the service centre staff representing the Ombudsman will contact the complainant to aid him in formulating the claim, making clear the factual circumstances and identifying the necessary documents (sec. 3 subsec. 3 phrase 2 RoP). The staff members may even contact the insurance undertaking to clarify the facts of the case (sec. 3 subsec. 3 phrase 3 RoP). If all these affords are insufficient in bringing a clear and unequivocal text for a complaint to fruition, the complainant is informed that under these conditions proceedings may not be carried out and the procedure is terminated (sec. 3 subsec. 4 RoP).

With the receipt of the complaint the Ombudsman – represented by the service centre[133] – makes the first evaluation if the claim is admissible. If the answer is in the negative the complaint is dismissed. This evaluation of the Ombudsman's jurisdiction is, however, to take place during all stages of the proceedings (sec. 5 subsec. 1 RoP). If the Ombudsman wishes to dismiss a claim on these grounds, he is (in principle) held to give the parties the opportunity to make a statement and to issue a reasoned decision (sec. 5 subsec. 2 RoP).[134]

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[131] This moment is also important since the period of limitation of the underlying claim is suspended from the moment at which the complaint is received; cp. sec. 12 subsec. 1 RoP.

[132] See supra ch. IV. 5.

[133] The service center is not independent in deciding if the complaint is inadmissible – as was for example the complaint center for the German Banking Ombudsman (Nr. 3 Procedural Rules) until 1995 – but is handling this task under the full authority of the Ombudsman.

[134] Slightly more than a third of all complaints are dismissed on the grounds of not falling within the Ombudsman's jurisdiction; cp. Ombudsmann für Versicherungen (fn. 21), p. 84. This appears more problematic than it actually is. Out of these cases dismissed, over 60 % regarded dismissal due to the fact that the insurer was not a member undertaking, that the complaint regarded private health insurance and that no previous complaint had been addressed to the insurer (or the insurer was not given ample time [6 weeks] to deal with the complaint); cp. *ibidem*, p. 88.

2. Remedial Stage

With admissibility established, the employee of the service centre forwards the complaint to the member undertaking in question.[135] In doing so the employee acting in the name of the Ombudsman request the undertaking to respond to the allegations[136] and sets a time limit, with the time for response being one month (cp. sec. 6 subsec. 1 phrase 1 RoP).[137] If the insurer does not respond within the established time limit the Ombudsman's decision will be based solely on the complainant's assertions (sec. 7 subsec. 1 phrase 1 RoP).[138]

In this regard the one month time limit is, one the one hand, intended to accelerate the procedure by incentivising swift responses of the insurer. On the other hand, one month is still regarded to be sufficient time for the insurer to rethink its decision in relation to the complaint. It is highly desired that the insurer under the "threat" of ombudsman proceedings re-evaluate its position and, if it seems fit, remedy the claim of the complainant.[139] In such a case there is no further need for the proceedings to move forward and the procedure is terminated. If, however, the undertaking decides to remedy the claim only in part, the question arises if the procedure can be terminated. Here it depends on the complainant's willingness to accept the decision and withdraw his complaint.[140] Otherwise the complaint would be altered to only cover that part of the claim that is still in dispute. About 20 % of all admissible complaints are terminated by the insurer's free decision to remedy the claim.[141]

If the insurer chooses not to remedy the claim but contest it, it will send its

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[135] The complaint is transmitted to the contact point of the undertaking. All undertakings are under a duty to establish such a contact point and inform the Ombudsman about it, cf. sec. 6 subsec. 2 RoP.

[136] The Ombudsman may only forgo requesting a response by the insurer if two cumulative criteria are met: Firstly, the complaint may be sufficiently evaluated via the materials supplied by the complainant and secondly this evaluation leads to the result that the complaint is manifestly unfounded; cp. sec. 6 subsec. 4 RoP.

[137] The time limit may be extended for up to an additional month, where such seems beneficial (sec. 6 subsec. 1 phrase 2 RoP). Whilst most authors seem to think that this will only occur when requested by the undertaking (cp. Hövel, in: Halm/Engelbrecht/Krahe [eds.] [fn. 59], ch. 3 para. 12) the wording does not disallow for the Ombudsman to extend the time limit *ex officio*.

[138] If the insurer's response is belated, the Ombudsman may admit such response if it regards the delay to be excused under the circumstances, sec. 7 subsec. 1 phrases 2 and 3 RoP.

[139] v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 414; Römer (fn. 63), p. 292.

[140] Römer (fn. 63), p. 292.

[141] Ombudsmann für Versicherungen (fn. 21), p. 89. In an additional 5 % of the cases the parties conclude a settlement agreement, cp. *ibidem*.

response to the complaint. This response will in turn, usually, be transmitted to the complainant (sec. 6 subsec. 3 RoP).

3. Procedural Stage

With the remedial stage concluded, the service centre turns the complaint over to the legal centre with its fully-trained lawyers (*Volljuristen*).[142] The employee entrusted with the complaint corresponds (with an emphasis on legal matters) with all parties in an attempt to make the case ready for decision. They are equally expected to sound out the possibility of an amicable arrangement and aid the parties in coming to such a conclusion. If, however, no such arrangement can be brokered the employee will take the decisions on behalf of the Ombudsman.[143] In doing so, the employee of the legal centre is acting under the authority and supervision of the Ombudsman. In making certain that his views are followed, the Ombudsman has established guidelines for the employees of the legal centre, granted underwriting authority to certain persons for certain cases and established which questions have to be transmitted to his personal review.[144] According to these arrangements at least cases of greater importance or with more problematic bearing are usually decided by the Ombudsman in person.[145]

In coming to a decision, the Ombudsman (represented by the legal centre) is to establish the facts *ex officio*, sec. 7 subsec. 2 RoP. This means that the Ombudsman takes an active approach (and is not in the passive role of an English court judge). This active role even supersedes the amount of activity demanded of and allowed to a German court judge since the principle of production of evidence (*Beibringungsgrundsatz*) is not (fully) applicable. The Ombudsman may request the parties to produce certain documents and may commence own investigations.[146]

There is, however, a certain restriction. Even though the Ombudsman is free in his consideration of evidence (sec. 7 subsec. 6 phrase 1 RoP), it is not entrusted with the taking of evidence besides documentary evidence (sec. 7 subsec. 6 phrase 2 RoP). Other than under some old English ombudsman schemes and the new FOS[147] there is formally no

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[142] See supra ch. IV. 5.

[143] This is regarded to be legal under the articles of association and the rules of procedure, see Lorenz (fn. 9), p. 548; in practice the decision has to be signed by two employees cojointly, see *ibidem*, p. 547.

[144] Ombudsmann für Versicherungen (fn. 21), p. 66.

[145] Cp. Ombudsmann für Versicherungen (fn. 21), p. 66. For a description of how this was done at least during the formative years cp. Römer, in: Versicherungsombudsmann e.V. (ed.) (fn. 6), p. 26.

[146] Cp. v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 416.

[147] Cp. v. Hippel (fn. 8), pp. 126 et seq.

possibility for site inspections, expert opinions and oral hearings (though not even the English schemes allowed for witness testimony – but only allowed for the possibility to sound out the complainant's credibility and the plausibility of his complaint). The Ombudsman has, however, adapted a very broad understanding of documentary evidence. He will for example give consideration to written witness or party statements.[148] It was even held possible that where both parties introduce conflicting written expert opinions or one party introduces an expert opinion which is contradictory – such written expert opinions would also be freely assessed as documentary evidence by the Ombudsman – the Ombudsman might be allowed to mandate an independent expert opinion.[149] From all of the above one may take that the Ombudsman will always do his best to make a complaint ready for adjudication. There is, however, a limit: In the end the procedure is – as is claimed by current Ombudsman Günter Hirsch – a written procedure.[150] Insofar any claim that simply cannot be decided by the mere provision of documentary means is unfitting for the Ombudsman and should be left for the courts.

VII. Decision

Once the Ombudsman has established the facts, and if the procedure was not terminated by the insurer having remedied the claim, by the conclusion of a settlement agreement or by the complaint being withdrawn by the complainant, the Ombudsman (either in person or represented by an employee of the legal centre) takes his decision. In light of the enormous case load it may only be considered a stellar performance that the Ombudsman is able to terminate admissible claims on average in less than four months.[151]

While the Ombudsman is very free in his appreciation of the evidence it does not enjoy the same freedom in his finding of the decision. Other than in some English ombudsman schemes of the past and present,[152] the Ombudsman is not empowered to base its decisions on what is fair and equitable (i.e. a decision *ex aequo et bono*), sec. 9 RoP. It is thus never appropriate for the Ombudsman to pass a decision as a goodwill gesture

[148] v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 417; Römer (fn. 63), p. 293.

[149] Römer (fn. 63), p. 293; in this direction also Scherpe (fn. 10), p. 101.

[150] Hirsch (fn. 24), p. 567.

[151] Ombudsmann für Versicherungen (fn. 21), p. 87. Inadmissible claims are dealt with in a matter of days rather than weeks, cp. *ibidem*.

[152] See v. Hippel (fn. 8), p. 127. For the Financial Ombudsman Service see sec. 8.2 of its Terms of Reference.

(so-called *Kullanzentscheidung*) – he may, at best, informally tell the insurer (this would not be a formal recommendation) that such a granting of the claim by the insurer as a goodwill gesture might be called for.[153] He must, on the contrary, base his decision solely on the applicable law. Insurance, capital investment, and sales and distribution practices (so-called *Wettbewerbsrichtlinien*) that may influence the insurance business shall, however, be given ample regard. The aforesaid should, however, not lead anyone to believe that considerations of fairness are irrelevant for the Ombudsman. The Ombudsman will, on the contrary, give due consideration to aspects of fairness and equity which he is allowed to do under many of the very broad blanket clauses (*Generalklauseln*) of German law (e.g. § 242 German Civil Code; 307 German Civil Code [concerning the interpretation of general terms and conditions]).[154]

The decisions of the Ombudsman may take on two forms, depending on the amount in dispute.

1. Binding Decision

If the amount in dispute[155] does not exceed € 10,000[156] the Ombudsman takes a binding decision (sec. 10 subsec. 3 phrase 2 alternative 1 RoP). It is to be noted that about 90 % of all complaints regard an amount in dispute that is below this threshold.[157] The decision is to be passed in writing, must contain reasons[158] and will be transmitted to all parties immediately (sec. 10 subsec. 4 phrases 1 and 2 RoP). The way the decision is written in practice depends to a certain degree on if it satisfies the complainant's claim in full (and is thus mostly addressed to the undertaking) or if the complainant has not been awarded at least part of his claim. In the latter case the Ombudsman will try to explain in accessible language to the layman why he could not prevail. In the former case the Ombudsman will

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[153] The first Ombudsman, Römer, has indicated that he did act in such a way where appropriate; cited in: Nitschke, Diskussionsbericht, in: Basedow *et al.* (eds.), Lebensversicherung – Altersvorsorge – Private Krankenversicherung – Versicherung als Geschäftsbesorgung – Gentest – Der Ombudsmann im Privatversicherungsrecht – Beiträge zur 12. Wissenschaftstagung des Bundes der Versicherten, Baden-Baden 2004, p. 209.

[154] See v. Hippel (fn. 8), p. 251.

[155] For the calculation of the amount in dispute see supra ch. V. 4. a).

[156] Up until 2010 the Ombudsman could take binding decisions only in cases with an amount in dispute up to € 5,000; cp. Versicherungsombudsmann e.V. (ed.) (fn. 6), p. 47.

[157] Ombudsmann für Versicherungen (fn. 21), p. 87.

[158] Though not explicitly demanded by the rules of procedure, sec. 15 subsec. 2 AoA requires the Ombudsman, to present these reasons in a manner understandable (for a consumer). The Ombudsman has been particularly successful in adopting a very transparent and easy to understand mode of explaining the insurance law to complainants; cp. Römer, in: Versicherungsombudsmann e.V. (ed.) (fn. 6), pp. 26 et seq.

turn the focus on explaining to the legally proficient insurer the fine details of the rationale behind the decision.[159]

The decision – this is the special feature of many modern ombudsman procedures (as opposed to reconciliation procedures utilising the name of ombudsman) – is binding but on the respondent, i.e. the insurance undertaking (sec. 11 subsec. 1 RoP). The complainant, in return, is not at all bound by the decision but is free to bring his claim before the competent courts (sec. 11 subsec. 2 phrase 1 RoP). In Germany there is still some unclarity what this means in practice. Some authors have forwarded the idea that the decision of an Ombudsman might be regarded as an arbitral award – only binding on the insurance undertaking – thus granting the complainant the right to seek direct execution of the award if the insurer should not freely fulfil its obligation.[160] This interpretation – well founded or not – has, however, been rejected by the majority of scholars.[161] It appears to be the prevailing opinion that the decision of the Ombudsman is either to be qualified as a (positive or negative) acknowledgment of indebtedness – granted by the insurer by acceding to the support organisation under the condition that and to the extent to which the Ombudsman finds in favour of the complainant – or as a sui generis decision having the properties of an acknowledgement of indebtedness.[162] Should an insurer be unwilling to conform to a decision, the complainant could not directly enforce the decision but would first have to lodge a claim out of the decision[163] (i.e. the acknowledgment of indebtedness) before the competent court. The insurer's only means of defence would be to demonstrate the invalidity of the (pseudo) acknowledgment of indebtedness.[164] Concerning the grounds on which the insurer may base its allegation of ineffectiveness of the Ombudsman's decision most authors want to apply *per analogiam* the grounds on which an arbitral award may be set aside (cp. sec. 1059

[159] Ombudsmann für Versicherungen (fn. 21), p. 15.

[160] Schlosser, Alternative Streitbeilegung in der Kreditwirtschaft, in: Bankrechtliche Vereinigung (Hrsg.), Kartengesteuerter Zahlungsverkehr – Außergerichtliche Streitschlichtung: Bankrechtstag 1998, Berlin and New York 1999, pp. 185–209 at 208; Jordans, Der rechtliche Charakter von Ombudsmann-Systemen und ihren Entscheidungen, in: Verbraucher und Recht 2003, pp. 253–260 at 260 *et passim*.

[161] Hoeren (fn. 5), p. 497; *idem* (fn. 13), p. 2731; v. Hippel (fn. 8), pp. 46–89, 111 et seqq.; Lorenz (fn. 9), p. 545; v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 435; Prölss, in: *idem*/Martin (eds.), Versicherungsvertragsgesetz, 28th ed., Munich 2010, Vorbem. I para. 148; Berger, Schiedsgerichtsbarkeit und Bankengeschäft – Eine Zeitenwende, in: WM – Zeitschrift für Wirtschafts- und Bankenrecht 2012, pp. 1701–1707 at 1701 (fn. 2).

[162] Cp. *i.a.* v. Hippel (fn. 8), pp. 99 et seqq., 112 et seq.

[163] v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 435.

[164] v. Hippel (fn. 8), p. 114.

German Code of Civil Procedure).[165] To general knowledge there has thus far, however, not been a single insurer to disregard a binding decision of the Ombudsman.[166] Insofar the question of how a complainant should react in such a situation is more of a *glass bead game*[167] than a pressing need.

The decision will usually award the complainant a claim. In this decision will also be included a claim for interest with the interest rate being the statutory interest rate of sec. 288 of the German Civil Code and the claim bearing interest from the moment at which the complaint was received by the Ombudsman (sec. 13 RoP).[168] The decision can, however, also be a declaratory decision by setting out e.g. that the policyholder is not obligated to refund a certain amount of benefits received by the insurer. This decision would also be binding on the insurer, who would not be allowed to pursue the claim in court.[169]

If the decision only grants the complainant a part of his claim, he remains free to petition the courts to gain the rest. Other than in some foreign ombudsman schemes,[170] such action would not alter the fact that the decision regarding the partial success remains binding and must be observed by the insurer.[171] While one could think about applying the principle of *non venire contra factum proprium*, such does not seem to be the concept favoured by the rules of procedure. Sec. 11 subsecc. 1 and 2 RoP are adamant in their position that a decision is binding and remains binding on the respondent while leaving the complainant the possibility

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[165] Cp. v. Hippel (fn. 8), pp. 109 et seq., 114 ; Lorenz (fn. 9), pp. 545 et seq.

[166] v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 435 (fn. 6). The picture is different in the UK, where one insurer petitioned the High Court to set aside a decision of the Insurance Ombudsman Bureau in 1992. In *Regina v. Insurance Ombudsman Bureau and the Insurance Ombudsmann ex parte Aegon Life Assurance Ltd.* [1995] CLC 88 it was held that the Ombudsman's decisions could not be reviewed at all. Under the new compulsory system of the FOS such is no longer true and limited judicial review is possible and scarcely made use of by insurers, cp. e.g. Summer, Insurance Law and the Financial Ombudsman Service, London 2010, para. 2.66.

[167] The invocation of the picture of Herman Hesse's *Glasperlenspiel* to describe the attempt to solve the problem of the Ombudman's decisions' binding effect was borrowed from Schlosser (fn. 160), p. 209.

[168] It is not entirely clear if this provision limits the complainant from claiming higher interest rates where applicable and proving that the insurer was in default at an earlier stage.

[169] According to the position of the prevailing opinion explained above, the insurer could in fact petition the court but the policyholder could object to the claim by raising the decision of the Ombudsman.

[170] E.g. sec. 8.8 of the Terms of Reference of the Australian FOS, which provides that for a determination (also for a recommendation) to have its binding effect on the insurer, the applicant has to declare a release from liability concerning all matters involved in the dispute.

[171] v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 423.

to always go before the courts. While one may have doubts if this is an equitable solution[172] it remains true: With the Ombudsman's decision the complainant may have his cake and eat it too!

2. Non-Binding Recommendation

In cases in which the amount in dispute exceeds € 10,000 (but is inferior to € 100,000[173]) the Ombudsman renders a non-binding recommendation. Such a recommendation conforms to the above described decision in all aspects save its binding effect. It also has to be passed in writing, must contain reasons and is to be transmitted to all parties immediately (sec. 10 subsec. 4 phrases 1 and 2 RoP). It, however, binds neither complainant nor respondent and here the undertaking is free to bring the case before the courts (sec. 11 subsec. 2 phrase 2 RoP) and to use all means of defence against a claim brought by the complainant in a court of law.

One could insofar believe this to be a rather dull blade. It nevertheless has proven to be quite an effective one – which will of course depend on the Ombudsman's persuasiveness and the industry's willingness to rather settle disputes than drag them out indefinitely. Insurers have almost without fail conformed their actions to such recommendations.[174]

3. Publication

In order to elude the reproach of practicing *closed-door* justice,[175] the Ombudsman should not only try to create transparency regarding its procedure, publish reports, seek out contact with the public but also publish his decisions and recommendations. Such a publication will also have the added benefit of providing new impulses for the development of the insurance law.[176] The Ombudsman is allowed to and does publish in an anonymised manner (such is also the norm for the publication of court decisions in Germany) selected decisions and recommendations on his website.[177]

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[172] Esp. critical v. Hippel (fn. 8), p. 29.

[173] This is the excess amount in dispute above which the Ombudsman lacks jurisdiction; cp. supra ch. V. 4. a).

[174] Römer (fn. 65), p. 1254 (fn. 37).

[175] This was a reproach made against the Private Banking Ombudsman on a regular basis due to his reservation to publish any materials; cp. Scherpe (fn. 10), p. 102 (fn. 34).

[176] In this direction also Scherpe (fn. 10), p. 102.

[177] Ombudsmann für Versicherungen (fn. 21), p. 15. v. Rintelen, in: Beckmann/Matusche-Beckmann (eds.) (fn. 18), para. 394 has nevertheless stated that there is room for improvement, e.g. systematic publication of all decisions.

VIII. Conclusion

With the establishment of the *Versicherungsombudsmann* the German insurance industry was able to square the circle, it being an institution that is cherished by both the undertakings and the customers. At first sight this might be surprising: Over a third of all complaints are dismissed as inadmissible[178] and of the remaining complaints only a rough third is decided (at least partially) in the complainant's favour.[179] This not overly impressive success rate for consumers is, however, also an indication for the success of the Ombudsman: Its mere existence has induced insurers to enhance their internal complaints handling which has in turn decreased the amount of "wrong" decisions.[180] Most importantly, the success of the Ombudsman cannot be measured by only turning to the hard numbers. Its most ambitious goal is to defuse disputes and ameliorate the relationship between insurers and their customers. As one complainant has put it in a letter of thanks: "even though my complaint against [...] was not met with success, my wife and I would like to thank you for your assiduous examination [of our case]. Your detailed reasoning has made us realise that my insurance was in the right to refuse".[181] If such a statement is indicative of the sentiments of only a portion of the complainants which were "unsuccessful", the Ombudsman is truly a success.

[178] Ombudsmann für Versicherungen (fn. 21), p. 84; for an explanation why this number is not as dramatic as it might appear see supra fn. 134.

[179] Ombudsmann für Versicherungen (fn. 21), pp. 81, 87.

[180] Cp. (albeit concerning the Banking Ombudsman) v. Hippel (fn. 8), p. 16 with further references.

[181] Taken from the correspondence in the case with the docket number 4618/2011-M reprinted in Versicherungsombudsmann e.V. (ed.) (fn. 6), p. 54.

Alternative Dispute Resolution Systems for Insurance Disputes - An Australian Perspective

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Insurance disputes in Australia can be resolved in a number of ways:

1) Litigation (with or without mediation and arbitration)
2) Mediation
3) Arbitration
4) The Financial Ombudsman Service (FOS).

The author will focus, primarily, on option four.

The external mechanism for the resolution of the vast majority of insurance related consumer disputes in Australia is the Financial Ombudsman Service. This industry initiative was introduced in 1991, and, at that stage, was referred to as the General Insurance Enquiries and Complaints Scheme (GIECS). It was established in response to what was considered to be a demonstrated need for an independent mechanism for the adjudication and resolution of consumer complaints and disputes with insurance companies. From the outset it was intended that the scheme would be free to consumers[1]

[1] Uninsured motorists could access the scheme, upon payment of a small fee, provided that the claim against an insurer's customer did not exceed a designated sum, which has gradually increased since its initial introduction, and is currently, $3000. The requirement to pay a fee has since been abolished.

and would produce an outcome that would be binding on insurers but not on consumers. A consumer, dissatisfied with a decision, would remain free to pursue a remedy through traditional mechanisms such as litigation.

The scheme was then, and remains to this day, fully funded by industry. The initial mechanism of funding was the payment of a fee, calculated on the basis of an insurer's percentage of market share, plus the payment of a fee for service, dependent upon the stage at which a matter was resolved. When first introduced, the fee for service charged to an insurer was lower if the insurer was successful in defending its decision in relation to a dispute. The fee structure was subsequently changed so that the "success fee" was scrapped in favour of a "fee for service" scheme, but with a substantially lower membership levy, that is, more "user pays".

In 1993, the GIECS was incorporated as a self regulation mechanism with 4 primary tasks.

1) The administration of Insurance Enquiries and Complaints Limited (IEC)
2) Monitoring insurer compliance with the General Insurance Code of Practice
3) Resolution of disputes between insurers and consumers and
4) Monitoring the industry's implementation and compliance with the general insurance information privacy principles

Subsequently in 2004 the GIECS merged with IEC to form a new administrative body known as the Insurance Ombudsman Service (IOS). Finally, following the merger of three separate schemes (Banking, Life and Superannuation, and General Insurance) the current Financial Ombudsman Scheme (FOS) was formed. This occurred in 2008 and it is now the body vested with responsibility to resolve disputes between financial service providers (including insurance brokers and authorised foreign insurers operating in Australia) and consumers.

The principles that underpin the operation of the FOS are outlined in the scheme's Terms of Reference (TOR):

In dealing with a dispute, the FOS:

a) must do what, in its opinion, is appropriate, with a view to resolving disputes in a cooperative, efficient, timely and fair manner;
b) shall proceed with a minimum of formality and technicality; and
c) shall be as transparent as possible, whilst acting in accordance with its confidentiality and privacy obligations.[2]

[2] Para 1.2. Financial Ombudsman Service Terms of Reference 1 January 2010 (as amended 1 January 2012)

Decisions are made by way of either a Recommendation, (which is not binding on either the financial service provider or the consumer) or by way of a Determination, which is binding on the financial service provider but not on the consumer. There is also a process of conciliation. This involves an FOS case manager working with both the insurer and the applicant to achieve a consensus view and accordingly resolve the dispute. A conciliated outcome achieved is binding on both parties.

The jurisdiction of the FOS, in the context of insurance, is confined to disputes that arise from a contract or obligation arising under Australian law,[3] and that relates to, inter alia:

(iii) an entitlement or benefit under a life insurance policy , by a person who is specified or referred to in the life insurance policy , whether by name or otherwise to whom the insurance cover extends or to whom money becomes payable under the life insurance policy;

(iv) an entitlement or benefit under a general insurance policy by a person who is specified or referred to in the policy , whether by name, or otherwise, as a person to whom the policy extends;

(vi) a claim under another person's motor vehicle insurance policy for property damage to an uninsured motor vehicle by a driver of the uninsured vehicle – but only where a valid claim has been lodged by the owner of the insured vehicle and any relevant excess paid.[4]

The FOS is also confined to hearing disputes that relate to retail insurance policies, residential strata title insurance products, small business insurance products and medical indemnity insurance products, and cannot consider insurance disputes:

1) about the level of a fee, premium charged or interest rate (subject to some qualifications);
2) about underwriting or actuarial factors leading to an offer of a life insurance policy on non standard terms;
3) in the case of a dispute about a general insurance policy – about rating factors and weightings the insurer applies to determine the insured's or proposed insured's base premium which is commercially sensitive information;
4) about a decision to refuse to provide insurance cover (subject to some qualifications);
5) that has already been dealt with by a court or dispute resolution tribunal established by legislation, or by another external dispute

[3] Ibid Para 4.2

[4] Ibid Para 4.2 (b)

resolution scheme approved by the Australian Securities and Investment Commission (ASIC);

6) in relation to which the consumer has commenced legal proceedings before the dispute was lodged with FOS (subject to certain qualifications) or has been lodged with another ASIC approved external dispute resolution scheme;
7) where the value of the Applicant's /consumer's claim in the dispute exceeds $500,000;
8) Where the applicant / consumer is a member of a group of related bodies corporate and that group has in excess of 20 employees (or 100 employees in the case of a manufacturing group). [5]

There are also a number of circumstances in which the FOS may exercise a discretion to decline to adjudicate a dispute, such as in instances where a dispute is frivolous, vexatious or lacking in substance or where the dispute relates to a financial service provider's practices or policies and does not involve any allegation of maladministration or inappropriate application of practice or policy.

While there are time constraints in respect of matters within the jurisdiction of FOS, the time limits are generous in terms of consumer access. The FOS will hear a dispute provided it is referred to FOS within 2 years of the final decision of an insurer's Internal Dispute Resolution process. In all other circumstances, within 6 years of the date when the Applicant / consumer "first became aware (or should reasonably have become aware) that they suffered the loss...".[6] In addition, however, the FOS retains an over arching authority under its TOR to "consider a dispute after these time limits if FOS considers that exceptional circumstances apply".[7] There is no guidance as to what constitutes "exceptional circumstances".

Once a Dispute is raised there are tight time constraints imposed on a FSP (Financial Service Provider / Insurer) to respond, and a failure to do so can result in a Determination being handed down by FOS in favour of a consumer without the benefit of the insurer's submission.[8]

The TOR prescribes very broad powers in respect of the FOS's capacity to require the provision of information by the FSP / Insurer (and a consumer). "...any information the FOS considers necessary" except where a party satisfies the FOS that to comply would breach a duty of confidentiality

5 Ibid Para 5.1

6 Ibid Para 6.2 (b) (i)

7 Ibid

8 Ibid Para 7.5

to a Third Party, would breach a court order or prejudice a current police investigation, or where the information either no longer exists or is not within a party's reasonable possession to control.[9]

Similarly the TOR empowers the FOS to direct a party to attend an interview or it can direct an FSP to appoint an expert to provide a report.[10]

In making a decision, the FOS is not bound by or constrained by any rule of evidence. Indeed the criteria for decision-making are:

"...When deciding a dispute and whether a remedy should be provided in accordance with para 9, FOS will do what in its opinion is fair and reasonable in all the circumstances, having regard to each of the following:

a) legal principles;

b) applicable industry codes or guidance as to practice;

c) good industry practice and;

d) previous, relevant decisions of FOS or a Predecessor Scheme (although FOS will not be bound by these).

The final criterion remains a source of contention for many insurers and other FSPs as it creates the potential for a level of inconsistency and uncertainty, despite what may amount to similar fact situations. This, in turn, makes it difficult to train staff and ensure a consistency of approach, particularly for insurers administering volume claims. Decisions from FOS that appear irreconcilably at odds with prior decisions can, and do, arise.

Decision making is based on written submissions from both sides. In most instances, following the receipt of written submissions, the FOS will issue a "Recommendation". The parties have 30 days to accept a Recommendation and if they do, the dispute is resolved. A Recommendation is written by the relevant case manager and does not involve the participation of an Ombudsman the FSP does not accept the Recommendation or either party asks that the matter proceed to a "Determination", the matter will proceed to a Determination from an Ombudsman or an Ombudsman's Panel (an Ombudsman, a consumer representative and an industry representative). In some cases involving high value claims disputes or significant legal or industry issues the dispute can proceed direct to Determination without the issuance of a Recommendation.[11]

In any event the outcome is not binding on a Claimant. Remedies open to FOS under its TOR include:

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[9] Ibid Para 7.2

[10] Ibid Para 7.3

[11] Ibid Para 8.6

a) the payment of a sum of money;

b) the forgiveness or variation of a debt;

c) the release of security for debt;

d) the repayment, waiver or variation of a fee or other amount paid to or owing to the Financial Services Provider or to its representative or agent including the variation in the applicable interest rate on a loan;

e) the reinstatement or rectification of a contract;

f) the variation of the terms of a Credit Contract in cases of financial hardship;

g) the meeting of a claim under an insurance policy by, for example, repairing, reinstating or replacing items of property; and

h) in the case of a Dispute involving a privacy issue with an individual - that the Financial Services Provider should not repeat conduct on the basis that it constitutes an interference with the privacy of an individual or that the Financial Services Provider should correct, add to or delete information pertaining to the Applicant.[12]

The FOS also has the power to order that an FSP compensate the claimant up to a maximum of $3000 "for consequential financial loss or damage"[13], which, in essence means that the FOS can order an insurer or other FSP to pay limited "general damages". However the FOS cannot order the payment of damages of this nature if the general insurance policy expressly excludes it. The payment is up to $3000 for "consequential financial loss" plus up to $3000 for "non financial loss". It can also order the FSP to "contribute to other legal or other professional costs or travel costs incurred by an Applicant up to a maximum of $3000".[14] However it cannot order the payment of "punitive, exemplary, or aggravated damages". They can also make an order for the payment of interest.

There remains in the TOR an unutilised provision that has been in existence since inception in the 1980s. This provision relates to "Test Case Procedures" -

An FSP can request that FOS abstain from adjudicating a dispute on the basis that the case involves:

"an issue which may have important consequences for the business of

[12] Ibid Para 9.1

[13] Ibid Para 9.3 (a)

[14] Ibid Para 9.4

the FSP or FSPs generally; or an important point of law".[15] There are tight restrictions on the ability of an FSP to participate in the process, including the insurer's/FSP's obligation to meet its own legal costs of the test case and the applicant's cost including any costs involved in an appeal, successful or otherwise. However, that said, the author is unaware of any circumstance in which an insurer has ever sought to invoke the provision.

In an attempt to resolve a dispute, the FOS is entitled to call upon the participants to consider negotiation, conciliation or mediation.

In addition to the capacity of the FOS to adjudicate claims related disputes, it can intervene in cases in which an insurer has declined to insure, has imposed harsher terms, excess (deductible), premium etc., but only in instances in which it is established that the insurer has done so for, inter alia, an improper purpose. It can also intervene in cases involving debt collection by an FSP such as circumstances in which an insurer is pursuing payment of a premium or excess, or is exercising a right of subrogation. Upon receipt of a request from an Applicant to intervene the FOS can order a stay of proceedings until the matter has been determined by FOS. This stay includes a direction to the FSP to take no further action "to recover a debt, the subject of the dispute, to protect any assets securing that debt or to assign any right to recover that debt".[16]

The FOS and its staff enjoy immunity from liability in the performance of their functions and Applicants are protected from any defamation proceedings in respect of any comments made, written or oral, concerning an FSP or its staff, during the course of an FOS adjudicated dispute.[17]

There are some notable commercial insurance product types that fall outside the jurisdiction of the FOS. These are:

1) Contractors All Risks;
2) Fidelity Guarantee;
3) Legal Liability (including Public Liability and Products liability);
4) Loss of profits / Business Interruption;
5) Professional Indemnity; and
6) Industrial Special Risks.[18]

Schedule 2 of the TOR outlines the jurisdictional limits to which an FOS

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[15] Ibid Para 10

[16] Ibid Para 13.1

[17] Ibid Paras 13.3 and 13.5

[18] Ibid Section G ;; Interpretation of Defined Terms – Para 20 .1

remedy is subject to. It constitutes the maximum award that can be made by FOS in respect of a dispute:

The table below specifies according to type of claim the maximum total value of the remedy that may be decided upon by FOS (excluding compensation for costs and interest payments).

	Type of Claim	Amount per Claim
1.	Claim on a Life Insurance Policy or a General Insurance Policy dealing with income stream risk or advice about such a contract. If the claim is in excess of this monthly limit, the monthly limit will apply unless: • the total amount payable under the policy can be calculated with certainty by reference to the expiry date of the policy and/ or age of the insured; and • that total amount is less than the amount specified in row 4. If this is the case, then the limit will be the amount in row 4.	$7,500 per month
2.	Third party claim on a General Insurance Policy providing cover in respect of property loss or damage caused by or resulting from impact of a motor vehicle	$3,000
3.	Claim against a General Insurance Broker except where the claim solely concerns its conduct in relation to a Life Insurance Policy (in which case row 1 or 4 applies, whichever is applicable).	$150,000
4.	Other	$280,000[19]

The FOS also retains the capacity to adjudicate disputes in which Fraud is alleged by an insurer. In such cases matters are heard by a specialist Ombudsman who in many cases conducts an interview with the Applicant and the FSP. The Ombudsman can decline to hear a fraud dispute in cases in which he considers that he does not have the capacity to call witnesses and test evidence – in other words – to test the veracity of the evidence and allegations.

[19] Ibid Schedule 2.

In addition to its function to adjudicate disputes, FOS is also vested with an authority, under its TOR, to provide reports and recommendations to government regulatory authorities such as the Australian Securities and Investments Commission (ASIC), the Privacy Commissioner and a regulated securities exchange. It also must collect and record comprehensive information pertaining to its dispute resolution function and publish the relevant data.[20] Furthermore it is also responsible for monitoring and reporting systemic issues on the part of FSPs including issues involving serious misconduct.

a) A systemic issue is an issue that will have an effect on other persons of the kind listed in paragraph 4.1 of these Terms of Reference, beyond the parties to the Dispute.

b) FOS must identify systemic issues and refer these to the relevant Financial Services Provider for remedial action. In each case, FOS must obtain a report from the Financial Services Provider as to the remedial action undertaken and continue to monitor the matter until a resolution has been achieved that is acceptable to FOS.

c) FOS must report systemic issues to ASIC in accordance with its obligations under ASIC Regulatory Guide 139.

11.3 Serious misconduct

FOS must also report all serious misconduct to ASIC. Serious misconduct is conduct which may be fraudulent, grossly negligent or involve wilful breaches of applicable laws or obligations under these Terms of Reference.[21]

These functions are performed in conjunction with the current FOS responsibility to monitor industry adherence to the General Insurance Code of Practice. This is a voluntary code entered into by Australian General Insurers in 2006,[22] the purpose of which is to ensure commitment on the part of signatories to..“to raising standards of service to our customers. This voluntary Code sets out the minimum standards we will uphold in the services we provide you”.

The Code encompasses:

1) Buying Insurance;
2) Insurance Claims;
3) Responding to catastrophes and disasters;
4) Information and education;

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[20] Op Cit FOS TOR Paras 11 and 12

[21] Ibid Paras 11.2 and 11.3

[22] 2010 General Insurance Code of Practice Para 1.1

5) Complaints handling procedures;
6) Code monitoring and enforcement.

The FOS adjudication scheme (as the General Insurance external dispute resolution mechanism), is simply one part of the ADR process. An integral part of ADR is the insurer's internal mechanism which operates in concert with the FOS. The Internal Dispute Resolution (IDR) function performed by insurers ensures the success of EDR. If not for an efficient, independent IDR, it would be difficult for the FOS to function. Absent IDR, FOS would be overwhelmed by disputes.

By way of example, the Brisbane floods of 2011 resulted in thousands of claims, many of which were excluded because the majority of insurance policies in the market at the time did not cover losses caused by flood (cover for storm water damage only). Following the decisions of the companies' IDR departments to reject the claims on the basis of the flood exclusion, the FOS received hundreds of claims disputes. Fortunately the situation is unlikely to occur now due to the widespread availability of flood cover under domestic insurance contracts. However, for 2 years FOS faced significant logistical challenges dealing with the volume of claims disputes arising from the 2011 storm events.

In this regard IDR acts as a filter for FOS and provides the insurer with an opportunity to resolve disputes before they are escalated to EDR (FOS). That said, many insureds, aware of the existence of FOS, contact FOS initially before accessing IDR and in many instances only come to IDR when advised to do so by FOS on the basis that FOS do not seek to formally intervene in the decision making process until the FSP has given its final IDR decision.

The advantage of IDR involvement (provided it is objective) is that it affords the FSP an opportunity to resolve disputes before incurring what can amount to substantial FOS fees and charges. However from the author's experience,[23] insureds / claimants are often disinclined to accept an IDR decision unless it is wholly or largely in their favour, aware of the fact that they have a right to access, without charge, the external independent scheme. For obvious reasons, in such cases it is less likely that a dispute will be resolved, if the IDR decision is unfavourable to an applicant.

Unfortunately there is no published or accessible data as to industry experience in the resolution of disputes without FOS involvement. However the author has the experience of his own organisation which indicates the following. Currently in 2013, the author's employer's IDR department

[23] The author headed up the IDR Department of a large general insurer for over 10 years

has resolved approximately 81.5 % of all IDR dispute referrals without FOS involvement by way of recommendation, determination, conciliation or mediation (although many of these cases had already been registered with FOS). In prior years: for 2009 the figure was 81.6% (out of a total of recorded disputes of 534), 2010 was 81.8% (out of a total of disputes of 797), 2011 was 72.1% (out of a total of 1103) and 2012, 84.5% (out of a total of 779 disputes). Accordingly IDR can and does, fulfil a useful and effective function in the resolution of disputes.

The published data provided by the FOS appears in its annual report.[24] The 2012/2013 report includes information concerning matters resolved by agreement with the financial service provider (FSP).

32,307 disputes were referred to FOS during the relevant year. Of that number 18,785 (56%) were resolved by agreement between the Applicant and the FSP with 2,720 by negotiation (8%), 1274 by assessment (4%) and 857 by conciliation (3%).[25]

Once FOS becomes involved, many general insurers seek to try and resolve a dispute by negotiation, although the experience is subject to wide fluctuations. In the case of one insurer resolution by negotiation was as high as 85% and for another as low as 13%. In the case of the former, for those disputes that ultimately proceeded to a Determination 3% were in the applicant's favour, while 10% were in favour of the FSP. Contrasting the former with the latter, where 51% were in favour of the applicant and only 34% in favour of the FSP.[26] This suggests one of two things. FOS looks more favourably upon FSPs that seek to negotiate than those that don't, or the FSP made a poor judgement call when the initial decision was made.

In the example of motor vehicle insurance disputes, the figures for negotiated resolution are even more stark. In the case of one insurer 100% of motor vehicle disputes were resolved by negotiation, with the lowest percentage by any insurer, at 53%. In the case of the latter 17% resulted in a determination in favour of the applicant, and 22% in favour of the FSP.[27]

Unfortunately, while the figure suggests a very high resolution rate with FOS participation it provides no insight as to industry outcomes absent any FOS involvement, whether that involvement meant simple FOS registration or direct participation.

[24] 2012-13 Financial Ombudsmans Service Annual Review (annual report)

[25] Ibid at page 50

[26] FOS Industry Comparative Tables 2012-2013 –Home Buildings #8

[27] Ibid – Motor Vehicle #9

Critique of FOS System

The stated objective of the FOS scheme is to "resolve disputes in a cooperative, efficient, timely and fair manner.....with the minimum formality and technicality."

From the standpoint of the consumer, it would appear that the scheme achieves those objectives, but that may not be the shared view of the industry. The FOS scheme is relatively expensive, and clearly, while cheaper than litigation for both parties, the reality is that, few consumers could afford to institute litigation or genuinely are committed enough to the merits of their cause, to pursue litigation.

As previously mentioned, FOS is funded entirely by the FSPs, with no financial commitment required from the consumer/applicant. The promotional material on the FOS website tends to encourage easy lodgement of a dispute supported by a team of consumer advisers within the organisation.

Once a dispute has been registered with FOS, the costs for the FSP begin to run and, accordingly, as fees are charged on a "fee for service" basis, the longer the matter progresses the greater the cost to the FSP. Accordingly for disputes involving smaller monetary amounts, (such as payment of an excess) once FOS is involved it is more cost effective to either waive or to pay the disputed sum, rather than incur FOS fees.

The FOS promotes the fact that its "membership base of 16,038 members has chosen us as their external dispute resolution scheme".[28] In the case of the general insurers, that isn't, strictly speaking, correct. There is no other EDR scheme for general insurance disputes currently available in Australia, and as participation in an ASIC approved EDR scheme is a condition of the issuance of an insurer's licence, insurers have no choice other than to sign up to the FOS. Accordingly it is arguably misleading to describe the general insurers' participation as entirely voluntary.[29]

Industry concern as to FOS powers focus on a number of key areas, namely:

1) Absence of any genuine right of review or appeal process;
2) Absence of adherence to precedent in the FOS approach to decision making;
3) The fact that by its TOR, FOS is not bound by any rules of law or evidence, in making its determinations;

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[28] Op Cit –FOS Annual Review 2102-2013 at page 19

[29] All holders of an Australian Financial Services License (AFSL) must hold membership of an approved EDR scheme. There is currently another scheme available for financial service providers, in Australia but it isn't resourced to handle general insurance disputes – COSL.

4) That, in Australia, FOS involvement in so many insurance related disputes effectively means that we are seeing very little evolution in insurance law outside liability, workers compensation, motor vehicle personal injury and professional indemnity.[30]
5) Perceived bias influenced by the pro consumer nature of the TOR.

In relation to the first issue, the general insurance industry specifically has voiced concern that there remains no satisfactory mechanism to review an FOS determination that on its face has applied the law incorrectly, or in which FOS has exceeded its jurisdiction (financial or otherwise)or in which the decision has produced an outcome to the FSP's detriment in either misconstruing the law or simply applying it incorrectly.

Recently the FOS approached the industry suggesting a mechanism for reviewing FOS determinations where the FSP asserted that the decision was either incorrect at law or in excess of jurisdiction. FOS proposed a mechanism which required FOS consent to pursue the review (which FOS was not bound to consent to), fully funded at every stage by the FSP (not FOS), which potentially could result in a decision which FOS was not bound to adhere to and which would not result in a reversal of the initial decision. The industry did not support the proposal and the issue relating to an appropriate "review mechanism" remains unresolved.

The Australian Courts have considered the issue of judicial review of voluntary tribunal decisions, in a number of cases over the last 3 years. Two are notable:

In the case of Utopia Financial Services Pty Ltd v Financial Ombudsman Service Ltd,[31] Justice L Miere, commented that the FOS discretion in deciding a remedy is very wide, and on the facts of the case was not amenable to judicial review. His decision was based on the fact that the TOR enabled FOS to do what, in its opinion, is fair and reasonable in all the circumstances. The argument being that if an organisation voluntarily signs up to a tribunal scheme that has rules that preclude any right of judicial appeal, that organisation effectively signs away (by contract or agreement) the right to request judicial review. A further case that considered this issue was Mickovski v Financial Ombudsman Service Limited and Anor.[32]

In that case the Victorian Court of Appeal held that the FOS TOR did not

[30] These areas fall outside the jurisdiction of FOS.

[31] [2012] WASC 279

[32] [2012] VSCA 185 . Contrast this decision with that of the NSW Supreme Court decision in Masu Financial Management Pty Ltd v Financial Industry Complaints Services Ltd (nos 1 and 2) (2004) 50 ACSR 554. The 2 decisions appear on their face to be irreconcilable. [2012] VSCA 185

give rise to judicial review in cases such as FOS applying the law incorrectly but did comment that in the event that a tribunal breached its contractual agreement with one of its member organisations such as might occur if the tribunal exceeded its jurisdiction, then in so doing it may breach its contract in which case a judicial review may be open to the aggrieved party. The court observed in Mickovski:

"Since the Act, as before, the public do not have to use the [FOS]. They can instead sue insurers in the courts. If they go before the [FOS], because [it] is not limited to purely legal considerations, in many cases their prospects of success will be better. But they have the choice of forum ... The [FOS's] power over its members is ... still, despite the Act, solely derived from contract and it simply cannot be said that it exercises governmental functions. In a nut shell, even if it can be said that it has now been woven into a governmental system, the source of its power is still contractual, its decisions are of an arbitrative nature in private law and those decisions are not, save very remotely, supported by any public law sanction. In the light of these factors, the [FOS] is not in my judgement a body susceptible to judicial review".[33]

Accordingly based on the fact that there was no apparent contractual breach the Court found that there was no right of appeal.

However, there may be circumstances that may give rise to a right of appeal where there has been a breach of contract between the FSP and FOS. This might occur, by way of illustration, if FOS exceeded its financial limit or made a determination that involved a class of insurance outside its TOR. To date the writer is unaware of any instance in which a legal challenge, on the grounds outlined, has been issued.

The concept of reviewing the decisions of quasi judicial bodies remains a vexed issue and notably was a topic raised by His Honour Justice Spigelman, the then Chief Justice of the NSW Supreme Court at the 7th Worldwide Common Law Judicial Conference in London in 2007, when His Honour observed:

"..... it is possible that the continued expansion in the use of non-judicial decision-making processes to resolve disputes and to determine rights can become so significant as to deprive the idea of judicial independence of a great deal of its practical content. We may not have given sufficient attention to this aspect of independence. This is a matter that can only be assessed in the context of a specific jurisdiction to another. One cannot determine any clear line between what must be judicial decision making and what may properly be regarded as administrative or quasi-judicial

[33] Ibid per Justice ......at page

decision making. Nevertheless, the extent to which matters capable of judicial determination are in fact removed to tribunals, often called courts, which do not have the benefit of the minimum requirements of traditional sections of the independence of the judiciary, then there may be cause for concern".[34]

There remains a general consensus in the industry that, in limited circumstances, the right to judicial review of FOS decisions should be an option available to it.

Another issue of concern to industry members relates to absence of FOS adherence to precedent. This is viewed in the context to FOS's own prior decisions. The TOR does not bind FOS to its own earlier decisions, which in turn creates potential problems for an industry that endeavours to train its staff based on FOS decisions. Obviously if similar facts and circumstances create FOS outcomes apparently at odds with one another it makes it difficult to train staff, which in turn creates the potential for a lack of confidence in the FOS decision making process. While FOS, understandably, asserts that consistency is important in ensuring confidence in the professionalism and independence of the process, inconsistent and seemingly irreconcilable decisions, belies that objective. However, FOS does endeavour, to a degree, to adhere to consistency of decision making. It is entirely understandable that a process such as the FOS scheme should not be entirely constrained by adherence to its own precedent, but that said, from an industry perspective, there is a view that similar facts and circumstances should provide a similar outcome.

Issue 3 relates to the application of the law and what is perceived by many in the industry as an issue of "fairness". This was addressed in a recent submission from the Insurance Council of Australia to the Competition and Consumer Policy Division of the Federal Dept of Treasury. The submission asserted that the current TOR creates ambiguity, by placing undue emphasis on "fair and reasonable".[35] The suggestion was made that the term "fairness" should be re-written as follows:

"... that industry schemes provide that the decision-maker makes determinations in accordance with relevant industry codes of practice and the law, and may, in doing so, consider what is fair and reasonable having regard to good industry practice".[36]

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[34] "Judicial Independence: Purposes and Threats" .". Address by the Hon JJ Spigelman AC Chief Justice of NSW – 7th Worldwide Common Law Judicial Conference 30 April 2007-London

[35] This refers to para 8.2 of the FOS Terms of Reference

[36] Letter from the ICA to CCAAC Secretariat, Consumer Policy Framework Unit , Competition and Consumer Policy Division ., Federal Treasury, dated 7/6/2013

In essence the submission suggests a redraft of the language used in the TOR (para 8.2) to stress that fairness needs to operate in the context of the law and industry codes of practice rather than independent of all the relevant criteria outlined in the language of TOR .

Item 4 constitutes the author's view that while the FOS scheme operates efficiently and effectively as a low cost dispute resolution scheme, its success has come at a price in terms of insurance law evolution. When the Insurance Contracts Act (1984) was enacted, understandably a great deal of litigation followed as the various stake holders sought to clarify the meaning and purpose of the legislation's provisions. As a consequence a vast body of case law developed from 1986 onwards. Unfortunately, or fortunately, depending upon your perspective, since the advent of the FOS and its predecessor schemes, the number of cases dealing with insurance law issues has reduced dramatically. While that is not an entirely bad outcome, as a consequence few cases are litigated that have the potential to expand knowledge and understanding of the law. By way of simple illustration, very few cases have appeared within the last 10 years dealing with:

- The rights of the innocent co-insured on issues of non disclosure;
- Third Party interests under a contract of insurance;
- Proof of dispatch of documentation;
- Remedies available for a breach of the Duty of Utmost Good Faith;
- Expansion of the law on the issue of the rights and remedies re joint and composite policies of insurance;
- Instalment contracts

An examination of the Australian CCH Insurance Reporter, dealing with decided cases up until 2011 revealed the following:

- 1994–1995: 20 cases
- 1998–1999: 13 cases
- 2010–2011: 7 cases (including one matter that was reported at first instance and on appeal)[37]

As a consequence there is diminishing scope for judicially determined law in many key areas of insurance law and in particular in issues arising under the Insurance Contracts Act (1984). This becomes an issue of increasing relevance given the recent amendments to the Insurance Contracts Act

[37] These numbers do not refer to matters outside FOS TOR such as CTP (Compulsory Third Party Bodily Injury) claims, Professional Indemnity, Liability, workers compensation or ISR (Industrial Special Risks).

(1984) enacted in 2013. It is hoped that FOS will recognise the need for legal evolution through judicial determination, and decline to hear matters related to the new amendments until such time as the Courts have been called upon to consider the provisions.

The final issue relates to industry perceptions of bias, based on the wording and language used in the TOR. Recent industry experience is rendering this an issue of declining relevance, but it exists, nonetheless. Fairness in outcome is critical to the industry's respect for the objectivity of the process. If industry perceives bias, that perception generates a lack of confidence in the objectivity of the adjudicators and the adjudication process. In an attempt to address these concerns, FOS has done a lot of positive work with industry though industry liaison meetings, workshops, training seminars, the annual FOS Conference and staff meetings. However it seems that the industry perceptions are unlikely to change significantly until there is a redrafting of the FOS TOR to deal with issues of fairness (balancing interests), rights of review (an appeal mechanism), deadlines imposed on FSPs for submissions, and fee structures.

Conclusions in Relation to the Financial Ombudsman Scheme

The Ombudsman Scheme for General Insurance, in one form or another, has functioned efficiently for over 20 years and, clearly, from the consumer standpoint, has provided a cost free, effective, efficient and relatively expeditious mechanism to challenge the decisions of insurers and brokers alike. It unashamedly claims to assist consumers to deal with the myriad of issues that arise in the decision making processes of insurance and produces outcomes that while binding on the FSP are not binding on the consumer.

Whether it serves the interest of insurers is a more contentious issue. Arguably a process fully funded by only one party that produces outcomes binding on one party only, for which there is no avenue of appeal for one party does not suggest a balanced approach to EDR. The fact that FOS is not required to adhere to rules of evidence, law, precedent or indeed good industry practice, does not point to a level playing field. Allied to these constraints is the further impediment that while an insurer must participate in an EDR scheme as a condition of its insurance licence, the only currently approved scheme for Australia's general insurers is FOS. That said the clock cannot be wound back, so for better or worse the industry will need to continue to work with FOS and the Federal Regulators to ensure that the scheme works as fairly as possible and satisfies the balancing of often conflicting interests between consumers and the industry.

Litigation, Mediation and Arbitration

For many years prior to the enactment of the Insurance Contracts Act (1984) many Australian contracts of insurance contained an arbitration provision, which enabled insurance disputes to be resolved by arbitration, which, based upon the provision, made it compulsory at the behest of the insurer. While cost effective for large commercial disputes it was potentially prohibitive in the case of smaller domestic insurance claims.

Section 43 of the Insurance Contracts Act (1984), effectively rendered compulsory arbitration clauses void.[38] Section 43 provides:

1) Where a provision included in a contract of insurance has the effect of:
    a) Requiring, authorising or otherwise providing for differences or disputes in connection with the contract to be referred to arbitration; or
    b) Limiting the rights otherwise conferred by the contract on the insured by reference to an agreement to submit a difference or dispute to arbitration,

 The provision is void

2) Subsection (1) does not affect an agreement to submit a dispute or difference to arbitration if the agreement was made after the dispute or difference arose.

It is notable, that contracts of marine Insurance frequently contain arbitration clauses, and as the Insurance Contracts Act does not apply to marine insurance, section 43 has no effect on such provisions in marine insurance. However for the bulk of insurance contracts written in Australia, section 43 has a direct effect, but as the provision notes, its impact is on compulsory arbitration only and does not affect a party's capacity to agree to arbitration after the dispute has arisen (subsection (2)).

Notwithstanding the provisions of section 43, an increasing number of larger insurance disputes in Australia are referred to either voluntary arbitration or mediation or court directed mediation or conciliation. Indeed, mediation is now an integral part of the litigation process.

The drive for mediation, conciliation and arbitration has arisen in conjunction with the judiciary expressing concerns as to delays in

[38] Designed to overcome the impact of the House of Lords decision in Scott v Avery (1986) 2 LJ Ex 308, The Crts decision was that a clause in a contract of insurance which made submission of a dispute under the contract to arbitration a condition precedent to liability, was effective to exclude the court's jurisdiction until the matter had been arbitrated.

litigation and the escalating costs associated with conventional litigation. Since the turn of the new millennium there has been a push for increased support for the judicial case management of disputes. The traditional common law adversarial approach to litigation has given way to an increased interventionist approach from the judiciary to become actively involved in case management. In all jurisdictions, both state and federal, and with the assistance and support of empowering legislation, judges began ordering parties to mediation as an alternative dispute resolution mechanism. The driving motivation for this approach is to facilitate the just, quick and cheaper resolution of the real issues in dispute.[39]

As an illustration, the NSW Civil Procedure Act[40] empowers the Court to order the parties to participate in mediation, in cases where it is deemed by the Court to be appropriate. The Court appoints a mediator in default of agreement between the parties.

Reflecting the approach taken by the Australian state legislatures, the Federal Government enacted similar legislation to apply to the Federal Court – The Dispute Resolution Act 2011. This legislation requires the parties to litigation to file a "genuine steps statement" at the time of issuing proceedings. The statement requires each party to list the steps taken to try to resolve the dispute prior to filing. The obligation applies to all parties to the litigation.

One of the obvious advantages of mediation, if it is not compulsory, is that by being consensual it reflects the parties' willingness to consider non adversarial resolution. The criticism that tends to occur when it is court directed is that the parties may not be willing participants and accordingly the opportunity for a successful outcome is potentially diminished. The legislation requires the parties to a mediation to participate in "good faith"[41] but there is no sanction imposed on a party who fails to do so. Given the nature of the process, another criticism often levelled relates to the selection of mediators. Parties to a mediation selecting only those mediators "sympathetic" to their position or view point can create an obstacle to resolution.

In relation to Arbitration, many of the criticisms levelled at mediation are just as relevant or applicable to arbitration. That said, the Courts have shown strong support for arbitration, by enforcing arbitrators awards as if it was a judgement of the court. However it appears that the Courts are reluctant to

[39] See Uniform Civil Procedure Rules 2005 (NSW) ,), with similar legislation in other Australian states and the Federal Court

[40] See Section 26 – Civil Procedure Act 2005 (NSW)

[41] By way of illustration see Section 27 of the Civil Procedure Act 2005 (NSW)

relinquish all control over the process, and in the Victorian Court of Appeal decision in Oil Basins Ltd v BHP Billiton Ltd,[42] the Court held that where the Arbitrator failed to provide adequate reasons for his decision, or the reasons were "not of an acceptable standard", this may amount to an error of law resulting in the overturning of the arbitrator's award. The reservation of judicial power to intervene is reflected in the legislation.

The approach of the courts to arbitration is dictated by the legislative reforms that have been enacted throughout Australia. The Standing Committee of Attorneys General, in 2009, formulated a new domestic arbitration regime modelled upon the 2006 UNCITRAL Model Law on International Commercial arbitration (Model Law). The resulting legislation was essentially consistent throughout the various state jurisdictions (Commercial Arbitration Acts - CAA). Using the Commercial Arbitration Act 2010 (NSW) as an example, rights of appeal against an arbitrator's decision are limited. Section 34A prohibits an appeal unless both parties consent. Even where consent is given pursuant to 34A, the party seeking to appeal must obtain leave. The legislation also requires that applications for leave be determined without a hearing, unless the court determines that a hearing is necessary. S 34 permits an appeal but requires a serious error, of a jurisdictional nature, to be. Recourse to a successful appeal will not be permitted unless it can be shown the arbitrators did not have jurisdiction or failed to exercise the jurisdiction correctly. Even if such matters are made out the court still retains an overriding discretion as to whether there will be any consequence.

Furthermore, before determining whether the award should be set aside, at the request of either party, a court may, pursuant to s34(4) and 34A(7) and (8) suspend its own process for a time to enable the arbitrator the opportunity to resume arbitral proceedings or take other action to rectify the action that provided the grounds to set aside the award.

The legislative intention of the CAA makes it clear that court intervention in arbitration should be minimised and that the paramount consideration of the legislature is the finality of the arbitral decisions. The CAA illustrates the shift in attitude towards a greater acceptance of arbitration as a dispute resolution mechanism.

In relation to arbitration in Australia the concluding remarks of the Hon Justice Clyde Croft, delivered at an arbitrator's conference in London in 2011 are worth repeating:

"these reforms ensure that the domestic and international arbitral regimes in Australia are unified, and hence bolster both international and domestic arbitrations, with the promise of consistent, uniform interpretation.

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[42] (2007) 18 VR 346

Nonetheless the importance of impartial, efficient, accessible, supportive, and "arbitration friendly", courts cannot be over stated. In this context, all involved in the arbitration have a role to play ....Crucial also is the role of the arbitrators and arbitral institutions, in adopting flexible, timely, and innovative processes to maximise efficiency of arbitral disputes ..... Building and maintaining, a reputation as a strong arbitral jurisdiction requires constant reinforcement, with positive and proactive measures by legislatures, governments, arbitral bodies, arbitration practitioners as well as the judiciary. Given the growth of arbitration across the globe in recent years, the way in which these disputes are handled will influence the ongoing development of commercial arbitration" [43]

Conclusions

The forms of alternative dispute resolution mechanisms available in Australia to deal with insurance disputes are wide and varied providing both the industry and consumers with a number of options that were simply unavailable 25 years ago. ADR has progressed a long way during this period and, allied to the consumer reforms embodied in the Insurance Contracts Act (1984), suggest that the environment for insureds is decidedly more "consumer centric". ADR, is now an integral part of insurance dispute resolution with both insurers and insureds, aware that ADR is not only cost effective, and, importantly, less adversarial, but at the same time, more expeditious than traditional litigation. In the case of conciliation and mediation, because all parties are required to participate in good faith, the potential to produce an outcome that satisfies the competing interests of all parties, is significantly enhanced. ADR (in all its manifestations), is, for insurance disputes, here to stay.

As the current AIDA President Michael Gill observed in a presentation at a recent AIDA conference:

"The concept of balancing the interests of all participants in the insurance industry, which has been central to Australia's recent reforms (including those in relation to alternative dispute resolution) has universal appeal. In Australia, the concept of a "fair go for all", sits at the centre of our culture".[44]

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[43] "Commercial Arbitration in Australia: The past, the present and the future". The Hon Justice Clyde Croft, paper delivered at a meeting of the Chartered Institute of Arbitrators, London May 25th 2011.

[44] "Using and Avoiding the Court System to Resolve (Re) Insurance Disputes: the Australian Experience". AIDA Budapest Colloquium. 30 November 2012. Michael Gill.

Resolving Consumer Insurance Complaints in the UK - The Financial Ombudsman Service

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Historical introduction[1]

The original UK insurance ombudsman was a private enterprise, created by the insurance industry itself. AIDA can lay claim to being (at least indirectly) one of the influences behind its creation.

The British Insurance Law Association (the UK chapter of AIDA) held a

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* This article is based upon a presentation given by the author to the twelfth AIDA Budapest Insurance Colloquium on 30 November 2012. The presentation has been modified in form for this publication and its substance updated so that the law is stated as at 1 January 2014.

1 The following account is based upon an article by Peter J Tyldesley entitled "The Insurance Ombudsman Bureau – the early history" published in (2003) 39 *Journal of Insurance Research and Practice*, pp 34-43 (available on Mr Tyldesley's website http://www.peterjtyldesley.com).

colloquium in July 1975 on the theme of "Insurance and the Consumer" at which speakers from Belgium, France, the Netherlands, Norway and Switzerland discussed the success of independent complaints systems in their respective jurisdictions. The Norwegian speaker, Hans Petter Lundgaard, was referred to in the colloquium documents as "the insurance ombudsman"[2] – and indeed the etymological root of the term is an old Norse word meaning "messenger".

One of the delegates at the BILA colloquium was Mike Harris of Guardian Royal Exchange (GRE), whose imagination was caught by the ideas put forward by the speakers. In September 1975, Mr Harris wrote a memorandum recommending the creation of a UK insurance ombudsman. The road to fulfilment of this concept proved to be somewhat long and rocky, but in 1981 the Insurance Ombudsman Bureau (IOB) came into being; it was the voluntary creation of three leading insurance companies (GRE, General Accident and Royal Insurance) with other insurers – but by no means the whole of the UK market – joining over the next few years.

Overview

The present Financial Ombudsman Service (FOS) is the creation of a statute, namely the Financial Services and Markets Act 2000 ("FSMA").[3] The FOS took over (with an expansion of) the functions of the IOB with effect from 1 December 2001. The scope of the FOS's work is wide, covering most financial services matters, including (apart from insurance) complaints about mortgages, investment advice, and consumer credit. Within the FOS, separate teams deal with (for example) retail banking, pensions, insurance, stocks and shares, and other investments.

The FOS is believed to be the largest ombudsman service in the world today.[4] Its latest annual review,[5] which gives statistics for the financial year commencing on 1 April 2102 and ending on 31 March 2013, shows that:

- the FOS received 2,161,439 initial complaints and enquiries – over 7,000 each working day;
- about one in four initial approaches turned into a formal dispute – a record 508,881 new cases;
- 223,229 cases were resolved (198,897 by adjudicators and 24,332

[2] His official title was head of the Norwegian Bureau for Insurance Disputes.

[3] See Part XVI (sections 225 to 234A and Schedule 17).

[4] See http://www.peterjtyldesley.com/fos/insurance/pages/background.html.

[5] Published on its website http://www.financial-ombudsman.org.uk.

by ombudsmen)[6], resulting in compensation for consumers in 49% of complaints;

- the FOS operated on a budget of £150 million, with about 2,600 employees;
- information was provided and enquiries handled in over 50 different languages and formats.

Confidentiality is assured during the complaint process, although complaints of general interest may become subjects for case studies published, on an anonymous basis, in *Ombudsman News*.[7] This publication has appeared regularly since January 2001. It was originally a monthly journal, although it now comes out less frequently. The latest issue (at the time of writing) is issue 114 dated December 2013, so the average is one issue about every six weeks.

Jurisdiction

The FOS has both compulsory and voluntary jurisdiction. Entities that are regulated by the Financial Conduct Authority or FCA (that is the arm of the UK financial services supervisor with responsibility for, inter alia, consumer protection) are required to cooperate with the FOS and comply with its decisions. Such regulated entities include all insurers authorised to conduct business in the UK.

The FOS's voluntary jurisdiction applies to businesses that are permitted to sign up to the FOS scheme in respect of complaints not covered by the compulsory jurisdiction: for example, banks and insurance companies that are based in one of the member state of the European Union and that are not regulated by the FCA but that deal predominately with UK consumers. Other business that have signed up voluntarily to the FOS jurisdiction include the Post Office in respect of (for example) disputes about purchase of foreign currency; online payment services such as PayPal; freight forwarders; and storage companies. Businesses subject to FOS jurisdiction, whether compulsorily or voluntarily, are henceforth referred to (using the FOS's own terminology) as "subject firms".

The FOS's jurisdiction is limited in financial terms: the maximum amount that it can award as compensation is £150,000 (which was increased from the previous limit of £100,000 in January 2012). It should be noted, however, that although the limit of FOS awards that can be enforced in court is £150,000, parties who come before the FOS may ask for a non-binding

6 See the description of the FOS's processes in the section headed "Procedure" below.

7 The current issue and previous issues of *Ombudsman News* may be found on the FOS website.

recommendation when the amount at stake is higher – and obviously, any such recommendation that the FOS is willing to make is likely to have a powerful influence in any subsequent settlement negotiations.

Although the services provided by the FOS are aimed predominantly at private individuals, it is (on the one hand) not every individual who can take his or her case to the FOS; and (on the other) the FOS's jurisdiction does extend to certain small businesses – but there are limits.

The exception relating to private individuals is unlikely to have much application to policyholders who wish to complain about the way they have been treated by insurance companies; a regulated firm can, however, dispute the entitlement of so-called "professional clients" to bring a complaint to the FOS. The class of "professional clients" is likely to be confined to experienced and sophisticated investors who wish to make complaints about stockbrokers or financial advisers.[8]

The FOS can also consider complaints from businesses that have an annual turnover of less than €2,000,000 and fewer than 10 employees – the EU term for such businesses is "micro-enterprises". It should be noted that for the FOS to have jurisdiction, both of the "micro-enterprise" criteria must be satisfied – they are not alternatives.

Funding

The service provided by the FOS is free to consumers, that is clients of subject firms. The FOS is funded by subject firms, which pay an annual levy – whose amount varies depending on the nature and size of the business concerned – and case fees. The annual levy currently ranges from about £100 for a small firm of financial advisors to over £300,000 for a high street bank or a major insurance company.

Under the current arrangements, businesses are entitled to have the first 25 complaints made against them during any financial year handled free of charge, but for the 26th (and any subsequent) cases, a fee of £550 per case applies. Case fee arrangements are reviewed annually and may change in future.

Procedure

A subject firm must be given an opportunity to resolve its customer's complaint before the FOS steps in. The normal procedure is as follows:

[8] The FOS does however have the power to consider whether a subject firm's classification of a potential claimant as a "professional client" is appropriate; if the FOS determines that the classification is not accurate, it can then go on to investigate the complaint.

- The process starts with the customer sending a letter of complaint to the subject firm.
- The firm then has eight weeks to investigate the complaint and issue a decision.
- If the customer is not satisfied with the firm's decision, it may approach the FOS.

There is a time limit within which the customer must act. Normally this is six months from the receipt of a final response from the firm, but that deadline will not apply if there are "exceptional circumstances", or if the firm does not tell the customer that he or she has six months to complain to the FOS. "Exceptional circumstances" are not defined, but an example given by the FOS on its website is if the consumer is incapacitated for the period during which he or she should have complained.

The FOS's procedures are aimed at achieving resolution of complaints quickly and with minimum formality. A complaint will initially be assigned to an adjudicator who will try to find a solution through conciliation or informal mediation including – where appropriate – speaking to each of the parties by telephone. The adjudicator may request clarification or further documents. If necessary, he or she will issue a preliminary assessment and ask the parties to comment. Very often, the matter will settle at that stage. If, however, the complaint is not resolved, either party may ask for an ombudsman's review and final decision. The ombudsman will review all of the evidence independently and issue a written provisional assessment, with a time limit for the parties to respond. Only after expiry of that time limit will a final determination be issued.

The customer's presentation of his or her complaint is not judged by the standards of formal court pleadings. The ombudsman will always look beyond the form of a complaint to its substance. The FOS has no power to compel witnesses to attend hearings, to take evidence on oath, or to permit a complaint (or the response to a complaint) to be tested by cross-examination.

Effect of FOS decision

The effect of a FOS decision is different for subject firms and for customers.

If a final decision goes in favour of the customer and the customer accepts it, that decision becomes final and binding on both parties. There are deadlines for acceptance, which will be set by the ombudsman. The FOS website does not give any information on the standard length of time –

presumably because each case will be treated on its own facts – but the typical time limit appears to be between one month and six weeks. This is consistent with the FOS's stated aim of resolving most complaints within a few months, although it is recognised that some claims may take longer, either because of their inherent complexity, or because of the sheer volume of similar claims that the FOS may have to deal with at any one time.

If the FOS rules against the complainant, the customer is not bound to accept that decision but can take the matter to the ordinary courts – subject, of course, to considerations such as the expiry of limitation periods.

The subject firm, on the other hand, has no such options: it will either be bound by the customer's acceptance of an ombudsman decision in the customer's favour, or if the ombudsman rules in favour of the subject firm, it will still be exposed to the risk that the customer wishes to have his or her complaint heard in court.

The remedies available from the FOS are limited. The FOS does not have any funds of its own to compensate customers. It does however have the power to order subject firms to pay compensation to customers or to take other steps, for example to amend any advertising which the FOS considers misleading. The FOS cannot fine firms or legislate for their future conduct: these functions remain the prerogative of the FCA.

Conflicts between FOS and UK legal system – and their resolution

There are fundamental differences of principle in the approach by the FOS on the one hand and the ordinary courts on the other to financial services complaints coming before each of them. The FOS makes its decisions "by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case."[9] The FOS need not apply strict rules of construction if their application would defeat the legitimate (subjective) expectations of the consumer. The operation of this principle in the insurance context means that some cases could be treated very differently by the FOS and the English courts. This can perhaps best be illustrated by considering how the FOS and the courts each approach cases in which an insurer has denied coverage on the grounds that the policyholder has made a material non-disclosure or misrepresentation.[10]

The strict position under English law (which will of course be applied by the courts) is that an insurer to whom a material misrepresentation or non-disclosure has been made may avoid the policy from its inception. Materiality is, for these purposes, judged by the standard of the "prudent

9 FSMA section 228(2).

10 An example appears below in the section headed "Selected 'war stories'".

insurer";[11] the question becomes whether a prudent insurer would, if the true facts had been disclosed, have accepted the risk and, if so, on what terms, particularly as regards the premium. Under the test laid down by the leading case of *Pan Atlantic Insurance Co Ltd v Pine Top Reinsurance Co Ltd,*[12] the basic text remains what a prudent insurer would have done, albeit that the underwriter who actually wrote the risk must show that he would have acted differently had the true facts been disclosed or represented. This creates an obvious difficulty for the consumer buying insurance, who cannot be presumed to know what will influence an underwriter, unless the insurance company – usually in a proposal form – illustrates by means of relevant questions exactly what it wants to know.

The FOS approach, by contrast, starts from the practical standpoint that the insurer should make clear to the would-be insured what the underwriter wants to know. The FOS will, accordingly, consider the following matters:

- Did the insurer ask a clear question?
- Was the insured's answer inaccurate?
- Was the insured's inaccuracy deliberate, negligent or innocent?
- Did the inaccurate answer influence the insurer's decision?
- What would the insurer have done if the answer had been accurate?

The FOS then has a range of possible remedies at its disposal including (for example) the imposition of exclusions or other conditions, or ordering the insurer to make a partial payment, to reflect the possibility that had the insurer known the truth, it would have imposed an increased premium or deductible.

It is to be noted that the FOS approach has had a significant impact on consumer insurance law in the UK, in that the Consumer Insurance (Disclosure and Representations) Act 2012, which came into force in April 2013, abolishes the duty of pre-contractual disclosure for consumers and replaces it with a duty to answer an insurer's questions carefully and honestly. In addition, the 2012 Act creates the possibility of a much wider range of remedies for the insurer than the previous all-or-nothing entitlement to avoid the policy from inception. The right of avoidance remains for cases in which the underwriter would not, had there not been any misrepresentation, have accepted the risk at all, but in other cases the

[11] A creation of statute (the Marine Insurance Act 1906, sections 18(2) (as regards non-disclosure) and 20(2) (as regards misrepresentation)) and considered by some commentators to be a mythical figure.

[12] [1995] 1 AC 501 (HL).

insurer's remedy is based upon what the underwriter would actually have done had the insured answered the questions truthfully; it could be (for example) the effective re-writing of the policy to insert an exclusion or an increased deductible. Further, if the insurer would only have accepted the risk subject to a higher premium, the indemnity payable to the insured will be proportionately reduced.

Selected "war stories"

Four case studies published in *Ombudsman News*, each one taken from a different market sector, may help to illustrate how the FOS works in practice.

Travel insurance – policy construction

The complainant made a claim for compensation for delay under a travel insurance policy for delay caused by the ash cloud produced by the eruption of the Eyjafjallajökull volcano in Iceland in 2010. The insurer denied indemnity on the grounds that the ash cloud did not constitute a "poor weather condition", which was the relevant peril insured against. The ombudsman upheld the insured's complaint on the basis that although a volcanic eruption was not itself a weather condition, a cloud of ash borne on the wind was included within the words "poor weather" within the ordinary and natural meaning of those words, notwithstanding that the cloud was caused by the eruption of a volcano. The insurer was ordered to pay the delayed passenger compensation under the travel policy.

Health insurance – non-disclosure

A health insurance proposal form asked the question whether the proposer had ever suffered from "back or spinal trouble". The insured had in fact suffered from, and received treatment for, back pain following childbirth about ten years previously. She did not, however, disclose this information in the proposal form because she did not believe that back pain due to childbirth was the type of "back or spinal trouble" about which the insurer wanted to know. In addition, most of the questions in the proposal form (but not the question about back pain) asked for information about medical consultations that had occurred during the previous five years. The insured later developed breast cancer, completely unrelated to her back condition. The insurer then learned of the back pain and sought to avoid the policy for non-disclosure. The FOS took the view that the insured had been slightly careless in completing the proposal form, but if she had answered the insurer's questions completely accurately, the insurer would have offered full cover except for back and spinal problems. The FOS accordingly required the insurer to reinstate the policy, subject to an exclusion for

spinal conditions, and to pay the complainant's breast cancer claim in full, together with interest.

Property insurance – warranties

An intruder broke into the insured's fish and chip shop and started a fire. The insurer claimed to be discharged from liability because the insured had warranted that the door of the shop was fitted with a five lever mortice lock, when in fact the lock had only three levers. The FOS found that the type of lock made no difference to the loss, as the intruder had in fact entered the shop by breaking through a panel in the door. As there was no causal connection between the breach of warranty and the loss, the insurer was ordered to pay the insured's claim.

Property insurance – non-disclosure

The consumer does not, however, always win disputes submitted to the FOS. In one case, the policyholder insured a shop with a flat above it. He did not disclose that the tenant of the flat was unsatisfactory in a number of respects and that the policyholder had started proceedings against the tenant for repossession. The tenant started a serious fire in the flat by smoking in bed. The FOS held that the insurer was justified in avoiding the policy for material non-disclosure, even though no specific questions about the tenancy of the flat had been asked. The insured should have realised that the underwriter would want to know about problem tenants.

FOS and proposed insurance contract law reform with regard to warranties

English insurance contract law is currently undergoing a process of change, brought about by a project to review and (where necessary) reform the law being conducted by the Law Commissions of England and Wales and of Scotland. The Commissions are statutory bodies entrusted with responsibility for periodically reviewing and (where appropriate) recommending reform of civil law in Great Britain. The insurance contract law project commenced in 2006. In the most recent consultation paper forming part of it (published in June 2012), the Law Commissions have proposed that a breach of warranty should only suspend (and not discharge) the insurer's liability and that, where a warranty in a policy is designed to reduce the risk of a particular type of loss, the insurer's liability should be suspended only in respect of a loss of that type.

The proposed change in the law does not, however, go quite as far as the FOS approach of requiring a causal link between breach of warranty and loss. In the example given above of the break-in to the fish and chip shop, the courts would probably deny the insured a remedy, even

under the amended warranty regime proposed by the Law Commissions, on the grounds that the loss occurred as the result of a break-in, which was precisely the sort of risk which the warranty about the type of lock was intended to reduce.

The future of FOS

The way in which the FOS operates has changed over the years and continues to change in order to enable the organisation to fulfil its responsibilities in the most efficient way. For example, the number of complaints which a subject firm is entitled to have adjudicated without charge was recently raised from three to 25 in order (amongst other factors) to encourage the use of FOS services. On the other hand, the proliferation in recent years of complaints alleging mis-selling of payment protection insurance or PPI (74% (378,699) of the new cases handled by the FOS in 2012-13 related to the sale of PPI whereas only 4% of total complaints were about insurance other than PPI) has caused the FOS to introduce a supplementary case fee of £350 (in addition to the standard case fee of £550) for PPI mis-selling complaints – but it is only charged when subject firms have more than 25 such complaints made against them in any one year.

Amendments to the FOS scheme made by the Financial Services Act 2012 include a requirement for a Memorandum of Understanding to be entered into between the FOS and the FCA, whereby the FOS must disclose information to the FCA which would assist in the advancement of the FCA's operational objectives. In addition, ombudsman decisions (but not adjudicator views) will be published in full on the FOS website – this has already come into effect. The effect of these changes is that the FOS is becoming more than a compulsory alternative dispute resolution scheme; it will also be a referral agency for the FCA's supervisory and enforcement teams.

When these proposals were consulted upon, respondents were (on the whole) supportive of the approach so long as commercially sensitive information was protected and the names of employees and subject firms were not disclosed. However, many respondents were of the opinion that "naming and shaming" would see the FOS crossing the line between dispute resolution service and regulator. The question must therefore be asked: will the FOS assume a new consumer protection role in future, that is, assisting the FCA to keep watch over insurers? And is this – albeit thirty years later than George Orwell[13] predicted – an instance of "Big Brother [will be] watching you"?

[13] George Orwell: *Nineteen Eighty-Four* (Secker and Warburg, London 1949)

La Mediation En Assurances En France[1]

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Très tôt, les assureurs ont eu conscience de l'intérêt d'éviter les recours juridictionnels tant pour leur coût, que pour leur influence néfaste sur l'image de la société d'assurance. Ainsi, la médiation en assurances et l'une des premières médiations institutionnelles qui a été mise en place en France.

C'est en effet en 1993 que les groupements d'assurance (Fédération Française des sociétés d'assurances – FFSA et Groupement des entreprises d'assurances – GEMA) se sont dotés d'une Charte de la médiation afin de poser les règles de base de l'utilisation de la médiation en matière d'assurance et d'encourager les parties à y recourir plutôt que de se tourner vers la voie judiciaire. Tous les assureurs membres de ces groupements (c'est-à-dire la quasi-totalité des assureurs français), ce sont ainsi engagés à recourir à un médiateur pour le règlement amiable des réclamations des assurés. Par la suite, ils ont été suivis par la Fédération Nationales de la Mutualité Française (FNMF) à compter de 2002, par la Chambre syndicale des courtiers en assurances (CSCA) à compter de 2008, par le Centre Technique des Institutions de prévoyance (CTIP) à compter de mars 2010.

Afin de mesurer l'avancée des assureurs français en la matière, on peut également mentionner que l'existence d'un médiateur en matière bancaire n'est obligatoire que depuis 2001 (Loi du 11 décembre 2001, art. L. 312-1-3 du Code monétaire et financier).

Ce qui est remarquable en assurance, c'est que ces avancées des modes

[1] Il est précisé que toutes les statistiques citées sont issues du rapport annuel du médiateur de la FFSA, présentant des chiffres regroupant tous les médiateurs en assurances, consultable sur www.ffsa.fr)

extrajudiciaires de règlement des litiges (REL comme ils sont nommés en droit de l'Union européenne) ont été obtenues par la voie conventionnelle, les assureurs se soumettant volontairement, par le biais de conventions conclues au niveau des deux fédérations professionnelles (la FFSA pour les sociétés anonymes d'assurance et les société d'assurance mutuelle distribuant leurs produits par le biais d'un réseau d'intermédiaires et le GEMA pour les société d'assurance mutuelle distribuant directement leurs produits).

Le législateur n'est intervenu qu'en seconde main, en venant imposer une obligation d'information des assurés à l'égard du traitement de leurs réclamations, obligation présupposant la reconnaissance implicite du dispositif de médiation mis en place à l'initiative des assurances. La loi n° 95-4 du 4 janvier 1994 est venue ajouter à l'article L.112-2 alinéa 2 du Code des assurances, relatif au formalisme informatif précontractuel, l'exigence de l'indication dans les documents remis à l'assuré des *« modalités d'examen des réclamations qu'il peut formuler au sujet du contrat, y compris, le cas échéant, l'existence d'une instance chargée en particulier de cet examen, sans préjudice pour lui d'intenter une action en justice »*. Les assureurs ont donc l'obligation d'informer les assurés sur l'existence d'un processus de traitement amiable des réclamations des assurés mais leur soumission à ce dispositif n'est pas imposée par la loi mais par la voie conventionnelle.

Si l'intention des assureurs est bonne et les résultats encourageants, l'Autorité de Contrôle Prudentiel et de Résolution (ACPR), autorité de contrôle commune aux secteurs de l'assurance et de la banque en France, a constaté que le dispositif pouvait être amélioré en y insufflant davantage de transparence et en harmonisant les pratiques qui avaient tendance à être assez hétérogènes entre les différentes sociétés d'assurance, tant la Charte de la médiation leur offrait de liberté. A cet effet, l'ACPR a formulé une recommandation sur le traitement des réclamations, en date du 15 décembre 2011, qui a engagé les assureurs à parfaire le système de règlement amiable des différends. C'est ce dispositif rénové que nous allons décrire, en répondant à différentes questions.

1) Quel est le périmètre de la médiation?

La médiation, telle qu'elle résulte des Chartes de la médiation, n'est prévue que pour les litiges opposant un particulier à une société d'assurance nés à l'occasion du contrat d'assurance. Dès lors, la médiation est limitée aux contrats d'assurance conclus dans le cadre de la vie privée ; les risques professionnels en sont, en principe, exclus.

La formulation du périmètre de la médiation est volontairement large mais elle ne va pas sans poser de difficultés de frontières. Ainsi, si le médiateur est compétent pour les problèmes juridiques découlant du lien contractuel, il sera incompétent, du moins techniquement, si ce sont les conclusions d'un expert qui sont contestées. Egalement, s'agissant de tarification, le médiateur ne sera pas compétent pour statuer sur les modalités de paiement des primes qui n'incombent qu'à la compagnie. Ou encore, il ne lui appartient pas de décider d'un geste commercial. Il peut y encourager mais certes pas l'imposer.

2) Qui est le médiateur?

La réponse à cette question est assez délicate puisque, à ce jour, il n'y a pas un médiateur en assurances mais neuf médiateurs. Deux médiateurs sont dits « professionnels » car ils sont rattachés aux fédérations professionnelles que sont la FFSA et le GEMA. Pour toutes les entreprises relevant du GEMA, seul le médiateur professionnel est appelé à intervenir. Il est donc unique. En revanche, pour les entreprises relevant de la FFSA, la Charte de la médiation a prévu que les entreprises qui le souhaitent pouvent faire appel à un médiateur de leur choix. Dans la mesure où ce médiateur est désigné par l'entreprise ou un groupe d'entreprises et qu'il est appelé à ne connaître que des réclamations portant sur des contrats distribués par cette entreprise, ce médiateur est improprement dénommé « médiateur d'entreprise » mais il reste indépendant et extérieur à l'entreprise. Sept entreprises ont fait ce choix. Il s'agit d'AXA, CNP Assurances, GMF, GROUPAMA, GENERALI, MMA et NEUFLIZE Vie. L'avantage de recourir à un médiateur indépendant est pour ces sociétés d'assurance, non seulement de pouvoir déterminer le domaine qu'elles entendent donner à la médiation (MMA a par exemple élargi la médiation aux risques professionnels) mais également de pouvoir avoir une gestion plus serrée et plus précise des réclamations et notamment des questions juridiques récurrentes qui remontent au médiateur, ce qui permet faire évoluer plus aisément les contrats et les pratiques au sein de l'entreprise.

Comme il peut être difficile pour l'assuré de connaître précisément le médiateur auquel il doit s'adresser, plusieurs initiatives ont été mises en place. Tout d'abord, une boîte postale (MEDIATION ASSURANCE, 1 rue Jules Lefebvre, 75431 PARIS cedex 09) indique à l'assuré sur simple demande les coordonnées du médiateur dont il dépend. Ensuite, l'ACPR par le biais d'une plateforme téléphonique réoriente les réclamants sur les différents médiateurs. Enfin, depuis la recommandation de l'ACPR, la société d'assurance qui oppose un refus à une réclamation mentionne dans ce courrier le possible accès et les coordonnées du médiateur.

Quant à la personne du médiateur, il s'agit d'une personnalité indépendante choisie pour ses compétences en matière d'assurance et, plus précisément en droit des assurances (ancien directeur de compagnie d'assurance, professeur de droit, ancien magistrat…)

3) Comment saisit-on le médiateur?

La saisine du médiateur repose sur la formulation par l'assuré d'une réclamation. La définition donnée par l'Union européenne dans une recommandation du 12 mai 2010 relative à l'utilisation d'une méthode harmonisée pour classer les réclamations est on ne peut plus large : *« une déclaration actant le mécontentement exprimé par un consommateur envers un professionnel »*. Le mécontentement du particulier constitue le germe du litige. L'appréhension est volontairement accueillante de façon à ne pas laisser s'enliser le mécontentement jusqu'à ce qu'il dégénère en conflit.

a) Conditions de saisine

Il n'y a que deux conditions à la saisine du médiateur : que toutes les voies de recours internes à l'entreprise d'assurance aient été épuisées et qu'aucune action en justice ne soit diligentée.

La médiation en assurances n'est, en effet, que le second niveau du traitement amiable des réclamations.

Au 1er niveau, la réclamation est portée devant un service interne à la compagnie d'assurance (la terminologie varie : service réclamations clients, service qualité, service consommateurs…) qui est indépendant des services de gestion de la société. Le dossier est réexaminé par le service réclamation qui vérifie l'opportunité de la position du service de gestion. Ce service va tenter de réaliser une conciliation, en interne, de façon à vider le contentieux. Si le différend persiste et que toutes les voies de recours internes sont épuisées, le réclamant pourra demander la saisine du médiateur.

Au 2nd niveau, le réclamant a la possibilité de solliciter l'avis du médiateur. Il s'agit même d'un droit à la médiation auquel se sont engagées les compagnies d'assurance dans la Charte de la médiation.

Le médiateur peut alors être saisi par l'assuré (84,1%), par la société d'assurance (0,1 %) ou, exclusivement pour la charte de la médiation de la FFSA, par tout tiers intéressé (associations de consommateurs (2,3 %), avocats (1,5 %), entourage de l'assuré (3,3 %)…).

Il faut encore préciser que la saisine du médiateur est totalement gratuite pour les assurés, les entreprises d'assurance le prenant à leur charge.

En application de ce dispositif, en 2012, 8 967 demandes de saisine ont été portées devant les médiateurs. Sur cette masse, seuls 60,9 % des dossiers satisfaisaient à la double condition de saisine et ont été acceptés en médiation. Les autres ont été renvoyés en procédure interne (35 %) ou déclarés hors périmètre (4,1 %).

On relèvera que le nombre de demandes de saisine était de 7 426 en 2011, 5 649 en 2010, 1 502 en 2005 et 471 en 1995. C'est dire si les chiffres ont explosé depuis la mise en place du dispositif.

b) Effet de la saisine

Depuis la loi du 17 juin 2008 réformant le droit français de la prescription, le nouvel article 2238 du Code civil prévoit que la saisine du médiateur suspend la prescription de l'action en justice. Le cours de la prescription est donc arrêté dès la saisine pour reprendre là où il en était resté une fois l'avis rendu pour une durée qui ne peut être inférieure à six mois.

4) Quel est la mission du médiateur?

Il ne faut pas se méprendre, la médiation en assurance n'a que très peu de choses en commun avec les médiations judiciaire et conventionnelle. Elle fonctionne, en revanche, comme beaucoup de médiations institutionnelles. En assurance, il s'agit d'une médiation sur pièces, donc hors la présence des parties. Il ne s'agit donc pas d'aider les parties à communiquer afin qu'elles parviennent elles-mêmes à trouver une solution à leur litige mais uniquement de proposer une solution au litige qui semble adaptée au médiateur.

Le médiateur doit ainsi rendre un avis sur l'issue du litige. A cet effet il peut se fonder sur le droit et/ou sur l'équité. Le rôle du médiateur en assurances est ainsi plus proche de celui d'un juge de l'amiable, qui n'a pas de pouvoir de coercition mais qui propose une solution qui tranche le différend, que d'un médiateur judiciaire ou conventionnel.

Pour accomplir cette mission, les médiateurs relevant de la charte de la FFSA disposent de trois mois à compter de leur saisine tandis que le médiateur du GEMA a six mois pour rendre son avis.

Il faut noter que la médiation est interrompue si une action est portée en justice.

5) Quelle est l'autorité des avis du médiateur?

A l'égard des assurés ou des tiers, l'avis n'a aucune force obligatoire. L'assuré ou le tiers disposent toujours du droit d'agir en justice, ce qui leur est d'ailleurs rappelé par le médiateur lorsqu'il rend son avis.

A l'égard des assureurs, les avis du médiateurs du GEMA ont force obligatoire. Ce n'est pas le cas pour les médiateurs obéissant à la Charte de la FFSA dont l'avis n'est que consultatif. Toutefois, en pratique, cet avis est suivi entre 98 et 99 % des cas.

Les statistiques montrent que sur les 441 avis rendus en 2012, 30,9 % sont favorables aux réclamants, 18,6 % leurs sont partiellement favorables et donc 50,5 % leurs sont défavorables (les statistiques sont à peu près similaires d'une année sur l'autre). Ces chiffres s'expliquent par les deux étapes du dispositif. Si la conciliation est envisageable, l'entreprise d'assurance, compte tenu du coût engendré par la médiation, préfère régler définitivement le différend en interne. Par conséquent, seuls les dossiers où la compagnie est sûre de sa position parviennent au médiateur.

En conclusion de cette présentation, il convient de mentionner l'impact déterminant que va avoir la directive 2013/11/UE du 21 mai 2013 relative au règlement extrajudiciaire des litiges de consommation sur le système de médiation en assurances, qui doit être transposée dans les Etats membres de l'Union européenne avant le 9 juillet 2015.

Cette directive prévoit que chaque Etat membre devra désigner une ou plusieurs autorités qui auront pour mission de dresser une liste des entités de REL reconnues comme obéissant aux critères d'indépendance, d'impartialité, de transparence, d'efficacité, de rapidité et d'équité posés par la directive. Dès lors, dans la mesure où la reconnaissance comme entité de REL dépendra de la volonté de l'autorité nommée par l'Etat membre, cela ne permet pas de savoir, à ce jour, si cette autorité souhaitera maintenir le système de médiation en assurances tel que nous l'avons décrit ou si elle préférera limiter le nombre de médiateur à deux (FFSA et GEMA), à un pour tout le secteur de l'assurance, voire à un unique médiateur pour les secteurs banque et assurance. En outre, si un ou plusieurs médiateurs en assurances sont reconnus, des modifications devront être apportées dans leur mode de fonctionnement, telles que : une désignation à parité par des assureurs et des assurés, un budget propre, un site internet propre au médiateur permettant de recueillir les dossiers de réclamations… De profonds bouleversements attendent ainsi la médiation en assurances à très court terme. Il reste à espérer que ce sera pour le plus grand profit des assurés et pas au détriment d'un système qui fonctionne bien et qui a fait ses preuves.

Alternative Dispute Resolution Sweden

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She is Chairman of the Swedish Chapter of AIDA (Association of Insurance Law/ Association Internationale de Droit des Assurances), member of AIDA's Presidential Council and Panel Member, Reinsurance Working Party of AIDA.

Introduction

Sweden has a long tradition of solving insurance related disputes out of court. The advantages are obvious: it is quicker and cheaper. The major disadvantage is of course the resulting scarcity of court precedents and thereby a lack of guidance which proves problematic in many instances.

There are a number of dispute resultion facilities of different character and size for different kinds of disputes. A brief overview is given below.

1. The National Board for Consumer Complaints (Sw.: Allmänna Reklamationsnämnden)

General background

The National Board for Consumer Complaints (ARN) is a public authority.

ARN's main task is to impartially try disputes between consumers and businesses.

ARN is divided into thirteen different departments among them an Insurance Department. The Insurance Department is primarily focussed upon insurance policies and interpretation.

ARN gives non-binding recommendations only.

In 2012 the Insurance Department received 923 complaints, which meant an increase of 16 % compared to 2011. In general 76 % of ARN's decisions were accepted and followed by business operators whilst recommendations made by the Insurance Department were 100 % (!) accepted and followed.

Cross-border disputes

ARN is the competent authority to try disputes between consumers in other EU countries and insurance companies in Sweden.

Swedish consumers who have a conflict with insurance companies in other countries within the EU can turn to their European Consumer Centre for advice and assistance. The Swedish European Consumer Centre is called *Konsument Europa*.

The Procedure

Claims are filed by consumers/policyholders. A claim to ARN must be made within six months from the point of time when the insurance company rejects a claim partially or wholly.

Group Actions are allowed.

A claim must exceed a fixed amount. The limit that applies in respect of matters that fall under ARN's Insurance Department is at present 2.000 SEK. In case a dispute is of a principle nature or if there are other special circumstances, ARN can choose to try the dispute despite the fact that the claim is below the stipulated limit of 2.000 SEK.

Contracts entered into in Sweden

Normally, ARN's inquiry is limited to contracts that have been entered into in Sweden.

Types of matters that ARN does not try

- disputes between private persons or between businesses
- disputes where a medical assessment is needed
- disputes concerning legal services
- disputes that have been submitted to court for trial
- disputes where the business operator has entered bankruptcy

ARN may also reject matters that, due to ARN's written procedures and simplified working methods, cannot be satisfactorily investigated or otherwise are not appropriate to ARN's inquiry.

How a dispute is settled

A department consists of a chairperson, a vice chairperson and four other members. The chairperson is a lawyer with court experience. The other members come from consumer and trade organisations.

A department constitutes a quorum, i.e. is competent to make a decision, when the chairperson and four other members are present.

Occasionally, inconsistent opinions have been given by ARN on the interpretation of identical policy wordings. There are at least two examples where the Swedish Supreme Court have granted leave of appeal in order to provide guidance through authoritative legal precedents (NJA 1986 p. 659 and NJA 1995 p. 392). Both cases concerned Theft Insurance for motor bikes.

2. The Road Traffic Injuries Commission (Sw.: Trafikskadenämnden)

General background

The Road Traffic Injuries Commission was established in 1936. The Commission is regulated by the Traffic Insurance Ordinance (1976:469) (*Sw*. trafikförsäkrings-förordningen). All insurance companies which provide traffic insurance are under an obligation to maintain and finance the Commission. The Commission's Regulations shall be approved by the Government. This means of course also that the regulations cannot be changed without Government approval.

The overriding purpose is to achieve a unitary and fair claims handling within the traffic insurance.

Under Swedish law all motor vehicles must be insured. According to the Traffic Damages Act (*Sw*.: Trafikskadelagen), which came into force in 1976, all victims of traffic accidents – drivers, passengers as well as pedestrians and cyclists are entitled to receive, in principle, full compensation for personal injuries suffered.

Uninsured or unidentified motor vehicles

In cases where uninsured or unidentified motor vehicles are involved, compensation is paid by the Swedish Motor Insurers (*Sw*. Trafikförsäkringsföreningen ”TFF”; formerly Motor Insurers' Bureau of Sweden).

The Commission's structure

Chairman

The chairman is appointed by the government. At present the chairman is a Supreme Administrative Court (*Sw*. Högsta förvaltningsdomstolen) judge.

Deputy chair persons

There are six deputy chairpersons. All must be lawyers and must not be employed by an insurance company. At present most of them are judges or former judges.

Representatives of insurance companies

Thirteen members of the commission represent insurance companies. They are appointed by the Swedish Financial Supervisory Authority (*Sw*. Finansinspektionen) on the recommendation of the Swedish Motor Insurers (*Sw*. Trafikförsäkringsföreningen "TFF").

These members are required to possess extensive and in depth knowledge and experience of claims handling.

Lay representatives

There are thirteen lay representatives. They are appointed by the Swedish Financial Supervisory Authority (*Sw*. Finansinspektionen) on the recommendation of the labour market interest organisations.

When the Commission's recommendation must be obtained

As mentioned the Commission's aim is to achieve a uniform and fair settlement of claims within the field of traffic insurance.

Insurance companies are obligated to obtain the Commission's recommendation in respect of:

(i) loss of income if the medical disability is 10 % or more or if the annual loss of income exceeds a certain level;

(ii) personal injury (physical and/or mental) as well as costs and 'other inconveniences' if the medical disability is 10 % or more;

(iii) loss of support for survivors in case the accident results in death and

(iv) a renwed assessment where there is a substantial change of the circumstances on which the Commission's recommendation was based.

The procedure

The insurance company prepares a memorandum (*Sw*. Nämndspromemoria) which sets out a presentation of the matter and a brief presentation of all relevant facts and figures – including a detailed account of the injured person's situation before and after the accident in respect of i.a. his/her working and living situation, the insurer's view and the injured persons

view. The degree of medical disability has been set by doctors with specific knowledge of insurance medicine. In addition, the memorandum contains the injured person's claims, where such claims are specified, and the insurance company's compensation offer.

The memorandum is sent to the injured person or his/her representative and he/she may add additional documentation and give his/her view.

Thereafter the memorandum and enclosures as well as the complete claims file is submitted to the Commission.

The members of the Commission receive the memorandum with enclosures a couple of weeks before the meeting. The case is normally presented by a lawyer from the Commission's secretariat. Since the participating members of the Commission have read the actual memoranda in advance, the presentation is normally quite brief and the discussions that follow are focussed on issues of complicated nature or otherwise of specific interest.

A dissenting opinion, which is relatively unusual, may be expressed in the Commission's recommendation.

It normally takes 2- 5 months from the point of time when the matter was submitted until the Commission's recommendation is rendered.

The proceeding before the Commission is free of charge for the claimant.

Statistics 2012

3.832 matters were referred to the Commission. 32 % concerned permantent disability between 1-9 %, i.e. non mandatory matters. Whiplash injuries accounted for 47,6 %. The claimants were represented by lawyers or other representatives in 66,4 % of the submitted matters. The Commission held 214 meetings.

Level of indemnity

The level of indemnity proposed by the insurance companies was

(i) accepted in 71 % of the cases;

(ii) raised in 23,5 % of the cases and

(iii) reduced in 5,6 % of the cases.

3. Insurance Sweden (*Sw*. Svensk Försäkring)

Insurance Sweden (*Sw*. Svensk Försäkring) is responsible for a number of industry-wide review boards. The review boards issue opinions on disputes between policyholders and insurance companies. The review boards' opinions provide guidance, for example on interpretation of insurance policy conditions and loss adjustment practices.

3.1 Personförsäkringsnämnden (PFN)

Personförsäkringsnämnden ("PFN") solely tries disputes between the insured (an individual consumer) and the insurance company in matters concerning:

(i) life-;

(ii) sickness-

(iii) accident insurance,

where medical assessment is required.

PFN's structure

Six members participate in PFN's decisions.

The PFN is composed of:

A *Chairman or a vice chairman* who shall be *lawyers* with *specific qualifications*. They must not be employed by an insurance company. They are appointed by Insurance Sweden (*Sw*. Svensk Försäkring).

Two members with extensive claims handling experience. They are appointed by Insurance Sweden.

Two members representing the consumer. They are appointed by the Consumer Advisers' Association (*Sw*. Konsumentvägledarnas förening).

One advisory doctor experienced in insurance medical issues. The doctor must not be tied to any insuarance company.

The procedure

An application received by PFN is forwarded to the insurance company. with a request for comments.

Once the comments are received they are sent to the insured, who may submit additional commentaries in writing to the PFN.

PFN's opinion is a non-binding recommendation only. Although PFN's opinion is not binding it is mostly accepted by the insurance company.

Normally, PFN's opinion is given within 4 – 6 months.

3.2 Ansvarsförsäkringens Personskadenämnd (APN)

APN tries claims handling issues concerning compensation for personal injury within liability insurance and other insurance with the exception of traffic insurance.

APN's overriding aim is to work for a uniform and fair settlement of personal injuries within the field of liability insurance or other insurance – with the exception of traffic insurance – where the injured person,

based on tort law, is entitled to compensation. APN does not try matters falling under the competence of the Pharmaceutical Injuries Board (*Sw*. Läkemedelskadenämnden).

The APN is composed of:

A Chairman and a vice chairman both appointed by Insurance Sweden (Sw. Svensk Försäkring) The present chairman is a recently retired Supreme Court judge.

Two members with extensive and in depth knowledge of personal injury claims handling within the liability insurance field. Both are appointed by Insurance Sweden (*Sw*. svensk Försäkring).

Two members representing claimants (the consumer interest). Both are appointed by the Consumer Advisers' Association (*Sw*. Konsumentvägledarnas förening).

The costs for APN are distributed between the participating insurance companies in relation to the number of referred cases from the respective company during the calendar year.

The insurance companies are obligated to seek APN's advice in respect of:

- compensation for loss of income, compensation for disfigurement and permanent disability where the medical disability is at least 10 %;
- where the yearly loss of income is estimated to at least half a base amount (at present 22.200 SEK)
- indemnity for loss of maintanence as a consequense of death
- reassessment of annuity or a lump sum in certain circumstances
- other issues if requested by the claimant.

Where the claimant is represented by a 'suitable' representative and the parties are in total agreement, the insurance company is not obligated to submit the matter to APN.

3.3 The Swedish Bar Association Establishes a Consumer Dispute Board

The Swedish Bar Association (Sw.Advokatsamfundet) makes plans for a Consumer Dispute Board with the task to try consumer disputes relating to lawyers' activities. This means the introduction of an alternative dispute resolution facility in accordance with the EC Directive on Alternative Dispute Resolution for Consumers (2013/11/EC), which was decided on 21 March 2013.

The aim is to give consumers access to a simple, inexpensive and expedited way of trying disputes with lawyers concerning e.g. fees. It will be possible to file an application via the website. The cost will be limited to 450 SEK.

The time for handling matters, which will be in writing, must not exceed 90 days. Each party shall carry its own costs.

Members of the Swedish Bar Association shall be obligated to participate in the procedure, which must be initiated within one year from the point in time when the consumer filed a complaint with the lawyer. The dispute must concern an amount of at least 1.000 SEK.

It is proposed that the Board shall consist of five members, a ‘private law' (family law, criminal law etc.) lawyer, a business lawyer, two consumer representatives and the fifth member shall be a former judge experienced in non mandatory civil matters. The chairman shall be a lawyer.

4. The Patient Injury Board

The right to compensation for injuries sustained in the Swedish health care system is regulated by the Patient Injury Act (1996:799) (*Sw*. Patientskadelagen).

All Swedish county councils and regions have taken out Patient Insurance with the Patient Insurance LÖF (*Sw*. Landstingens Ömsesidiga Försäkringsbolag). Approximately 10.000 injuries are reported each year. About 45 % of the reported injuries are compensated.

What is covered by the insurance?

(i) The injury must have been avoidable;

(ii) The injury may be compensable if it was caused by defective medical equipment or the incorrect use of such equipment;

(iii) The Injury may be compensable if the diagnosis was delayed and the medical condition worsened due to the delay;

(iv) The injury may be compensable if it was caused by an infectuos agent which was transferred in connection with medical care and treatment;

(v) The injury may be compensable if it was caused by an accident in connection with medical or dental care and

(vi) The injury may be compensable if it was caused by a pharmaceutical that was incorrectly prescribed.

5. The Pharmaceutical Injury Board

The Pharmaceutical Insurance (Sw. Läkemedelsförsäkringen)

In Sweden there is a type of insurance available for those suffering from adverse effects of pharmaceutical treatment. The insurance protects

everyone who has been treated with prescribed pharmaceutical products or pharmaceuticals purchased from a legitimate seller in Sweden.

In addition the insurance covers patients who received the pharmaceuticals at a hospital or who are suffering from adverse reactions or effects due to participation in clinical trials covered by the insurance.

Traffic Injuries and Work Related Injuries

The Traffic Insurance generally covers also injuries caused during treatment of traffic injuries.

Likewise injuries caused during treatment of work related injuries shall primarily be handled by AFA Work Injury Insurance. AFA is owned by Sweden's labour market parties.

The Pharmaceutical Injury Board

The Pharmaceutical Injury Board (*Sw*. Läkemedelsskadenämnden) is an independant body composed by medical experts, laymen and lawyers.

The Board consists of seven members and as many substitutes. The Chairman and a majority of the members are appointed by the Government. The Board's regulations are approved by the Government.

The Board, which is independent, deals with matters of principle interest and decisions from the Pharmaceutical Insurance which are appealed. Both the injured person and the insurer can submit a matter to the Board.

The Board's decisions are advisory only, i.e. non-binding.

The Board's decisions which are deemed of principle interest are published.

The Function and Operation of the Insurance Ombudsman in Greece through the Independent Authority of the Consumer Ombudsman

Dr. Kyriaki Noussia

Dr. Kyriaki Noussia is an attorney at law admitted to the Athens Bar as a Greek Barrister and is licensed to appear before the Supreme Court and the Conseil d'Etat. She specialises in arbitration and in international commercial law. She has an extensive and wide-ranging experience inter alia in insurance, reinsurance, marine insurance, arbitration and mediation, banking and finance, energy, oil and gas, investment and environmental law. Since 2011 she has set up her own legal practice and is able to give legal advice on the above areas of law both in a stand-alone and in a transactional context as well as on the contentious side. Prior to that she has held numerous academic positions abroad, such as at the University of Hamburg, Faculty of Law and the Max Planck Institute for Comparative and international Private Law in Hamburg, Germany, where she was an Alexander von Humboldt Research Fellow (2007–2010). Prior to that she has been a C.S.E.T. Lecturer in Common Law at the University of Birmingham, UK (Birmingham Law School). In 2013 she was a Fulbright (Greece) Visiting Scholar at Columbia Law School, USA. She is also a member of various associations and committees in the fields of international commercial law, arbitration, international procedural law, insurance and reinsurance law, transportation law and private international law.

Introduction

In Greece there is not, as of yet, directly and separately formatted the institution of the Insurance Ombudsman. Hence, the responsibilities that would fall under the scope of operation of the institution of the Insurance Ombudsman are covered by and fall under the responsibilities of the institution of the Independent Authority of the Hellenic Consumer Ombudsman as the Hellenic Consumer Ombudsman covers policyholders insofar as consumer insurances are concerned. The Consumer Ombudsman operates as an extrajudicial body consensual resolution of consumer disputes, but also as an advisory institution to the side of the State to treat problems within its remit. Within its oversight also fall the local Amicable Settlement Committees which are located in the various Prefectural Authorities of Greece.

The Consumer Ombudsman is a relatively Independent Authority which was formed and created via Law 3297/2004 in 2004. It is being supervised by the Greek Ministry of Development. Via the activation and operation of the Independent Authority of the Consumer Ombudsman, the Greek public administration is placed in line with the recommendation of the European Union in as far as the conclusions of the Green Paper on improving the functioning of the Ombudsmen responsible for handling consumer disputes are concerned, but also in accordance with a number of other legal texts addressing the question of the formation of such institutions in the Member States and further more in accordance with the creation of a wide network of national bodies-court settlement of consumer disputes.

The formation of the Independent Authority of the Consumer Ombudsman is being surrounded and has been inspired by the dynamics of alternative (extra-judicial) resolution of consumer disputes (Alternative Dispute Resolution) which have long been promoted by the European Commission as a flexible, direct, effective and inexpensive way, if compared to the traditional judicial process, to settle disputes arising out of transactions between consumers and suppliers.

In this context, the European Commission adopted Recommendation 98/257/EC on the principles applicable to the bodies responsible for out -of-court settlement of consumer disputes, and Recommendation 2001/310/EC concerning the criteria to be applied in the process of conciliation, so that consumers and suppliers would rest assured that their differences are resolved with impartiality, objectivity and effectiveness.

Other relevant instruments at European level in relation to the history of court settlement of consumer disputes are:

(a) the proposal for a Directive of the European Parliament and of the Council on certain aspects of mediation in civil and commercial matters [COM (2004) 718 final]. This proposal is intended, first, to establish a minimum harmonization at European level as to civil proceedings and, secondly, to promote the use of mediation in the European Courts creating some necessary tools, and

(b) The Commission Communication of 4 April 2001 on broadening consumer access to other dispute resolution systems [COM (2001) 161 final].

The Consumer Ombudsman albeit one of the independent authorities of the Greek State, never the less, it does not adhere to the clerical hierarchy of any Ministry of the State. This differentiates the Consumer Ombudsman from the Hellenic Ombudsman which is a constitutionally sanctioned Independent Authority, founded in October 1998 and operating under the

provisions of Law 3094/2003. The Hellenic Ombudsman as such has a wider scope of activity if contrasted to the Consumer Ombudsman.

The Function of the Independent Authority of the Consumer Ombudsman as far as Consumer Insurances are concerned.

The Consumer Ombudsman deals on a regular basis with a large amount of consumer insurance cases. The procedure of a petition or motion in front of the Consumer Ombudsman involves a hearing, with or without the representation by a lawyer. The Consumer Ombudsman addresses the cases of its competence either by raising its own motion (ex officio) or following a signed petition of at least one stakeholder, within three months after the party concerned became fully aware of an act or omission adversely affecting him and constituting a consumer dispute. In the same way the Consumer Ombudsman addresses also cases dealing with requests from consumers or consumer associations and suppliers which have been refused to be presented and be dealt with by other established bodies responsible for the extrajudicial settling of individual consumer disputes. The Consumer Ombudsman does not deal with cases pending before the judicial authorities or with references deemed manifestly vague, unfounded, trivial or which are being exercised improperly or in breach of the principle of good faith.

The decisions of the Consumer Ombudsman bear heavy legal authority and are being published in leading law journals. Also the decisions of Consumer Ombudsman are often being referred to in the text of judicial decisions of ordinary state courts and in that sense help the process of the creation of legal precedent.

The Consumer Ombudsman does not finally resolve the disputes submitted under it but only makes recommendations. Due to the fact that the operation of the Consumer Ombudsman is based on EU law and incentives designated for the promotion of ADR and is a result of the need for ADR hence its decisions are categorized as recommendations. Notwithstanding the above categorization as non-binding recommendations, still the decisions of the Consumer Ombudsman are capable of holding some influence. The Consumer Ombudsman has various conciliation committees and provides its services to the consumers for free. Statistics have shown that in Greece, as far as consumer insurance disputes are concerned, only policyholders who are consumers have sought recourse to the Consumer Ombudsman and not insurance companies.

Notwithstanding the Independent Authority of the Consumer Ombudsman which *inter alia* deals with cases of consumer insurance disputes, another responsible authority for such cases is that of the General Secretariat for

Consumer Affairs. The General Secretariat for Consumer Affairs forms part of the Greek Government as it belongs to and is part of the Greek Ministry of Development. The General Secretariat for Consumer Affairs has the ability to impose fines on providers and hence in terms of insurance it can also impose fines to insurance undertakings who act against the reasonable interest of consumer policyholders. If, for example, there is an abusive or a non-transparent clause in an insurance contract, the General Secretariat for Consumer Affairs may impose a fine. It need be stated at this point, that such a control, i.e. for example a control for the existence of any abusive or non-transparent clauses in insurance contracts, is also being exercised by the insurance companies. However, in this sense, the General Secretariat for Consumer Affairs is placed above the private self-control of insurance companies.

Mediation, Conciliation and Arbitration as Opposed to the recourse to the Consumer Ombudsman

The recourse to the Consumer Ombudsman is being distinguished from the recourse to other ADR forms such as mediation, conciliation and arbitration. All three, mediation, conciliation and arbitration, exist in Greece and in the Greek legal system, however mediation and conciliation are not established by law and are being used for the resolution of commercial (non-consumer) disputes. Recently, however, the certification of mediators in Greece, also for consumer disputes, has been established so as to have disputes resolved under mediation and so as not to have the need to resort to ordinary state courts all the time.

If a comparison is made, one could say that mediation is considered as a more neutral process to which both parties resort to. In the event of recourse to the Consumer Ombudsman we have only one party resorting to it, i.e. the consumer, and moreover this is an ADR method of dispute resolution which is non-committal. Hence it could be said that the role of the Consumer has a moral character in favor of the consumer, i.e. by definition it protects the consumer. Within the institutional role of the Consumer Ombudsman comes not only the need and obligation to protect consumers, but also the need and obligation to update consumers, generally defend their interests and in that sense also act in a way as a *pro bono* lawyer of the consumer.

If we were to prioritize the various authorities and levels of consumer protection offered with regard to differences arising out of consumers insurances, first comes the already imposed by EU law obligation of the insurance companies to have in operation a mechanism for handling complaints, secondly comes the availability of recourse to the Consumer Ombudsman for an amicable ADR, thirdly comes the mechanism of the

General Secretariat for Consumer Affairs which imposes fines, fourthly comes the availability of mediation process, then comes the availability of arbitration for the resolution of non- consumer insurance cases and lastly comes the availability of the option to resort to State courts.

The Way Forward

There have been many talks and pressures for the creation of a special Authority of the Insurance Ombudsman in Greece as well, in line with the existence of the said authority in some other countries. Hence, a draft law has been created which entails and envisages the creation of the separate Authority exclusively for the Insurance Ombudsman in Greece, hopefully by the end of the calendar year 2014.

The Finnish System for Dispute Resolutions

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Taisto Hujala has been working as legal counsel and department manager in a very large number of areas involving insurance. He has been a member of several claims boards (MPTL, worker's compensation) and accomplishes various tasks: Vice President of the Finnish Patient Claims Board, President of The Finnish Insurance Lawyers' Association (AIDA Section), Member of the Presidential Council of A.I.D.A, President of The Expert Forum in The Financial and Insurance Institute, Member of the politico-legal committee in the Finnish Lawyers' Association and Member of the Board of Alumni Association in Helsinki University.

This presentation is a short summary of the Finnish system for dispute resolutions in insurance industry.

In Finland it has always been very natural to have certain, and some years ago several claims boards for solving insurance claim cases. The purpose has been to create very easy, fast and economically not costly ways for insurance clients to have their problems solved. Especially when the interest of a claim is not high, disputes should be solved in an easiest possible way.

The claims boards in Finland can be divided at least to the next different categories:

1) The Claims board which handles claims concerning all consumer issues incl. insurance
2) The Claims boards which handle claims and give recommendations concerning mandatory insurance
3) The Claims board which handle claims concerning only voluntary insurance
4) Appeal organs in insurance companies
5) Organs for Social Insurance matters
6) District Court – Appeal Court – Supreme Court, the general Courts

1 The Claims board for all consumer issues

The Consumer Complaint Board

The Board can give recommendations widely in disputes which relate to issues such as sale of real estate or non-real estate property, sale of service etc. The service can also concern voluntary insurance claims. The claimant has to be considered as a consumer and the counterpart has to be a company or an entrepreneur. A dispute between two companies or between to consumers cannot be solved there.

The Board can only give recommendations which cannot be enforced by coercive measures. The Consumer cannot appeal the recommendation.

The members of the Board represent Consumer authorities and different business sectors.

2 The Claims board which handle claims and give recommendations concerning mandatory insurance

Traffic Accident Board

The Traffic Accident Board can give recommendations both to the insured parts and to the Insurance companies, when the Traffic Accident Act is concerned. The recommendations can concern individual questions, such as causation, the amount of different damages etc.

The Traffic Accident Board also gives yearly certain general guidelines and rules to insurance companies for their claims handling. Especially the guidelines concerning personal injuries, such as compensation level for pain and suffering etc. can be interpreted in other insurance sectors, like patient insurance, liability insurance and criminal cases in District Courts etc.

The members represent different authorities, ministry, traffic associations and consumers. Because of the several cases concerning personal injuries there are members with medical expertise, such as orthopedists, traumatologists, neurologists etc.

The Patient Injuries Board

The Patient Injuries Board is a Claims Board which handles only cases which relate to Patient Injuries Act. The Board can give statements and recommendations, which cannot be enforced by coercive measures. The board gives statements also to District Courts when they deal with a Patient injury case. The Board can also give general guidelines for claims handling.

The members of the board represent the Ministry of Social Affairs and Health, insurance branch, tort law, and very widely different medical sectors and units.

3 The Claims boards which handle claims concerning only voluntary insurance

In Finland we have a long history of having voluntary organs for dispute resolutions. They have been established by contracts between the Insurance sector and the Consumer Agency.

The Finnish Financial Ombudsman Bureau (formerly The Finnish Insurance Ombudsman Bureau) was established in 1971. It is a voluntary organ which gives advice and assistance to insurance and bank consumers.

Related to the Bureau there are special Complaints Boards for insurance, banking and securities. The Insurance Complaints Board gives yearly recommendations in about 1 000 claim issues. Because of its legal, unofficial status the Board can only give recommendations, but they are almost 100 per cent followed by insurance and bank companies.

4 The Appeal organs in Insurance companies

Some Finnish Insurance companies have organized their own appeal organs inside the companies. Those organs can be built by the company's own personnel or there can be customers involved. It is clear that if the appeal organ of an insurance company has only its own personnel, it cannot look so objective than in the case where the organ has members from outside the company. But also when there are company's own people in the appeal organ, it can give useful help and information between the customer and the company. It can also give extra information to both the customers and also to help the company organization to improve its products and to write the terms and conditions in a more understandable way.

In Finland at least one Insurance Company has a certain Customer Panel for claims issues where the members of the panel are chosen among the company's own customers. The customer members of the panel are chosen every two years, and there is one member from the company and an outside lawyer as a chairperson.

5 Organs for Social Insurance matters

The Accident Appeal Board

The Board is an important part of the appeal system in the social insurance scheme. It is the first instance dealing with matters falling under the scope of statutory accident insurance.

The appeals can relate to decisions made my insurance companies concerning accidents at work, occupational diseases, accidents to

agricultural entrepreneurs, and accidents and diseases suffered by soldiers during national service. The decisions can be enforced in the same way as legally valid litigation judgements.

The Board has lawyer members, physician members and also members who are familiar with the working life conditions and the labour market, and the members are appointed by the proposals by the employee and employer associations.

The Employment Pensions Appeal Board

The Board has many similar features compared to the Accident Appeal Board. It handles all pension appeal matters, whether they concern private or public sector. It is independent from pension insurance companies.

It has members who represent employee and employer associations, both private sector and public sector, including the municipalities and the state, and of course lawyer and physician members.

The decisions can also be enforced the same way as the legally valid litigation judgements.

The Insurance Court

This special court is a special appeal court for appeals

6 The District Court – The Appeal Court – The Supreme Court, the general Courts

In Finland there are 27 District Courts, 6 Appeal Courts and the Supreme Court. These courts serve as general courts in all legal matter which are not handled by the special boards or the Insurance Court, or by special Administrative Courts.

Insurance litigations which concern motor third party liability or patience insurance, or any voluntary insurance can go before these general courts. The decisions can naturally be enforced.

Dispute Resolution in Insurance: The South African Ombud[1]

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1. Overview of South African Insurance legislation

1.1 General

The following statutes apply to the insurance industry and each contains provisions relating to dispute resolution within that specific sector of insurance business:

Long-term Insurance Act[2]; Short-term Insurance Act[3]; Financial Advisory and Intermediary Services Act[4]; and Policyholder Protection Rules issued in terms of the Long-term Insurance Act and Short-term Insurance Acts.

The industry is regulated by the Financial Services Board or 'FSB'.[5]

For general orientation, the scope and applications of the different acts are set out briefly below, followed by a discussion on the role of the Ombud in each of the sectors.

1.2 The Long-term Insurance Act

In accordance with this Act (hereinafter 'LTIA') a long-term policy" means an assistance policy, a disability policy, fund policy, health policy, life

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1 The neutral generic term Ombud is more often used, and not the term Ombudsman as used in other countries. see the general website www.ombud.co.za.

2 Act 52 of 1998.

3 Act 53 of 1998.

4 Act 37 of 2002.

5 Financial Services Board Act 97 of 1990.

policy or sinking fund policy, or a contract comprising a combination of any of those policies; and includes a contract whereby any such contract is varied.[6]

The Act provides for the registration of long-term insurers; for the control of certain activities of long-term insurers and intermediaries, and for matters connected therewith. As the Act is of a regulatory nature, it prescribes rules for the registration of insurers, business and administrative practices and policies of insurers and intermediaries, financial arrangements, judicial management and the final winding-up of insurers. The Act also creates punishable offences and prescribes penalties for non-compliance. Disputes are referred to the Long-term Ombud or in some sectors to specialised adjudicators.[7]

1.3 The Short-term Insurance Act

The Act (hereinafter 'STIA') deals with short-term policies that include an engineering policy, guarantee policy, liability policy, miscellaneous policy, motor policy, accident and health policy, property policy or transportation policy or a contract comprising a combination of any of those policies; and includes a contract whereby any such contract is renewed or varied.[8]

The Act provides for the registration of short-term insurers; the control of certain activities of short-term insurers and intermediaries; and for matters connected therewith as short-term insurance business, which include business and administrative practices and policies, financial arrangements, judicial management and winding-up of insurers, and prescribes specific fee structures. The Act also regulates approved reinsurance policies.

1.4 Policyholder Protection Rules

Consumer protection measures are furthermore found in Policyholder Protection Rules ('PPR') are issued from time to time in terms of the abovementioned acts. New rules became operational on 1 January 2011. These rules deal with obligatory and standardized disclosures, consequences of failure to pay premiums and non-compliance, cancellation of policies, cooling-off periods, the prescribed contents of insurance agreements and the like. Both the Long-term and Short-term PPR, for example, prohibit the parties from agreeing to a prescription period of less than 6 months. The PPR also state that prescription may only start running once the 90 day time limitation for representations as prescribed for a disputed or rejected claim have passed.

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[6] Section 1 of the LTIA.

[7] See par 2.3.4 to, for example, the Pension Funds Adjudicator.

[8] Section 1.

1.5 The Financial Advisory and Intermediary Services Act

This Act (hereinafter 'FAIS') regulates the industry, by creating a regulatory framework in terms of which a financial service provider (an insurer) accepts responsibility for the conduct of his representatives.

The FAIS Act creates a regulatory structure for intermediary and advisory services provided in respect of financial products. A 'financial services provider' denotes any person other than a representative who furnishes advice, or furnishes advice and renders any intermediary service or renders an intermediary service as a regular feature of his business.[9]

The Act refers to the representatives of financial service providers, and not to the representatives of clients. The provisions of Policyholder Protection Rules for both the Long-term and Short-term Insurance Acts still apply.

The term 'advice' is broadly defined as 'any recommendation, guidance or proposal of a financial nature furnished by any means or medium, to any client or group of clients.' It must relate to the purchase of any financial product or the investment in any financial product, and includes loan agreements and cessions. This excludes: factual advice given on the procedure to enter into a transaction relating to a financial product in answer to routine queries, the display or distribution of promotional material; any analysis or report on a financial product without an express or implied recommendation, guidance or proposal; advice given by a board of management or trustees, or board member on any pension fund organization, friendly society or medical scheme to its members; and any other exclusions announced from time to time in the Government Gazette

The term 'intermediary service' includes any act other than the furnishing of advice that is performed by a person for or on behalf of a client or a financial product supplier, with the that result that a client enters into, or offers to enter into any transaction in respect of such a product. It does not include where a bank acts merely as a conduit between a financial service provider and a client for the collection and accounting for premiums or other amounts due by the client to the supplier.

In addition to the registration and licensing of financial service providers as defined above, the Act also focuses on the duties of financial service providers and provides for codes of conduct for the various types of service providers.

FAIS prescribes specific rules on claim procedures, the process and methods of assessment and determination, dispute resolution and appeals.

[9] Section 1

It must be noted that these services also fall within the scope of the Consumer Protection Act 68 of 2008. However, because insurance dispute resolution must take place in accordance with the dedicated insurance legislation, and not in terms of this general consumer protection statute, the dispute resolution procedures for consumer disputes are not dealt with in this contribution.

2. Dispute Resolution Procedures

2.1 General

The following dispute resolution procedures exist within the insurance industry: internal dispute resolution procedures; voluntary ombud schemes; statutory ombud schemes; statutory adjudication; arbitration and litigation.

Voluntary schemes include the Ombudsman for Long-term Insurance; Ombudsman for Short-term Insurance; the Ombudsman for Banking Services and the Credit Information Ombud).

Statutory schemes include the Ombud for Financial Service Providers; Pension Fund Adjudicator and Council for Medical Schemes.[10]

These procedures satisfy section 34 of the Constitution of the Republic of South Africa 1996 on the right of access to a court, tribunal or other forum. An alternative dispute resolution scheme provides for a faster and more affordable way in which disputes in the insurance industry can be resolved, rather than following a costly and lengthy litigation process in the civil courts. Decisions are based on law and equity which also assists the insured by introducing greater consumer protection measures.

2.2 Regulation of Ombud Schemes

The Financial Services Ombud Schemes Act[11] regulates these schemes. In order to qualify for recognition as a scheme, it must comply with the following requirements:[12]

(a) a majority of financial institutions, based on asset value, gross income or client base (as the Council may determine in general or in a particular instance), in a particular category of financial institutions must participate in the scheme;

(b) a body that is not controlled by participants in the scheme and to

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[10] For a concise summary of the structure of these ombud schemes, see Millard D *Modern Insurance Law in South Africa* (2013) chapter 9.

[11] Act 37 of 2004.

[12] Section 10.

which the ombud is accountable must - (i) appoint the ombud, settle the remuneration and monitor the performance and independence of the ombud; and (ii) monitor the continued compliance by the scheme with its constitution, the provisions of the scheme and this Act and report any non-compliance to the Council;

(c) the scheme must provide for minimum requirements relating to qualifications, competence, knowledge and experience with which the ombud must comply;

(d) the scheme must have sufficient human, financial and operational resources, and be funded by the participants in the scheme, to enable the ombud to function efficiently and timeously;

(e) the proposed procedures of the scheme must enable the ombud-

(i) to resolve a complaint through mediation, conciliation, recommendation;

(ii) to act independently in resolving a complaint or in making a determination;

(iii) to follow informal, fair and cost-effective procedures;

(iv) where appropriate, to apply principles of equity in resolving a complaint;

(v) to report to the registrar and to a body representative of the relevant category of financial institutions on matters which may be of interest to them;

(f) provision must be made for the effective enforcement of determinations of the Ombud;

(g) provision must be made to ensure that the questions, concerns and complaints of consumers are treated equitably and consistently in a timely, efficient and courteous manner;

(h) the scheme must provide for ways in which it will co-operate with the Council's functions of promoting the education of clients and co-ordinating the activities contemplated in section 8(l)(c); and

(i) any other requirements that may be prescribed and that are not in conflict with the aims and objects of this Act.

A scheme must submit its application for recognition in the prescribed manner and form to the Council.[13]

[13] Section 11.

2.3 Internal dispute resolution schemes:

Insurance disputes between insurers and insureds may be solved by internal complaint resolution procedures as agreed upon between the insurer and the insured. An insured must first exhaust these schemes before he may refer the dispute for resolution under another scheme such as the ombud or to adjudication or litigation.

All policies do not have to be in writing. Insurers must, however, within a reasonable period from date of contract inform a policyholder in writing of details of any internal complaint resolution systems and procedures, as well as full particulars relating to the Insurance Ombud schemes.

An insurer must accept, reject or dispute a claim within a reasonable period after receiving the claim, and then notify the policyholder in writing of his decision within 10 days of taking the decision.

Where an insurer rejects a claim or disputes the quantum of the benefit claimed, he must inform the policyholder in the written notification of: (i) the reasons for his decision; (ii) that the policyholder has a period of not less than 90 days from date of receipt of such a notification to make representations to the insurer in respect of the latter's decision; (iii) the right of the policyholder to lodge a complaint in terms of the and the relevant provisions of the Financial Services Ombud Schemes Act, in plain understandable language; (iv) any time limitation provision for instituting legal action and the implications thereof, in an easily understood manner; and (v) where the policy does not contain a time limitation, the prescription period that will apply in terms of the Prescription Act[14] (at the moment a prescription period of 3 years applies) and the implications thereof in an easily understood manner.

The insurer must then, within 45 days of receipt of such a representation, notify the policyholder in writing of his decision to accept, reject or dispute the claim. This notification must contain reasons for the decision, the facts that informed the decision and (iii) to (v) in (b) above, where the claim is rejected or disputed.

Despite any agreement on a time limitation, a policyholder may request the court to condone non-compliance where good cause exists for the failure and where the clause is unfair to the policyholder.

During a dispute resolution, the Short-term PPR prohibits clauses on polygraph, lie detector and truth verification procedures. Any clause in a policy that any dispute under the policy can only be resolved by arbitration is also prohibited.

[14] Act 68 of 1969.

3. Voluntary Ombud schemes

3.1 Voluntary Schemes for insurance disputes

Where a dispute continues to exist between an insurer and an insured, the parties may then refer the dispute for resolution to the voluntary schemes created by insurers, namely the Ombudsman for Long-term Insurance, the Ombudsman for Short-term Insurance. These voluntary ombudsmen are funded and regulated by the industry to serve as a form of structured dispute resolution alternative to litigation. The parties to the dispute agree to be bound by the decision of the ombud.

Some of the benefits that the ombud scheme offers are informality of the process; ready access to a dispute resolution procedure; cost effectiveness; speedy resolution of disputes; mediation rather than adjudication; and the right to afford due weight to equity.

3.2 The Short-term Ombud

3.2.1 Structure of the Ombud

The Office of the Ombudsman for Short-Term Insurance is a company not for profit, and is accountable to its board of directors. It is a voluntary scheme that has been granted recognition in terms of the provisions of the Financial Services Ombud Schemes Act.[15] Founded in August 1989, the Office of the Ombudsman for Short-Term Insurance provides consumers with a free, efficient and fair dispute resolution mechanism. It offers consumers with a “no risk” mechanism to resolve disputes with insurers. All personal lines short-term insurers as well as Lloyd’s, have agreed to abide by the Ombudsman’s jurisdiction and decisions.

The Office can assist consumers with personal lines short-term insurance dispute such as motor; house owners (buildings); householders (contents); movable asset; travel; disability; credit protection insurance and commercial insurance on a limited basis, i.e. claimants such as small businesses, including a sole proprietor or trader, a juristic person, partnership or trust that has a turnover in the last financial year of less than R25 million. The service is free of charge.

3.2.2 Procedure and determination

A complainant must first exhaust internal complaint mechanisms before lodging his complaint with the Ombud. Where legal proceedings have commenced a claim cannot be determined by the Ombud. The two procedures cannot run simultaneously.

The Ombudsman’s task is to act as an independent and objective “mediator”

[15] See footnote 10 above.

or informal arbitrator and he/she does not represent either of the parties to the dispute.

The Ombud is not under instructions of anyone when exercising his authority to make a ruling. The Ombud resolves disputes after establishing all material facts and by applying criteria of law, equity and fairness. A written directive is issued, which is binding on the insurance company but not in the complainant.

The complainant, who wishes to appeal the decision, may escalate the dispute resolution to another procedure such as arbitration or approach a court of law.

3.3 The Long-term Ombud

3.3.1 Structure of the Ombud

The office for the Ombudsman for Long-term Insurance was established in 1985 and has also been granted recognition in terms of the provisions of the Financial Services Ombud Schemes Act. It is a voluntary association not for gain that initially started as a form of self-regulation by subscribing insurers who developed their own rules and procedures over time. Not all insurers are members. It remains an independent office that is accountable to an independent Long-term Ombudsman Council for providing an efficient and independent service to policyholders and others in response to disputes arising from long-term insurance policies.

The function of the Ombud office is to mediate in disputes between subscribing members of the long-term insurance industry and policyholders, successors-in-title, beneficiaries, the person whose life is insured, a premium payer or any person representing any of these persons. This service is also free to complainants.

3.3.2 Procedure and determination

Complainants who submit a complaint to the Ombudsman may still decide to follow the conventional civil justice process, although these two processes are not allowed to proceed simultaneously. The Ombud may also not determine a dispute where a previous Ombud ruling has been made, where the dispute is subject to past, pending or contemplated legal proceedings or where the claim has prescribed. Where the Ombud may decline to handle a complaint where, for example, there appears to be little chance of success, is better dealt with by a court of law or where no loss or inconvenience is suffered.

The Ombud may refer the dispute to an assessor or to an adjudicator, where the issue before it is complex and a simple determination by the Ombud is not possible.

Industry subscribers are bound by the Ombudsman's rulings. Complainants are however not bound and may take legal recourse to another forum such as arbitration or commence with litigation.

3.3.3 Appeals

There is provision in the rules for an informal appeal process, provided that the Ombud agrees to grant leave to appeal. Application for leave to appeal must be made within one month from the final determination. The appeal is heard by a tribunal as proposed by the Ombud and agreed to by all parties.

The determination by the tribunal is binding upon the insurer. Where the complainant is the appellant and loses, the tribunal determination is binding upon the claimant as well. However, where the insurer is the appellant and the appeal determination is in his favour, the claimant may then still take legal recourse by referring the matter to another forum or continue with litigation.

In contrast to the rulings of the FAIS Ombud, the rulings of the Long-term Ombud do not create precedents. The latter are made on principles of fairness and equity.

4. Statutory Schemes

4.1 The Office of the Financial Advisory and Intermediary Services Ombud

In disputes where advisors, brokers and intermediaries are involved, the dispute resolution process resorts under the jurisdiction of the Office of the Ombud for Financial Service Providers (the 'FAIS Ombud'). This is a statutory ombudsman scheme as regulated by the Financial Services Ombud Schemes Act.[16] The Act prescribes the claim procedures, the process and methods of assessment and determination and appeals in the Rules on Proceedings of the Office of the Ombud for Financial Service Providers.[17]

A dispute between a client and a financial service provider or one of its representatives, must first exhaust the internal complaint resolution system and procedures of the provider.[18]

Where it remains unresolved after a period of six weeks has expired from date of referral to the respondent,[19] the FAIS Ombud may adjudicate the

[16] Act 37 of 2004.

[17] 2003; promulgated in terms of section 26 of the FAIS Act.

[18] Part XI of the General Code of Conduct for Authorised Financial Service Providers and Representatives.

[19] Rule 4(a)(iv) of the Ombud Rules.

matter. A complainant may decide to refer the matter to the Ombud or may as an alternative agree to arbitration or in all cases approach the court. Insurers who wish to address a dispute for resolution must, however, refer the matter to the FAIS Ombud.

Any form of relief may be sought. A complainant may seek an award of an amount of money as redress for financial prejudice or damage suffered. A jurisdictional limit of R 800 000 is placed on an award of this nature.[20]

4.2 Special adjudicators

In some areas special adjudicators have been appointed in the insurance industry to deal with specialised insurance issues. The Pension Funds Adjudicator serves as an example.[21] The Council for Medical Schemes has its own complaint procedure and provides for submission of disputes regarding medical aid claims to the Registrar's Office.[22] Where, however, the complaint is pertaining to the conduct of a broker, the FAIS Ombud has jurisdiction, and where it relates to health insurance products the relevant insurance ombud should be approached. As this is not an Ombud scheme in the true sense of the word, and as it is regulated by statute, a long discussion on the process is omitted from this article.

5. The FAIS Ombud claims procedure and determination

5.1 Procedure and determination

The prescribed Complaint Registration Form must be completed and the claim submitted to the Ombud Office. A claim cannot be heard by the Ombud if it has prescribed.[23] Once the claim has been assessed, registered and found to be justiciable, the complaint follows three stages: the initial, the investigative and finally the adjudicative stage.[24]

The Ombud may follow and implement any procedure, which includes conciliation and mediation to attempt a settlement by the parties. It may allow any party the right of legal representation. It may make recommendations to the parties. Should any party reject the Ombud recommendation, he may proceed to determine the matter.

In the determination, the Ombud has wide-ranging powers: (a) the complaint

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[20] It may be mentioned that the jurisdiction of the lower courts or magistrates courts are far lower, and a claim of this nature brought before the FAIS Ombud will provide an obvious advantage to the insured as complainant.

[21] Pension Funds Act 24 of 1956; section 30.

[22] Medical Schemes Act 131 of 1998; section 47.

[23] See par 2.3 above on the 3-year prescription period.

[24] Section 27(5) of the FAIS Act.

may be dismissed; (b) uphold the complaint wholly or only partially; (c) award an amount of money to provide redress for financial damage or prejudice; (d) issue a direction that any party must take the necessary steps as the Ombud may deem appropriate and just for purposes of his determination; (e) make any order that a court of law could make (which includes an order for payment of interest); (f) make an order as to costs.

In contrast to the voluntary ombud schemes, the rulings of the FAIS Ombud do create precedents, where it is possible to enforce the determination as such in other cases. Determinations based on the criteria of fairness depending on the specific facts and circumstances might not be suitable for subsequent general enforcement.

5.2 Appeals

Any party may apply, in writing, for leave to appeal within one month from the date of the Ombud determination. The Ombud may decide to refuse or allow the appeal, depending on whether it is of the opinion that the Board of Appeal would change the original determination.

Where the Ombud refuses the request for leave to appeal, the Board of Appeal may be petitioned directly for leave to appeal, provided that it is within one month from date of the refusal of the Ombud to allow leave to appeal.

The Board of Appeal may hear the appeal with or without the participation of the Ombud. The decision of the Board is final and binding.

The complainant may not take the matter to court where he has chosen to follow the FAIS Ombud route for dispute resolution.

6. Conclusion

A complainant is not obliged to approach any Ombud for the determination of all disputes. The complainant can elect to participate in the voluntary schemes, where suitable, or to approach a court of law or to refer the matter to arbitration. Once a complainant has chosen his forum, he is bound to pursue the matter within the rules and procedures of the suitable forum. Where, however, the matter has to be heard by a statutory scheme such as the FAIS Ombud, the complainant must adhere to the procedures and rules created by statute. Where a specific section of the industry has a specialist statutory adjudicator, the complainant has no choice but to follow the adjudication procedure according to its rules and procedures. As the latter is not a formal Ombud scheme, it has not been incorporated in great detail in the discussion above.

Turkish Special Arbitration Scheme for Claims Against Insurers

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Policyholders expect that the insurers pay promptly and without shortage. But sometimes insurers refuse to effect payment and the policyholders have to apply for redress. In many countries the need to protect the policyholders (at least the consumers) against insurers has pushed the Legislators or the insurance sector or the Regulator to implement different solutions.

Turkish legislator, upon initiative and initial preparatory work of the Turkish Regulator, has enacted special rules to create a special arbitration scheme for claims against the insurers arising out of insurance contracts.

We will examine below the main points of this special scheme.

Dispute resolution methods

In Turkey, the principal dispute resolution methods regarding the insurance are "complaints" and "legal actions".

Complaints

Very often the policyholder or the insured will, upon unwillingness of the insurer to pay the insurance money, formulate a complaint hoping redress.

Insurance Intermediary

It is not rare that the policyholders/insured formulate their complaint at first glance to the insurance intermediary in the expectation that the intermediary will put pressure on the insurer. Not only brokers who are

appointed by the policyholders but also insurance agents who owe a legal duty of loyalty to the insurer regularly interfere and try to convince the insurer to pay or to ease the process that might lead to payment. The insurance agent will consider that after all, the policyholder being a component of its portfolio deserves special support, despite the fact that such initiative often creates a conflict with its legal duties.

Insurance Undertaking

Insurers establish in accordance with legal requirements special services for complaints. The person who will deal with the complaint must be different from the one who rejected the claim. However, it is rare that a positive outcome is achieved through this option.

Regulator

In Turkey, the most efficient complaint is doubtless that filed with the Regulator. In our country the Regulator has come to the conclusion (and is persevering with its position) that it should examine the complaints made by policyholders in order to augment its awareness (about what is going on in the practice). The Regulator, if persuaded that the insurer is in breach of its contractual obligations, demands the insurer not to insist on its decision to reject the claim. Where this approach is not complied with, the Regulator imposes sanctions.

Courts

In case the policyholder or the insured does not receive any or adequate sum from the insurer upon materialization of the risk, despite redress mechanisms available, there will be no other option but to resort to legal action.

Commercial Courts

In Turkey, the insurance contract is regulated in the Commercial Code providing that matters arising out of commercial provisions must be decided by commercial courts regardless of whether all the parties involved are traders. So commercial courts dealt with insurance law disputes during decades until the enactment of the consumer legislation. Consumer courts established by that special legislation began thereafter to examine the disputes between insurers and consumers. But this practice was challenged by some insurers and this led to an interesting decision of the Turkish Court of Cassation which stated that the rules about the competence of the commercial courts (with regard to the matters regulated by the Commercial Code) were “lex specialis” vis-à-vis the rules in the consumer legislation and would apply therefore exclusively[1]. We don’t think this reasoning to be

1 11th Civil Chamber, decision no.E.2000/10656, K.2001/197 dated 18.1.2001.

right. On the contrary the provisions of the (Turkish) Consumer Protection Act should have priority over the commercial provisions, the main objective of the consumer legislations being to establish the supremacy of rules aimed at protecting the consumer. Where one of the parties is a consumer, the need of its protection prevails and takes the precedence[2].

Other Courts of First Instance

Where no commercial court exists (in most departments commercial courts are not founded yet) or where commercial courts are not competent (this is for example the case for certain insurance contracts regulated in special acts such as the motor vehicle operator liability insurance) the disputes generated by insurance relationship are decided by the ordinary courts of first instance. Concerning the direct action of the victim in liability insurances, it is not clear whether consumer courts are competent if the policyholder is a consumer. It seems difficult to find a link between the consumer protection and the direct action.

Consumer Courts

If a dispute arises between a consumer and a trader it will be referred normally to a consumer court. Insurance being a "service" within the ambit of the consumer legislation, protective norms will apply to safeguard the legitimate interests of the weak party.

Arbitration

Insurance relationship arises necessarily out of a contract concluded with a trader (insurer). Thus it is a private law matter. Arbitration is a dispute resolution means widely used in private law and at first glance there seem to be no obstacle to refer to arbitration for insurance litigation. However the problem arises to know whether by referring to arbitration the mandatory rules are circumvented. This is the case when the arbitrators are given the authority to decide "ex aequo et bono" and not in accordance with material law provisions.

According to Turkish International Arbitration Act

If the insurance contract contains a foreign element or if the parties so agree, the arbitration will be conducted in accordance with the International Arbitration Act. This act will apply especially to disputes between Turkish insurers and foreign reinsurers.

2 However one must recognize also the reality: Commercial courts are much more convenient for insurance law disputes that require special knowledge and experience in respect of rules applicable to insurance contracts (but they may lack of expertise with regards to the protection afforded by consumer law provisions).

According to Turkish Civil Proceedings Act

The common rules for arbitration are in the Civil Proceedings Act. The parties may agree that their eventual disputes in the context of their contract shall be referred to arbitration.

In our view, if an arbitration clause (stipulating that arbitration will take place in accordance with the provisions of the Civil Proceedings Act) is inserted to the insurance contract, this will have the effect of lifting the option to apply to the special arbitration scheme for insurance defined in the Insurance Activities (Control) Act.

According to Insurance Activities (Control) Act Article 30 (= Special Arbitration Scheme for Insurance)

Turkish Insurance Activities (control) Act (enacted in 2007) provides a special arbitration scheme for insurance disputes. We will examine this scheme in details below.

No Ombudsman – Alternative to Ombudsman

Turkish law did not provide for Ombudsman service. The special arbitration scheme for insurance is said to have been designed as an alternative to the Ombudsman solution.

Administration

The "Special Insurance Arbitration Scheme" is managed by a commission constituted within the Union of Insurers, Reinsurers & Pension Companies. The majority of its five members are selected by the Regulator. The composition of the Commission is as follows: One representative of the Regulator, one academic, two representatives of the Union and one representative of the Consumer Association. The Regulator appoints its own representative, the consumer association representative (amongst three candidates proposed by that association) and the academic.

Claims eligible

The Special Arbitration Scheme for Insurance is provided only for claims against the Insurer and the "Account".

Claims against the Pension Companies arising from the pension contract are not within the scope of arbitration. But disputes under life assurance contracts or "yearly income insurance" contracts concluded with a Pension Company (authorized to sell life assurance products if titular of a valid licence in the class of insurance "life") will fall under the arbitration since claims arising out of insurance contracts are subject to arbitration.

Pursuant to an amendment made in 2012, claims against the "Account"

(Insurance Fund) are also eligible for arbitration. The “Account” is a fund that compensates death, personal injuries, loss and damages

- where compulsory insurances are not taken or
- the insured could not be identified, or
- in other cases mentioned by the law.

Claims addressed by the insurer based on the contract of insurance are not eligible: e.g. for return of excessive payments of insurance monies or for the premium.

Claimants- Defendant Insurer

Claimants who may apply to arbitration are

- policyholders (they are party to the insurance contract)
- insured (in case of insurance on account of a person other than the policyholder, when this person is entitled to sue the insurer)
- beneficiary (in personal insurances i.e. life, accident, sickness)
- third party victim (in liability insurances – Turkish law grants the victim the right to sue directly the liability insurer)
- subrogees of the persons above including insurers (in case the indemnity insurer is subrogated to the rights of the insured, the subrogated insurer may apply to the special arbitration scheme against the liability insurer of the person liable for the indemnified loss).

Claimant may be any policyholder or insured or beneficiary, regardless of whether it is a consumer, professional or trader. The Turkish special arbitration scheme is not designed exclusively for consumers.

Resort to arbitration is possible only against the insurer who adhered to the arbitration system (recourse is possible only against members of the “Club”). Although membership is “voluntary”, nearly “all” the Turkish insurers are members. As of March 2014, market shares of member companies cover 95% in non-life and 96% in life business. The Regulator made it very clear that it would appreciate the insurers became “member”. This invitation was very largely accepted. 55 insurance undertakings are members of the system (the overall number of insurance undertakings is 67).

To become a member, the insurance company must make a written declaration to the Commission. When necessary formalities are fulfilled, the insurer becomes bound by the arbitration application even in the absence of an express arbitration clause in the insurance contract.

Against an insurer who is member of the special arbitration scheme, the

claimant has to choose between state courts or special arbitration. The claimant may prefer courts or arbitration in its sole discretion. However once the choice is made, it is not possible to change it.

Arbitrators

Arbitrators have to work only in life or non-life fields.

They are not necessarily jurists. In our view this is one of the weaknesses of the system.

Requirements for being an arbitrator are experience, clean record of crime and high studies. The Regulator has the duty to check whether the candidates who apply for being inscribed in the official list of arbitrators fulfil the conditions. As of March 2014 there are ca.125 arbitrators in the official list (this is the number of the first layer arbitrators).

The Commission appoints the arbitrators in accordance with turn (their order in the list). But if the first arbitrator whose turn has come does not have sufficient expertise for the dispute in question, the next (appropriate) arbitrator will be appointed.

Arbitrators must be impartial. To help achieving this goal, a prohibition is provided: Persons working in insurance companies, insurance intermediaries, loss adjusters (or their spouses or children) are prohibited to act as arbitrator.

Arbitrators appointed in arbitration proceedings conducted pursuant to Civil Proceedings Act must fulfil also the requirements of the special arbitration scheme. In our opinion this is going too far. Insurance is not more important than other areas where arbitration is possible. There is no reason justifying additional requirements for insurance arbitrators chosen by the free will of the concerned parties when the arbitration is subject to general rules.

Costs

Special arbitration scheme is not “gratis”. An application fee is collected from the applicant (claimant). But those fees are not too high (for claims up to TL 5.000 only TL 35 –ca. EURO 10; for claims between TL 5.000 and TL 15.000 only TL 100 –ca. EURO 30; for claims higher than TL 15.000 only TL 250 – ca. EURO 75; Turkish “Lira” being a very unstable currency the equivalents expressed in EURO above may have become lesser until the reading).

The system is alimented by insurers and the “Account”. Insurers pay an annual fixed subscription fee + a fee per file (paid beginning from the 30th file of the year). Funding by the “Account” occurs upon request by the

Regulator. In case the annual budget is not sufficient, additional support has to be provided by the "Union" or the "Account" (what is meant by this word will be explained a few lines further).

Arbitrators are paid directly by the Commission as well as notification/ service expenses.

Other costs are borne by the loosing party (witness expenses, expertise).

Conditions of application

The claimant must first have made a request to the insurer. Application to start special arbitration is allowed only in case of negative answer or no answer within 15 days.

Disputes referred to (ordinary or consumer) courts cannot be brought later to arbitration (choice made once and for all).

Consequences of the application: The legal action is deemed initiated at the date of application (prescription interrupted that very day). The applicant cannot start legal action at state courts from that moment.

Rapporteur

The application is examined first by a "rapporteur" (who must have clean criminal record, be experienced in insurance and have completed high studies).

If the case is not resolved while in the hands of the rapporteur, it will be then submitted to the arbitrators.

The rapporteur has to complete its examination within 15 days. It has to examine whether the formal application conditions are fulfilled (the rapporteur takes no decision as to the merits of the claim).

The rapporteur must prepare a report stating the factual and legal grounds of the dispute and containing information about the allegations together with the list of evidences submitted by the parties concerned.

Procedural Rules

For disputes over TL 15.000, a panel of arbitrators (at least three persons) must be appointed.

Unanimity is not required. Arbitrators can take a decision by a simple majority.

The arbitral decision is rendered "on the file" (hearing is optional). The case must be decided within 4 months following appointment (if not extended later by mutual agreement). Otherwise the case will be sent to the competent Court.

Upon dismissal of the claim one fifth of the minimum official lawyer fees only will be charged to the applicant. This solution is provided in order to lighten the economic burden put on the claimant's shoulder, but is obviously contrary to law (in that it decreases the holy and untouchable fees of the lawyer).

The applicant will not pay any fee for the arbitrators (only the application fee is incumbent on it).

The arbitrators are empowered to take certain steps. They may in particular

- Upon demand of one party decide for preventive measures
- Upon demand of one party, gather (or determine) the evidences
- Appoint experts
- Conduct investigation on site

The arbitral decisions concerning disputes up to TL 5.000 are final. The parties concerned cannot appeal against them. If the claim is over TL 5.000 appeal to the upper layer within the special arbitration scheme is possible. Upon appeal the enforcement is suspended. There are special panels of arbitrators created solely for appeal purposes. The appeal proceedings must not last more than two months. The decision rendered upon appeal is final. However for disputes over TL 40.000 it is allowed to seize the Supreme Court for a further objection.

For objection and appeal purposes what is relevant is the amount of the dispute and not the amount allowed by the arbitrators. If in respect of a claim for TL 50.000, the arbitrators condemned the insurer to pay TL 30.000, both parties would be entitled to appeal.

Objection to the Supreme Court for procedural grounds is possible regardless of the amount (e.g. decision rendered after the arbitration period is exhausted; decision on something which was not claimed; decision outside the competence of the arbitrators; no decision for the claims and defences).

Are the arbitrators allowed to decide "ex aequo et bono" ("according to the right and good" or "from equity and conscience")? We believe this is not possible for two reasons:

- The Civil Proceedings Act (applicable as complementary) clearly states that the arbitrators are not empowered to decide "ex aequo et bono" if not expressly authorized by the concerned parties to do so.
- The decisions about claims higher than TL 40.000 are subject to appeal. But appeal is relevant only for legal errors. Appeal against a decision

based on the equity does not seem logic. Therefore the arbitrators must base their decision on material law provisions. As it is not justifiable to have different regimes for small claims and the big ones, the requirement to apply material law provisions exists also for claims less than TL 40.000.

The arbitral decisions are enforceable immediately. The principle is that appeal does not stop enforcement. But enforcement may be postponed by a judicial decision, if adequate security is furnished. The solution is the same for court decisions.

Pros and Cons

Advantages of the special arbitration scheme

The special insurance arbitration scheme is advantageous for policyholders/ insured/ beneficiaries especially in two respects:

- Costs are considerably less (but we must underline that this fact encourages and increases the "hopeless" applications – "let's try, we lose nothing" temptation)
- High speed is achieved (this is particularly important in a country where the average duration of court cases is relatively long – two years)

The "high speed" is also of utmost importance for insurers: For claims made against them, insurers have to constitute important "reserves" that may adversely affect their financial sheets.

The arbitral awards were so far more detailed than the court decisions. As courts are submerged in a very large number of disputes, often decisions are written as shortly as possible.

One of the principles of the private arbitration is "privacy". Arbitral awards may not be published without the express consent of the parties to the dispute. However decisions rendered of the special arbitration scheme for insurance are regularly published (without giving the names) in the hope that insurers would draw the necessary lessons.

Disadvantages

The special arbitration scheme should also extend to disputes generated by pension contracts.

The special arbitration scheme should comprise only "small claims". In our opinion the submission of large claims to arbitration is not a good solution since those claims require more time and special procedures for being adequately decided. There are claims brought to arbitration for more than three million US$. In the worst scenario, such big claims would be decided by a panel with a majority of non-jurists, after an examination on the file

and within two months. In that context, the defendant insurers would have been given only one opportunity for their written submissions.

In the list of arbitrators there are as much non-jurists as jurists. In my belief, a non-jurist arbitrator should not be appointed as “sole arbitrator” since decisions ex aequo et bono are not allowed. Whether it is an appropriate solution to appoint non-jurist arbitrators in the panel seems also debatable.

On the other hand the level of the arbitrators seems also to be a controversial issue. The quality of the decisions rendered in the special arbitration is not below the court decisions. However this “not bad” level is not sufficient. It should be improved. This requires arbitrators of higher formation.

Reliability

Is the new special arbitration scheme reliable? This is vital for its future and intended purpose. Although the number of applications increases each year, we don’t believe that this demonstrates a widespread “take up” by the targeted consumers. More than half of the applications are finally rejected. This fact shows that the proper victims don’t choose yet the special arbitration and prefer courts.

Some figures

Start: August 2009
The number of applications: increase each year.
As of end September 2012: 4.731 applications.
92% non-life; 8% life
A total of 2798 cases were decided by arbitrators
Average duration: 61 days
80% of claims: below TL 15.000

Conclusion

The special insurance arbitration scheme has been revealed so far as useful. It must be maintained but at the same time immediately improved.