An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0005
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Delayed or inadequate communication Premium rate increases
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a 'Unit Linked Whole of Life' assurance policy with the Provider's predecessor, Norwich Union Life Insurance Society, on the 01st March 1991. The Policy is a joint life second death, trust policy.

The dispute relates to the increasing premium which will be required to maintain life cover when a policy review is due in 2023. The Complainants submit that the Provider has not been clear, or acted fairly, in keeping them informed about the policy and that the documentation provided to them has been misleading and inaccurate.

The Complainants' Case

The Complainants submit that they took the policy in question out, on the advice of KPMG, in 1991. They say that it was sold to them on the basis that both the cover and the premiums would increase by, and only by, the rate of inflation up to age 70. They submit that at the time of incepting the policy, they were 45 and 42 years of age and that this was an important factor in their decision to enter into such a long term financial commitment.

The Complainants explain that in August 2015, an insurance broker, who was advising them in relation to an Approved Retirement Fund, suggested that they should look at this "Section 60" Policy in more detail, as the current premium did not cover the cost of the life cover and the balance was eroding the fund value. The Complainants say that this came as

a shock because the Provider had never advised them of this, or cautioned that there was a risk of this occurring.

The complaint is that the Provider failed, on an ongoing basis, since inception, to provide the Complainants with sufficient information about their policy or to inform them that the policy would become unsustainable at a future date.

The Complainants submit that the Provider has always been aware this would be the case at some future date were they to live beyond 70 years of age, but that it did not advise them of this eventuality.

The Complainants say that the Provider did not furnish any warning to them that the premium they were paying was not sufficient to cover the cost of their life cover, despite the Provider's position that it conducts reviews in order "*to check if the premium you pay is enough to meet the cost of your life cover until your next review date which is 1st March 2021*".

The Complainants submit that despite this, the Provider gave no indication of any risk in this regard and that, it had reassured them, as recently as January 2016 that "*no increase in premium is required as a result of this review*".

The Complainants say that this information was materially misleading, as the premium they are paying is not enough to meet the cost of their life cover and that the fund which they have built up through premiums, of approximately €114,000 will be required to subsidise the shortfall.

The Complainants submit that the information provided to them was misleading and incorrect and that had it not been for a general conversation which they had about the policy with a financial broker who was advising them on a different matter, they submit that they would not have been aware that the annual premium is due to increase substantially in 2023.

The Complainants say that had they been so advised, then they would have been in a position to take remedial action, e.g., to switch to a guaranteed whole life policy or to increase the premium to an affordable level in order to protect the fund value which had built up. The Complainants submit that, as one of them is now over 70 years of age, per the policy, indexation no longer applies. The Complainants submit that therefore, due to their age, health and the associated costs of these actions, alternative options are no longer feasible.

The Complainants contend that they had budgeted to be in a position to pay the current premium on the policy (€6,128.03) and say that they cannot foresee how they will be in a position to pay a premium of many times the current level within 6 years, and that this is a matter of serious concern and worry for them.

They submit that if they terminate the policy now, the result will be to expose their children to an inheritance tax liability, which they had planned to not burden them with.

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The Complainants submit that it is not satisfactory that the Provider is relying on "*generic wording and risk statements in [its] defence*". The Complainants submit that pursuant to the Consumer Protection Code, the Provider has an obligation to ensure all information provided to them, as consumers, is clear and comprehensible and that the method of presentation does not disguise, diminish or obscure important information. The Complainants submit that the Provider has failed to adhere to these principles and, as a result, they have been misled.

The Complainants are seeking to have the Provider meet any shortfall between the current premium and any increase in premium at a later date required to maintain the policy or to have the Provider switch them to a guaranteed whole life policy, with no penalty to them.

The Complainants also complain about to what they describe as oversights and errors by the Provider and submit that:

- By letter dated 12 September 2012, the Provider advised them that the next review date was 2013, which was incorrect.

- The Provider omitted an important document in their data access request of March 2016.

- On 14 February 2011, the broker relationship which KPMG had with the Provider, ended. The Complainants submit that they were never informed of this by either the Provider or KPMG. They say that the Provider informed them in December 2015 that they had "*appointed Aviva Direct as your new agent and we have confirmed this to you in writing*". The Complainants say that, in circumstances where they did not have an agent acting on their behalves since at least 2011, the new agent should have been appointed at a much earlier stage. Failure to do that, they say, left them with a time lag in excess of five years with no advice on the policy.

- By letter dated 01st November 2016, the Provider acknowledged an error in its premium estimates. It advised the Complainants that it had made a miscalculation on what the projected increase would be at the review in 2024 and that whilst it had previously advised (by letter dated 23rd June 2016) the Complainants that they would need to pay €68,662.62 per annum, to keep their level of cover in place, the figure should have been €48,058.43.

The Provider's Case

The Provider says that the Complainants' policy is a unit linked life assurance policy and that the workings of the policy mean that with each premium paid, units are purchased in the designated investment fund and are allocated to the current unit holding. It says that once the units have been allocated to the unit holding, all costs associated with the policy are then deducted by cancelling units equivalent to the cost of providing the life cover benefit. The Provider submits that both the workings of the policy and how it is

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administered were set out in the policy general provisions, which were issued to the Complainants' Broker on commencement of the policy.

The Provider submits that the nature of a unit linked protection affords the policyholders the chance to contribute a premium in the early years that more than covers the cost of the provision of the policy benefits and the balance of the premium remains invested in the designated investment fund (i.e. as accumulated units). The Provider submits that this allows the policyholders to build up a fund which is accessible at all times, or it can help to supplement the premium paid in future years, allowing the same level of life cover to be maintained.

The Provider acknowledges that the premium required to maintain the Complainants' policy after the 2023 review, will increase considerably, when compared to the existing premium paid. The Provider submits, however, that the increase in premium is the best way to maintain this policy, bearing in mind the long term nature of this type of policy (whole of life) and the increasing cost of the life cover benefit.

The Provider acknowledges that the fund value has been supplementing the premium paid, since July 2012.

On the issue of conducting reviews, the Provider submits that policy reviews are an integral part of ensuring that the policy taken out by its policyholders can be maintained on a whole of life basis and allows the Provider certainty that there are always enough units in the fund to support the increasing cost of cover; a policy review clause is built into the policy general provisions.

In relation to the Complainants' submission that it did not meet the required standard of being clear, fair and that its documentation was misleading and inaccurate, the Provider points to the policy general provisions furnished to the Complainants in 1991, which state that the policy is subject to reviews. The Provider points, in this respect, to Section 1, "*Definitions"*, part (f) entitled, *"policy review date: the 10th anniversary of the currency date and each 5th anniversary thereafter except that where the insured has attained age 70 the policy review date shall be each yearly anniversary of the currency date".*

The Provider submits that the purpose of the reviews is to ensure that the premiums being paid are sufficient to support the policy benefits.

The Provider says that there was an onus on the Complainants to ensure that they understood the nature of the policy as well as its individual features. It says that it issued a letter on 01st March 1991, to the Complainants, which highlighted the importance of making sure that the policy issued met their needs. The Provider submits that, having considered the information provided, if the Complainants felt that the policy was not suitable for their particular needs, then they should have discussed this at the time with their financial advisor.

The Provider accepts that a review of the Policy should have been carried out in 2001, 2006 and 2011 but that, unfortunately, it omitted to carry out reviews at that time. It

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contends that, although it did not carry out policy reviews at these times, the Complainants were not financially impacted by this in any way. It submits that it had the policy rebuilt and, on that basis, it determined that had it reviewed the policy on the above dates, that no alterations would have been required until 2023, because the premium and the fund value was enough to sustain the life cover until then.

The Provider submits that the first review took place in September 2012 and that the review indicated that the premium being paid at that time was sufficient to maintain the policy benefits until the next review date. The Provider says that this was a clear reminder to the Complainants that this policy was reviewable and that the premium might increase in the future and suggests that it was an opportune time for the Complainants to review their life assurance needs and to speak with their financial advisor.

The Provider says that a second review was completed in January 2016 and that it advised the Complainants at that time that an increase in premium was not required, as the premium being paid at that time was sufficient to maintain the policy benefits until the next review date, in March 2021. It says that at the Complainants' request, it also carried out some calculations to see what the results of future reviews might look like, in order to provide them with further information and assistance.

The Provider says that although the Complainants are contesting the reviewable nature of the policy, they were clearly informed of its reviewable nature when they took out the policy, and again when the policy was reviewed, in 2012. The Provider notes that the Complainants are seeking to have it maintain the original life cover benefit on the policy of €1,586,919 at a current yearly premium of €6,128.03 for the whole of the policy (i.e. a Guaranteed Whole of Life contract) but that it is unable to offer this, and submits that this is an unrealistic expectation.

The Provider notes that the policy in question was issued under Section 60 of the Finance Act 1985, which relates to insurance policies effected for the purpose of paying inheritance tax. The Provider submits that it did not sell this product to the Complainants but that rather Stokes Kennedy Crowley, now KPMG, acted on the Complainants behalf in arranging this policy, and that KPMG were therefore responsible for explaining both the workings and features of the product prior to the Complainants completing the application form and this extended to explaining the charging structure, the whole of life policy, section 60, the policy review provision, etc.

The Provider submits that as the administrator of this policy, it does not provide financial advice and that if the Complainants required financial advice at any time, they needed to seek the services of their financial advisor. It says that it cannot comment on any discussion which took place between the Complainants and their financial advisor on the suitability of the product. The Provider submits that in addition to the broker's responsibilities there was also an onus on the Complainants to ensure that they were familiar with both the workings and features of their policy.

The Provider does not agree with the Complainants, that it has been negligent and submits that if the Complainants required any information at any time this would have been

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provided on request. In response to the other alleged oversights and error which the Complainants have pointed to, it submits, as follows:

- Regarding the letter dated 12th September 2012 in which the Provider advised that the next review date was 2013, which was incorrect, it says that this was a typographical error, which it apologised for and submits that it is not of material significance.

- Regarding the omission of the letter of the 08th December 2015 from the Complainant's data access request of March 2016, the Provider submits that this was a minor error, and the Complainants have confirmed they received this letter.

- Regarding the alleged failure of either the Provider or KPMG to inform the Complainants that KPMG's agency with the Provider had ended and that a new Agent should have been appointed at a much earlier stage, the Provider says that KPMG's Agency was suspended on its systems until it received a written request from KPMG in January 2015. The Provider says that on 22nd January 2015, KPMG fully cancelled its agency and that it issued a letter on 08th December 2015 to the Complainants advising them that KMPG, which previously advised them on their policy, no longer had an agency with it. The Provider submits that in order to ensure the Complainants could easily access advice on their future needs, it asked Aviva Direct Ireland Limited (Aviva Direct) to provide this service unless the Complainants told it otherwise. The Provider submits that it advised the Complainants that if they had already appointed a new broker which had an agency with the Provider, then it would update its records accordingly. It says that it also gave them the option to appoint a different financial adviser, if they preferred. The Provider says that it gave the Complainants a month to think about this change (from 08th December 2015 to 12th January 2016) and that it wrote to the Complainants on 08th December 2015 and the Complainants have advised it that they received this letter.

Decision

During the investigation of this complaint by the Financial Services Ombudsman's Bureau, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I was satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I was also satisfied that the submissions and evidence furnished were sufficient to enable a determination to be made in this complaint without the necessity for holding an Oral Hearing.

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A Preliminary Finding was issued to the parties on 12 December 2017 outlining the preliminary determination of the Financial Services Ombudsman in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Finding would be issued to the parties, on the same terms as the Preliminary Finding, in order to conclude the matter.

Following the commencement of the ***Financial Services and Pensions Ombudsman Act 2017***, on 1 January 2018, the final determination of this office is now issued to the parties, by way of this Legally Binding Decision of the Financial Services and Pensions Ombudsman.

An email was received from the Complainants, dated 04th January 2018, acknowledging receipt of the Preliminary Finding. In the absence of any additional submissions from the parties, the final determination of this office is set out below.

The issue to be determined is whether the Provider correctly and reasonably administered the policy, particularly in relation to the Review of the Policy and its communication of same over the years.

I note that the Complainants have submitted that the Policy was sold to them in 1991, on the basis that both the cover and the premiums would increase by, and only by, the rate of inflation, up to age of 70, and that this was an important factor in their decision to enter into such a long term financial commitment. However, the sale of the Policy is not an issue which can be considered as part of the within adjudication as the Policy was sold to the Complainants by their broker, rather than by the Provider. Indeed, I note that the sale of the Policy in any event occurred 25 years before the complaint was made to this Office.

Insofar as the conduct of the Provider is concerned, this Office can examine the complaint that the Provider failed to provide the Complainants with sufficient information about their policy and did not furnish them with any warning that the premium they were paying was not sufficient to cover the cost of their life cover, despite the Provider's assertion that it conducts reviews in order to check if the premium paid is enough to meet the cost of the life cover until the next review date. The Complainants submit that as recently as in January 2016 they were told that "*no increase in premium is required as a result of this review.*"

Policy Reviews

The Provider acknowledges that a review of the Policy should have been carried out on the tenth anniversary of the Policy, in 2001 and subsequently in 2006 and 2011 but that this did not occur. In that regard, the conduct which resulted in the Company failing to carry out policy reviews until 2012, constituted continuing conduct as defined by sub sections 57BX (5) of the Central Bank and Financial Services Authority of Ireland Act 2004, i.e., "*conduct that consists of a series of acts or omissions is taken to have occurred when the*

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last of those acts or omissions occurred." This Office can, accordingly, investigate these matters.

By correspondence dated 24th October 2017, the Provider stated that it came to its attention in 2012, "*as part of the Central Bank clean up*", that previous reviews were not carried out. It has submitted that, "*in order to rectify this issue we wrote to every customer affected which included the Complainants to let them know what the current situation was, in relation to the reviews."*

I note that Section 14 of the Terms and Conditions of the Plan, headed "*Policy Reviews*" provides for the occurrence of policy reviews:

"On each Policy review Date the Society will adjust the Servicing Fee to a level then being charged for similar policies and will also review the relationship between the Premium then payable and the Guaranteed Benefit, having regard to the amount of secured benefits at the time. If the Society cannot insure the Guaranteed benefit until the next Policy Review Date then the Grantees will have the option of reducing the Guaranteed Benefit to an amount allowable by the Society for the Premium then payable or to increase the rate of Premium payable in the future to the amount required by the Society. The Society may additionally require special reviews where alterations are made under paragraphs 5(c), 9, 10, 11 or 12 so as to determine the amount of guaranteed benefit, which can be sustained until the next Policy review Date having regard to the amount of secured benefits and the rate of Premium then payable. In the even that a special review requires there to be an alteration in the relationship between the Premium and the Guaranteed Benefit, the Grantees will have the option to adjust either the premium or the Guaranteed Benefit or both within the time limits quoted by the Society at the time."

Section 1(f) provides a definition of "*Policy Review Date*" and sets out the dates on which reviews should occur, namely;

"*The tenth anniversary of the Currency Date and each fifth anniversary thereafter except that where the insured has attained age 70 the Policy Review Date shall be each yearly anniversary of the Currency Date".*

Consequently, it is clear that the policy premium was indeed subject to review. However, whilst the policy provided for reviews, as noted, a number of reviews were not carried out on the scheduled dates by the Provider.

On 12 September 2012 the Provider wrote to the Complainants and advised them, as follows:

"You have a Unit Linked Whole of Life plan with us, which has an inbuilt review clause.

The next review date on your policy is March 2013. The purpose of the review is to check if the premium you pay is sufficient to maintain your policy benefits until the next scheduled review date.

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We would like to provide you with an early indication of the review we will conduct and any changes that may be required to your current premium.

We estimate that the premium you are currently paying will be sufficient to maintain your benefits. However, we will conduct a full review and correspond with you again in advance of your premium renewal date."

The Provider acknowledges that its letter of 12th September 2012 did advise the Complainants that the next review was to take place in March 2013. It submits that this was an administration error and, as per its letter of 23rd June 2016, the next review was instead scheduled for March 2016 and not 2013.

It submits that an automatic internal review did occur in January 2013 which showed that the policy was on target. The Provider has explained this as meaning that between the premium paid and the policy value which had been built up there was enough to maintain the life cover to the next review date. The Provider has submitted that, on this basis, there was no need to communicate this to the Complainants as there was no financial impact to the Complainants.

Following the review which took place in January 2016, the Complainants were advised that an increase in premium was not required as the premium being paid at that time was sufficient to maintain the policy benefits until the next review date, in March 2021:

I am writing to tell you that we have reviewed your policy. We do this to check if the premium you pay is enough to meet the cost of your life cover until your next review date which is 01st March 2021.

I am happy to confirm that no increase in premium is required as a result of this review. This means that assuming you continue to pay your premium, your benefits are guaranteed until your next review date. The benefits attaching to your policy are listed below:

Your Current Premium & Benefits:
Premium €6,128.03 Yearly
Life Cover €1,586,919.00

Subsequently, at the Complainants' request, the Provider carried out some calculations to inform the Complainants what the results of future reviews might look like.

By letter dated 23rd June 2016 from the Provider, it advised that it estimated that at the Review in March 2023 an alteration would be required to maintain the policy and that it estimated that two options will be available to the Complainants – an increase of yearly premium to €22,776.04 to maintain life cover of €1,586,919.00 or decrease the sum assured to €1,165,602.00 and continue to pay €6,067.36. It also estimated that in March 2024 the Complainants would need to pay a premium of €68,662.62 to maintain life cover. By letter dated 01st November 2016 it provided a revised figure of €48,058.43, in this regard, saying there had been an error in the previous calculation, of June 2016.

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The Complainants submit that prior to this, the Provider gave no indication of any risk in this regard and that, it had reassured them, as recently as January 2016 that "*no increase in premium is required as a result of this review*". They say that this information was materially misleading, as the premium they have been paying is not enough to meet the cost of their life cover.

Having reviewed the evidence before me, I consider that it would have been more accurate of the Provider to have advised, following the review, in January 2016, that no premium increase will be needed until 2023 because there is enough between the fund and the premium to support the life cover cost until then. This was not made clear to the Complainants, however.

Failure to Conduct Reviews

The Provider's failure to conduct policy reviews, as per the terms and conditions of the Policy, is highly unsatisfactory. I accept the Provider's assertion that when it came to its attention that there had been a failure to carry out reviews in 2001, 2006 and 2011 that it had the Complainants' policy rebuilt and it determined that the failure to conduct reviews had not had any material financial impact upon the Complainants. This however is to ignore the fact that reviews are a feature of the policy, which are there to provide an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, it gives the policyholder an up to date picture of the level of cover chosen and provides an indication as to how long the policy fund is likely to sustain that cover. This is particularly important as it enables the policyholder to consider what, if any, action needs to be taken.

In not carrying out reviews and thereby depriving the Complainants of the results of the first and subsequent review of the policy, they were denied an early opportunity to decide what action they wished to take regarding the policy. Indeed, more than a decade elapsed during which time they received no details of any policy review, so that they were considerably older by the time they were alerted to the future cost of maintaining cover at the original level.

Premium Increase

The premium required to maintain the Complainants' policy after the 2023 review will increase considerably, when compared to the existing premium paid.

By letter dated 23rd June 2016 the Provider stated:

"I would now like to explain how your policy works. Each month when you pay your premium, units are bought in the [Provider] IRL Multi Asset Dynamic Fund Net Series Y. from your fund units are then deducted to pay for your life cover, fees and charges. The cost of providing life cover increases as you get older. This means more units are used from your fund to pay for the increasing cost of cover.

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At the start of your policy the premiums you paid were at a higher rate than the actual cost of providing life cover. This allows your fund value to build up to support the increasing cost of cover as you get older."

By cover letter dated 11th May 2017, the Provider has explained the factors that affect premiums as including the costs of life cover, fund performance and changes in the assumptions used in the calculations of estimated values at the maturity date, which were based on investment and interest rate conditions which had existed during the 1990s. It has stated:

..the cost of providing the life cover of €1,586,919 is currently on average €1,239.20 per month and the premium being paid by the customer is currently €510.67 per month (€6,128.03 annually). The fund value has been supplementing the premium paid since July 2012. It's worth keeping in mind that the costs associated with the life cover benefit vary and are dependent on a number of factors, most notably the age of the life assured, the level of benefits and the policy value. This means that the costs and invariably the premium increase as the life assured gets older. These factors have and will contribute to the increase in the premium required to maintain the policy beyond 2023."

In this instance, and in the context of the Unit Linked Whole of Life policy purchased, I am satisfied that the Provider has provided an explanation for its premium increase. While certainly the premium sought is very substantial, I am satisfied that the Company has provided a justification for the said increase in accordance with the policy review clause. It is disappointing and of concern, however, that the information made available to the Complainants over the years failed to alert them to this aspect of how the policy operates.

I accept that the documentation sent to the Complainants in respect of their Policy did not set any expectation that the protection benefits and premium would remain at the same level throughout the lifetime of the Policy. Having reviewed the express wording of the policy terms and conditions, I accept that the Complainants were on notice from the time of commencement of the policy that the policy premium level was to be reviewed on the 10th anniversary of the Policy and every 5 years after that, except where the policyholder has reached 70 years of age, when a yearly review would occur.

The entity which sold the Policy, and not the Provider, was primarily responsible for the provision of advice to applicants in relation to a suitable policy, and such policy benefits and features, including advice/information in relation to charges, policy reviews and specialised tax advice where required. I note that the Provider says that it (or its predecessors) did not provide advice to the Complainants and I do not find any basis for finding that it was under a duty to do so at the time the policy was sold.

I consider, however, that greater communication by the Provider was required over the years as regard the extent to which the fund value was being used to support the cost of cover and in relation to the Reviews that took place over the years and this could have been explained more clearly to the Complainants.

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I accept that there was a failure by the Provider to adequately inform the Complainants about how the policy was being administered, relative to the contractually required Reviews.

In relation to the further issued raised by the Complainants, I accept that when the Provider advised that the next review date was 2013, within its letter dated 12 September 2012, this was incorrect and should have read "2016" and that this was an administrative error on the part of the Provider; similarly, within the Provider's letter of the 01st November 2016, the Provider acknowledged a previous error in its premium estimates (the figure should have been €48,058.43, not €68,662.62 as had been previously advised).

The differential is notable and worrying and must surely have left the Complainants somewhat stunned and worried as to the reliability of the information being made available by the Provider.

I accept also that the Provider's letter of the 08th December 2015 was omitted from the bundle of documents which comprised the Complainants' data access request of March 2016 and which should have been included. Whilst this is an administrative failing on the part of the Provider, I am satisfied that the Complainants have confirmed that they had previously received this letter and did not suffer any undue prejudice as a result.

Regarding the alleged failure of the Provider to inform the Complainants that KPMG's agency had ended and their submission that a new Agent should have been appointed at a much earlier stage, I note the Provider says that KPMG's Agency was suspended on its systems until it received a written request from KPMG to terminate its Agency with it, which it did in January 2015. The Provider submits that on 14 February 2011, KPMG asked it to suspend its agency account and that it was on these instructions that the Provider did so. It submits that it did not write to the Complainants about this at the time as it says the onus was on the Broker to discuss this with its clients. The Provider has further submitted that it was the Broker and the Complainants' responsibility to ensure that the Complainants had ongoing access to financial advice.

The letter from KPMG, dated 22nd January 2015, stated as follows:

"*Further to your recent correspondence, I wish to advise that we no longer act as agent to policyholders. Would you please remove us as agent from your records?*"

The Provider confirmed this termination by letter dated 19th April 2015, to the Broker, stating:

"*We refer to your letter advising us to cancel your above intermediary. We wish to confirm your appointment with [the Provider] has been terminated.*"

It issued a letter to the Complainants on 08th December 2015 to advise them that the broker who had advised them on their policy, no longer has an agency with it, advising as follows:

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"We are contacting you because the financial adviser who previously advised you on this policy no longer has an agency with [the Provider]. Your policy terms and conditions or the service you receive from us are not affected in any way.

This means that they can no longer deal with us about your policy and we are not authorised to provide you with financial advice which you may need from time to time.

To ensure you can easily access advice on your future needs we have asked Aviva Direct Ireland Limited (Aviva Direct) to provide this service. Unless you tell it otherwise we will send your policy details to them and they will be your agent for your policy…If however you have already appointed a new broker who has an [Provider] agency please let us know and we will update our records. Or if you would now prefer to appoint a different financial adviser you can find more details through either of the main broker associations in Ireland by visiting www.iba.ie or www.piba.ie and then let us know the new details."

The Provider also submits that the Broker who advised on this policy is the agent of Complainants and that it acted on their behalf, rather than on the Provider's behalf. It submits that the onus was on the Broker to inform the Complainants that it had terminated its relationship with the Provider.

I am satisfied, in this regard, that KPMG, formerly Stokes Kennedy Crowley, were acting as financial advisors of the Complainants in relation to the Policy and were their agent in this regard. Consequently, I am satisfied that the responsibility and obligation to inform the Complainants, who were clients of theirs, that they no longer held an agency with the Provider, fell upon KPMG. I do not find that the Provider acted wrongly or unfairly in asking Aviva Direct to provide this service to the Complainants when it did and this was simply an option which was open to the Complainants to accept or reject.

Annual Benefit Statements

Certain valuation information was furnished by the Provider within the annual Statement which issued to the Complainants. The Provider submits that Annual Benefit Statements are automatically issued from an administration system but says it does not have copies on its files for the years preceding 2009. I have therefore examined these Statements from 2009, onwards.

The "Anniversary Statement" which set out the Policy Details, as at 01st March 2009, stated that the Revised Premium was €5,529.58. It stated that the Number of Units held was 8,116.3104, the unit price was €7.6790 and the Current Value at the time was €62,325.15.

The "Anniversary Statement" which set out the Policy Details, as at 01st March 2010, stated that the Revised Premium was €5,830.61. It stated that the Number of Units held was 8,467.3952, the unit price was €8.8820 and the Current Value at the time was €75,207.40.

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The "Anniversary Statement" which set out the Policy Details, at 01st March 2011, stated that the "Revised Premium" was €5,888.92. It stated that the Number of Units held was 8,672.5599, the unit price was €10.1350 and the Current Value at the time was €87, 896.39.

As at 21st December 2012, the "Premium Amount" was €5,947.81 yearly, and the number of Units Held was 8,902.7678. The Fund value was €95,998.55.

The following year, as at 23rd December 2013, the Premium Amount was €6,007.29 yearly, the Fund Value was €106,199.62, the number of Units Held was 8,819.8335 (Unit Value €12.0410). This was approximately 83 units less than the previous year.

The Statement dated December 2014 shows the number of Units held as 8,643.7175 (Unit Value €13.4600) and the Fund Value at €16,344.44. This illustrates the Provider's assertion that, from 2012 the fund value has been supplementing the premium paid, since July 2012.

The most recent Annual Benefit Statement, as at 22nd December 2016, shows that the Premium Amount was €6,128.03 yearly, the Fund Value was €123,291.03 the number of Units held was 7,921.5518 (Unit price € 15.5640). This was approximately **428** Units less than the previous year, 2015, when the number of Units held was 8,349.6219.

I note that, from 2012 the nature of the Annual Benefit Statement document changed, to include more information, including a section headed "*Important Notes*", which the Provider has pointed to, as including advice that:

"Where risk benefits are paid for by deduction of units from fund(s), this will have the effect of decreasing your fund value over the lifetime of the policy.

"Where applicable, reviews will be carried out on whole of life unit linked contracts. The purpose of the review is to check if the premium you pay is sufficient to maintain your policy benefits until the next scheduled review date. If following a review, your current premium is not enough to maintain your policy benefits, we will write to you, advising you of your options."

I appreciate that on page 5 of the document, it advises that there will be a decrease in the fund value over the lifetime of the policy when risk benefits are paid for by deduction of units from a fund. However, I consider that some notice should have been furnished to the Complainants that this had begun to occur on the Policy in question, due to the potentially significant consequences of same.

Overall, I am satisfied that the continuous failure of the Provider to conduct reviews on the Review Dates, as per the terms and conditions of the Policy, in 2001, 2006 and 2011, constitutes a significant lapse by the Provider in the administration of this policy. I am also satisfied that, having conducted reviews, the Provider should have been clearer in 2012, in its explanation of the fact that although no premium increase was then needed until 2023, this was due to the fact that there was enough value between the built up fund and the premium together, to support the life cover cost until then, as well as the fact that the

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fund value had been supplementing the premium paid since July 2012 and was therefore being slowly eroded.

I accept the Complainants submission, that had they been so advised, then they would at least have been in a position to take remedial action, e.g., to explore switching to a term assurance or to increase the premium to an affordable level in order to protect the fund value which had built up; the situation is now exacerbated as one of them is now over 70 years of age.

I do not accept, however, that the lapses warrant a direction for the Provider to indefinitely maintain the benefits as they were and at their existing lower cost. I believe nevertheless, that in light of the continuous failure of the Provider from 2001 until 2012, to conduct the policy reviews prescribed by the policy terms and conditions, compounded by the poor quality of the information in the annual policy valuations, particularly before 2012, the Company should continue to provide cover to the Complainants at the premium they are currently paying, beyond 2023 (when it has been forecast that an increase will be required) and instead, I direct that the Provider should continue to make available the same cover to the Complainants at the same premium level (increased only for indexation, if this is what the parties have agreed) for a further period, up to 31 December 2026. In that regard, I direct the Provider to update all relevant systems and records to take account of this position, within a period of 30 days of the date of this Decision.

It is important that the Complainants bear in mind, however, that after that date in 2026, the premium is likely to increase significantly, to a multiple of its current level and it will be a matter then for the Complainants to decide, whether they wish to continue cover pursuant to the policy, at the premium which then becomes payable, based on their mortality risk or to perhaps agree to a reduced level of cover, in return for a lesser premium. It may be useful for the Complainants, between now and 31 December 2026 to liaise with the Provider with a view to gaining a better understanding of the future premium level which is likely to arise from 2027, in order to decide what level of cover, if any, they will continue with from that time.

Having regard to the particular circumstances of this case, in particular the failing that has been noted above, and the inconvenience caused to the Complainants as a result, it is my Preliminary Finding that the complaint is partly upheld and I consider it appropriate to direct the Provider as outlined above.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(c) and (g)***.

Pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider should continue to make available the same cover to the Complainants at the same premium level (increased only for indexation, if this is what the parties have agreed) for a further period, up to 31 December 2026.

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Pursuant to ***Section 60(8)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** the Respondent Provider is now required, not later than 14 days after the 30 day period specified above for the amendment of its systems in order to implement the direction made pursuant to Section 60(4), to notify this office in writing of the action taken or proposed to be taken in consequence of the said directions outlined above.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
DIRECTOR OF ADJUDICATION AND LEGAL SERVICES

18 January 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—
(a) ensures that—
(i) a complainant shall not be identified by name, address or otherwise,
(ii) a provider shall not be identified by name or address,
and
(b) in accordance with the Data Protection Acts 1988 and 2003.