An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2018-0124 |
| **Sector:** | Insurance |
| **Product / Service:** | Life |
| **Conduct(s) complained of:** | Failure to advise on key product/service features<br>Fees & charges applied (life) |
| **Outcome:** | Upheld |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

## Background

There are two, related, aspects to the complaint. The first complaint relates to the alleged responsibility on the part of the Provider for the Complainant's failure to "convert" or "extend" a convertible death benefit in a life assurance policy before it expired. The second aspect relates to overcharging of premiums on the same policy, which overcharging has been admitted and the premiums repaid by the Provider, together with compensation of €100.

## The Complainant's Case

On approximately the **6th January, 1984**, the Complainant and her husband who died in 2015, incepted a life assurance policy with the Provider's predecessor in title, *via* a broker. The policy offered two core benefits which were set out in the policy schedule as follows:-

> *"1. A guaranteed death benefit, payable on the death of the [first deceasor of the proposers] before 10th January 2014 (the maturity date),…*
>
> *2. An additional convertible death benefit of [IR]£51,370 payable on the death of the [first deceasor of the proposers] before the 10th January, 2009 (the expiry date)"*.

The premium was IR£65 *per* month, commencing on the 10th January, 1984, until the 10th December, 2008, (*i.e.* the final payment before the expiry of the second above benefit

(referring to below as "the convertible death benefit") and IR£35 *per* month from the 10th January, 2009, to the 10th December, 2013 (*i.e.* the final payment before the expiry of the first above cover ("the guaranteed death benefit"). The guaranteed death benefit had a value of €10,000 and the convertible death benefit had a value of €65,227.

Under Section A, condition 12 of the policy conditions of the *"Lasersaver — Policy Contract — Second Series"*, the Complainant and her husband were entitled to "convert" or "extend" the convertible death benefit beyond its expiry date on the 10th January, 2009, without the need for any further medical tests.

Condition 12 stated that:-

> *"[a]t any time before the Maturity Date, the Proposer may effect a new policy or policies on the life of the Life Assured to replace in whole or in part the Additional Convertible Death Benefit and that without further evidence of health provided ...."*

This was possible provided certain conditions were satisfied. The Provider does not dispute that the Complainant and her husband would have been entitled to convert the convertible death benefit, such that the Complainant could have benefited from it upon the death of her husband, had the conversion happened before the benefit expired.

There are two, related, aspects to the complaint. Firstly, the Complainant maintains that, as a result of the Provider's conduct, the convertible death benefit expired in 2009 and she and her husband lost the opportunity to extend it. Secondly, the Provider overcharged the Complainant and her husband by collecting five years of premiums on the expired convertible death benefit and the Provider would never have refunded those amounts, if the Complainant had not raised the issue.

Before dealing with each of those aspects, it would be helpful to summarise the key correspondence between the parties relating to the Policy, some of which was not known or available to the Complainant, at the time the complaint was initially submitted.

**Summary of key correspondence**

Apart from correspondence and documentation which was generated around the time of the inception of the Policy, the first substantive correspondence related to two part surrenders of IR£4,000 made on the Policy, one on the 26th September, 1997, and the other on the 19th September, 1998. By letter dated the 19th August, 1999, the Provider provided details of those surrenders to the Complainant and her husband which details, on the face of it, appear to have been requested by the Complainant or her husband ("the 1999 letter").

A letter dated the 19th June, 2001, was also produced ("the June 2001 letter") during the course of this investigation. That letter also appears to have been prompted by an enquiry on the part of the Complainant or her husband and it advised them, some eight years before the scheduled expiry date of the convertible death benefit, that *"the convertible term assurance option allows you to replace the life cover of £51,370 without submitting evidence*

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*of health, provided this is done before 10 January 2014. This is achieved by the issue of a replacement policy".* The letter was inaccurate insofar as the relevant benefit expired on the 10th January, 2009, not the 10th January, 2014, but it offered the Complainant two options with which to replace the convertible death benefit. The letter also stated *"[i]f you decide to leave the Policy as it is for present, we will of course be in contact with you again shortly before the expiry date, 10th January 2014"* [emphasis added].

A further letter dated the 16th April, 2013, was produced during the investigation which, again, appears to have been prompted by an enquiry by the Complainant and her husband. That letter confirms that the Policy had a then current value of €1,819.18 and *"would mature on your survival until the 10 January 2014"* ("the April 2013 letter").

In addition, two annual statements were produced, the first dated May 2013 (providing an annual benefit statement for 2012) ("the 2012 statement") and the second dated February 2014 (providing an annual benefit statement for 2013) ("the 2013 statement").

A letter dated the 4th April, 2014 was produced, explaining how the value of the Policy would be worked out *"when you want to take some or all of your money or if we get a claim"* ("the April 2014 letter").

By letter dated the 30th October, 2014, the Provider explained that it could not proceed with a transfer of the Policy without a copy of photo ID and signed instruction ("the October 2014 letter"). This letter had been issued in response to a request dated the 26th October, 2014, on behalf of the Complainant and her husband in which it had been noted that *"original policy document has been mislaid".*

By letter dated the 25th November, 2014, the Provider enclosed a cheque by way of repayment for overcharged premiums amounting to €2,301.79 with a cheque for €100 as *"compensation for any stress or inconvenience"*.

Finally, by letter dated the 11th January, 2016, the Provider dealt with the two aspects of the complaint which had by then emerged and had been pursued in correspondence from the Complainant, or her representatives on the 31st August, 2015, the 12th November, 2015, the 9th December, 2015, and the 11th January 2016. Therein, the Provider confirmed that this could be treated as a final response letter, if a complaint was to be made to the FSO.

**Responsibility for non-conversion of convertible death benefit**

The Complainant initially maintained that she and her husband were not notified before its expiry in 2009, of their entitlement to extend the convertible death benefit, notwithstanding it being normal industry practice and the normal practice of the Provider (as indeed admitted by the Provider in its final response letter). She says that had they known it was due to expire, they would have extended it.

The Complainant submitted that the overcharging complained of in the second aspect of the complaint, which consisted of the continued collection of premiums on the expired

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convertible death benefit, led the Complainant and her husband to believe that the convertible death benefit was still in force.

The Complainant also notes that in the annual policy statements for 2012 and 2013 (issued in May 2013 and February 2014 respectively) which she accepts were received, the status of the policy was described as *"in force"* and she says that this gave no indication that the relevant benefit had expired. The Complainant notes that 25 annual statements ought to have been received between the inception of the policy and the expiry of the convertible death benefit but she is adamant and only two such statements were received.

During the course of this investigation the Provider produced, in particular, the June 2001 letter and the April 2013 letter which the Complainant addressed in a further submission.

The Complainant noted that while she had no memory of the June 2001 letter, she accepts that it may have been received by her or her husband. However, she notes that this letter erroneously stated that the convertible death benefit was due to expire on the 10th January, 2014, and, therefore, that the Complainant and her husband were misled by the Provider as to the actual expiry of that benefit. She also notes that this letter drew attention to the expiry of the convertible death benefit some thirteen years before it would purportedly expire and, in those circumstances and in particular given the Provider's assurance that it would be in contact again before the expiry, *"this misleading information was relied upon by [the Complainant and her husband] both as to the date of expiry of the policy and moreover the certainty with which they have expressed their intention to notify [the Complainant and her husband] closer to the date of expiry".*

The Complainant also maintains that the April 2013 letter misled her and her husband by not differentiating between the two elements of the Policy and stating that the Policy would mature upon survival to the 10th January, 2014.

**Overcharging**

The second aspect of the complaint relates to the continued collection by the Provider of premiums on the expired convertible death benefit. More particularly, although the premiums ought to have adjusted downward from IR£65 or €82.53 *per* month to IR£35 *per* month or €44.44 *per* month upon the expiry of the convertible death benefit, the Provider continued to collect €82.53 *per* month until the 11th December, 2013.
The Complainant alleges that the Provider would never have refunded those amounts, if the Complainant had not raised the matter. More particularly, in approximately November, 2014, upon learning that the Complainant's husband was terminally ill, the Complainant telephoned the Provider to ensure that all was in order with the Policy. She was informed that the convertible death benefit had expired on the 10th January, 2009. As appears from the correspondence above, a cheque for the overcharged sums together with a cheque for €100 in compensation were enclosed with the November 2014 letter. Those cheques were cashed by the Complainant.

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**Current position**

The Complainant's husband died in early 2015. Since the policy had expired, in full, on 10 January 2014, the Complainant did not benefit from any life assurance cover payable in the event of his death.

Although the Complainant queried whether a balance remains on the policy to which she is entitled, given that the closing statement of the Policy dated the 23rd December, 2013 records a balance of €1,894.27, this issue has not been specifically addressed. The Provider however, has made an open offer of €10,000 (detailed below) which the Complainant declined.

The Complainant maintains that the Provider's conduct as set out above amounts to unreasonable, unjust, oppressive or improperly discriminatory conduct contrary to s. 60(2)(b) of the ***Financial Services and Pensions Ombudsman Act 2017***. She would now like to have the option to extend the convertible death benefit, with effect from January 2009, thereby allowing her to benefit from this aspect of the Policy.

**The Provider's Case**

The Provider has responded to both aspects of the complaint in the manner set out below.

**Responsibility for non-conversion of convertible death benefit**

The Provider relies on the terms of the Policy. It highlights the descriptions of the guaranteed death benefit and the convertible death benefit as set out in the Policy schedule and clause 12 of the Policy Conditions which were furnished to the Complainant and her husband at the inception of the policy. The Provider notes that the option to convert the convertible death benefit before 10th January, 2009, was *"very clearly brought to their attention when the policy was taken out".* I note that the provision of such information at that time, occurred in 1984, 25 years before the expiry of the convertible death benefit, and 30 years before the scheduled full expiry of the policy.

The Provider notes that it was not obliged to notify the Complainant and her husband prior to the expiry of the convertible death benefit. However in its final response letter, it has acknowledged that it was its normal practice to do so. Indeed, I note that the correspondence from 2001, also suggests that it was a clear practice on the part of the Provider, at that time, to make contact "*shortly before*" the anticipated expiry date of that convertible option, and this is what was promised to the Complainant and her husband in 2001.

The Provider also submits that there was an onus on the broker to explain how the Policy worked as the Provider was not a party to the sale of the Policy and, further, that there was an onus on the Complainant to be familiar with its terms and conditions.

During the course of the investigation, the Provider produced the June 2001 letter as *"evidence that the option to convert the policy was brought to the Complainant's attention*

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*after the policy was taken out".* The Provider also notes that the Complainant did not attempt to convert the convertible death benefit before its expiry on the 10th January, 2009, or before the incorrect expiry date cited in the June 2001 letter *i.e.* the 10th January, 2014. The Provider submits that if the Complainant and her husband had *"sought to exercise the option at <u>any time</u> up to January 2014,* [the Provider] *would have most likely honoured it given the incorrect information within this letter".*

The Provider also clarifies that the entire policy expired on the 10th January, 2014, with the last premium collected on the 10th December, 2013. It also submits that its conduct ought to be judged against the consumer protection requirements prevailing in 2009, as this was the date of the expiry of the convertible death benefit.

**Overcharging**

In relation to the overcharging element of the complaint, the Provider admits that it overcharged the Complainant for five years, by continuing to collect premiums until the end of the policy as though the convertible death benefit had not expired. The Provider notes that:-

> *"Unfortunately our system was not updated when the conversion benefit expired in 2009. This had resulted in an overpayment of premiums for an expired benefit from 2009 to 2013. This was obviously very regrettable. In recognition of this customer service we have tried to resolve this complaint by refunding the overpaid premiums of €2,301.79 and issued compensation of €100 which the Complainant accepted. We are prepared to revisit this issue at this point in an effort to resolve the complaint and we will include detail of this at a later stage".*

The Provider offered a sum of €10,000 in an attempt to resolve the matter, noting that it felt this to be *"a genuine and substantial effort on our behalf",* that it took account of the various errors made and the Complainant's personal circumstances.

The Provider was not willing to treat the policy as converted from 2009 so that the Complainant could receive the death benefit, as it took the view that this would be disproportionate having regard to the relevant customer service failures, and this would also take no account of the onus on the Complainant and her husband or their financial advisors. The Provider also notes that this would be a speculative remedy as it would fail to take into account that the Complainant and her husband did not convert the policy in 2001, or at any point thereafter.

**<u>Decision</u>**

During the investigation of this complaint by this Office, 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.

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In arriving at my Legally Binding Decision 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 am 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 am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 16 July 2018, outlining the preliminary determination of this office 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 Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

**Time limits**

It appears from the evidence that the Complainant did not discover that the convertible death benefit had expired until approximately November 2014 and, as the complaint was made to the FSO within three years of that date, in July 2016, this element of the complaint is considered to have been made within time pursuant to s. 51(2)(ii) of the ***Financial Services and Pensions Ombudsman Act 2017***, in circumstances where the complaint is made in relation to a *"long-term financial service*" within the meaning of the Act.

I am also satisfied that the second element of the complaint pertaining to the overcharging comes within the jurisdiction of the FSPO, in circumstances where the conduct complained of constitutes conduct of a continuing nature, within the meaning of s.51(5) of the 2017 governing legislation, and the last event of overcharging occurred on or about 11 December 2013.

**Responsibility for non-conversion of convertible death benefit**

I am satisfied that the Provider is substantially responsible for the failure by the Complainant and her husband to convert the convertible death benefit prior to its expiry in 2009, for the following reasons.

Firstly, while I accept that the Provider was not expressly contractually obliged to inform the Complainant and her husband of the upcoming expiry of the benefit, on its own admission it was normal practice for it to do so. Judged against the consumer protection requirements prevailing in 2009, it is clear that in this instance, that Provider's clear practice was not

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adhered to and the Provider failed in that respect to notify the Complainant and her husband prior to the expiry of the convertible death benefit.

Whilst the Provider has suggested that it would be a speculative remedy to require the Provider to treat the policy as converted from 2009, because this would fail to take into account that the Complainant and her husband did not convert the policy in 2001, or at any point thereafter, nevertheless, I am satisfied that on the basis of the evidence available, the Complainant and her husband made a number of enquiries over the years in relation to this particular option to convert the benefit. I take the view that it is appropriate therefore to form the opinion that if the Provider had adhered to its own practice and written to the Complainant and her husband "*shortly before*" that option was due to expire, the Complainant and her husband most likely would have selected one of the options available to them in January 2009, which the Provider has confirmed as follows:-

- Level Term policy for a term of 15 years – monthly premium €119.77.
- Guaranteed Whole of Life policy – monthly premium €364.31.

I am satisfied that the Complainant and her husband were entitled to rely on the June 2001 letter regarding the expiry date of the convertible death benefit and the steps which the Provider would take prior to its expiry. That letter explicitly informed the Complainant and her husband that the convertible death benefit would expire on the 10th January, 2014, when in fact it was due to expire five years before that date. In addition, although the Provider undertook to contact the Complainant and her husband before the expiry of the convertible death benefit, it never did so. It must be recalled that this information was furnished in response to an enquiry by the Complainant or her husband and, therefore, it is reasonable to suppose that it was relied upon by them.

On balance, I am satisfied that the Provider was largely responsible for the Complainant and her husband's failure to convert the convertible death benefit and I take the view in that regard that the Provider's conduct was unreasonable, unjust, or oppressive in its application to the Complainant and her husband per s. 60(2)(c) of the Act of 2017.

**Overcharging**

The Provider has admitted that it overcharged the Complainant and her husband for five years by continuing to collect premiums in respect of an expired benefit. This in my opinion compounded the error of the Provider in the 2001 letter which had advised that the convertible option would remain open to the Complainant and her husband until 2014. Once it recognised the error, I note that the Provider repaid the sums overcharged immediately, and it also paid €100 in compensation to the Complainant, though it is unclear to me why that figure was considered to be the appropriate amount.

I am satisfied that the overcharging was contrary to law within the meaning of s. 60(2)(a) of the Act of 2017, being a clear breach of the terms of the Policy and, further, that such overcharging was unreasonable, unjust, or oppressive in its application to the Complainant and her husband within the meaning of s. 60(2)(b) of the Act. I am also satisfied that €100 was wholly inadequate compensation for the relevant conduct, particularly since the

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overcharged premiums seem likely never to have been repaid, if the Complainant had not raised the issue with the Provider.

In seeking to direct the appropriate redress for these events there is of course an element of conjecture which is required in determining what is fair and reasonable to both parties. I note that the policy expired in 2014, a year before the Complainant's husband died and, consequently, no life assurance benefits were payable. I cannot however ignore the fact that a number of enquiries were made over the years by the Complainant and her husband, in relation to what was a very valuable element of the cover which the Complainant and her husband had elected to put in place in 1984. Accordingly, it seems to me that if the Complainant and her husband had received a reminder "*shortly before*" January 2009 about the convertible death benefit, it is more likely than not, in my opinion, that they would have elected to convert that option in some manner. I am also cognisant that, in that event, a not insignificant sum would have been paid in the form of premiums to the Provider from that time, prior to the Complainant's husband's death, irrespective of which option had been selected. Whilst the cost of selecting the guaranteed whole of life policy at a premium of €364.31, might well have been considered prohibitively expensive by the Complainant and her husband, again, there is no degree of certainty that the Complainant and her husband would have selected the more cost effective option, which would have continued to provide cover, but only until the Complainant and her husband were in their 70s.

Taking all of these aspects of the matter into consideration, and in order to do justice as between the parties, taking into account what I consider to be very significant errors on the part of the Provider, against the context of what for many consumers is one of the most essential financial products, I direct the Respondent Provider to make a compensatory payment to the Complainant totalling €35,000, to an account of the Complainant's choosing, within a period of 35 days of the Complainant's nomination of account details to the Provider.

**Conclusion**

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €35,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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**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 INVESTIGATION, ADJUDICATION**
**AND LEGAL SERVICES**

8 August 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) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.**