An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2018-0131 |
| **Sector:** | Insurance |
| **Product / Service:** | Whole-of-Life |
| **Conduct(s) complained of:** | Results of policy review/failure to notify of policy reviews<br>Delayed or inadequate communication |
| **Outcome:** | Partially upheld |

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

**Background**

The Complainants' complaint is in relation to the Provider's administration of their Whole of Life Assurance Policy. A recent Review of the Policy resulted in the Provider requesting an increase in premiums to support the cover being provided under the policy.

The Complainants consider that the increase in premium requested by the Provider is excessive and is a result of the Provider's failure to administer the plan in accordance with its Terms and Conditions. It is argued that Reviews were not carried out as scheduled.

The Provider points out that the plan in question was sold by an independent intermediary.

The complaint is that the Provider has not correctly administered the Policy, particularly in relation to the Review of the policy over the years.

**The Complainants' Case**

The Complainants state that the Provider is at pains to point out that, in the event of a successful claim being made, then full payout would have been made, and that clients had been undercharged in relation to the level of benefits. The Complainants state that however the reality here is that, if Policy reviews were carried out in line with the Policy conditions, then they would have had the option to review benefits versus costs, and change type of cover perhaps to term assurance, or switch to another Life Company. The

Complainants state that this option has effectively been taken from them due to the Provider's systems failures.

The Complainants say that in plain language, the key issues here are that due to systems failure on the part of the Provider, which is fully admitted and accepted by the Provider, and this failure has effectively meant that they are unable to maintain the level of cover due to the increase in premium from €192 monthly to €1,500 approx monthly, and furthermore they are not in a position, due to deterioration in health/ age profile , to seek to arrange this cover elsewhere.

The Complainants conclude that the 'offer' of €1,000 made by the Provider is unrealistic, unfair and absolute nonsense, bearing in mind the comments made above, and in their correspondence to this office.

The Complainants state that due to the failure of the Provider to comply with the Terms and Conditions as set out in Policy Documents, and its admittance of this fact, the Complainants are seeking full refund of premiums paid.

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**The Provider's Case**

The Complainants plan is a unit-linked, whole of life protection plan. The plan provides protection benefits for the duration of the Complainants lives, as long as the required payment is paid.

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The plan commenced in November 1991, and to date, the Complainants have paid €36,000.43 into their plan. The benefits provided by the plan prior to the most recent review being carried out were as follows: Life Cover and Accelerated Specified Illness Cover of €408,488 for the First Complainant and €204,731 for the Second Complainant. With a total premium payment of €192.47.

The Provider explains that when the plan started, the payments were calculated based on the Complainants age, health, gender and the level of cover being applied for. The Provider states that with a whole of life plan such as this, it is not possible to factor in the maturity date of the benefits as to do so over a person's entire lifetime would be too costly.

The Provider states that it is more beneficial for payments to be set for a certain period, and then to conduct reviews on a regular basis to see whether the payments are still sufficient to cover the cost of the benefits.

The Provider says that open ended plans such as the Complainants' Plan will be subject to reviews at regular intervals, but as it is not a fixed-term plan it can be continued indefinitely throughout a customers' lifetime, irrespective of their age or state of health.

The Provider states that each time a payment is received, it is used to purchase units in a fund. The cost of providing the benefits and maintaining that plan is then debited from that fund.
The Provider submits that this process of unit deduction is described in the original Terms and Conditions document which was sent to the Complainants when they started the plan. The following statement from the Terms and Conditions document is noted in that regard:

*"14. Life and Disability Cover Charge*

*(a) The Life and Disability Cover ('the Cover') is the amount by which the Sum Assured for the time being in force is greater than the Benefit Fund as defined in Clause B. The cost of provision of the Cover shall be recovered by a Cover charge.*

*(b) The amount of the Cover charged each month shall be equal to the Cover as set out in sub-Clause(a) above as at the start of each month multiplied by a Factor determined from time to time by the Actuary having regard to*

- *(i)* *the age of the Life Assured at the Policy Anniversary which coincides with or precedes the calculation (or, in the first Policy Year, at the Commencement Date) and*
- *(ii)* *Such other factors relevant to the mortality and disability risk as were agreed between the Policyholder and the Company at the Commencement Date or subsequently.*

*(c) The Cover charge is deducted from the Benefit Fund by proportionate cancellation of units in each Unit Fund. If the charge made on any occasion exceeds the value of the Benefit Fund the excess shall be carried forward with interest at 10% per annum, or at such other rates as the Actuary may decide, and added to the charge made on the next occasion".*

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The Provider submits that the monthly payment made by the Complainants is not designed to solely cover the cost of providing benefits. As outlined above, the payment is used to purchase units in a fund which are then surrendered to cover the cost of providing the benefits, in accordance with the Terms and Conditions of the plan. The cost of the assurance increases with age, so in the early years the monthly payment exceeds the cost of the benefits and the fund value builds up. In the later years the cost exceeds the payment, and more units are being surrendered from the fund than are being purchased by the monthly payment.

Paragraph 15 of the Complainants Terms and Conditions provide for the plan to be reviewed every five years, and annually from age 65 onwards.

Paragraph 15 states:

**(a)** *The Sum Assured and Premium currently in force under this Policy shall be reviewed by the Actuary on the fifth Policy Anniversary or such other date as is shown on the policy Face. Thereafter the Sum Assured and Premium shall be reviewed at every fifth Policy Anniversary unless and until the Life Assured attains age 65 in which case the Review shall be made at each Policy Anniversary, such Reviews to be in addition to such Policy Reviews as the Actuary may make in accordance with the provisions of Clause 5 and/or Clause 23.*

**(b)** *At the Policy Review the Actuary will determine the Maximum Sum Assured which the Company is willing to allow until the next following Review and in determining such Maximum Sum Assured the Actuary will have regard inter alia to the value of Units allocated to the Policy, to whether or not the inflation Protector option is in operation, to future allocations of Units to be made in respect of Premiums payable until the next Review and to current rates of mortality and disability.*

**(c)** *If the current Sum Assured under the Policy shall exceed the Maximum as determined by the Actuary at Review the Sum Assured shall be reduced to not more than the said Maximum or, at the option of the Policyholder, the amount of Premium shall be increased to such amount as the Actuary may determine".*

The Provider submits that as the plan started in 1991, the first review due on the plan was in 1996, then 2001, 2006, 2011, 2016 and annually from age 65 (which would be 2030 for the First Complainant). The Provider accepts that it did not carry out the scheduled reviews due on the Complainants' Plan.

The Provider's position is that had the scheduled reviews been carried out, an increase in payment would have been requested so that more units would be purchased in order to maintain the level of cover that was on the plan until the next scheduled review.

The Provider states that as such, the Complainants were being undercharged for the level of cover that they were benefiting from previous review dates, and that the current payment

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of €192.47 was less than the amount that it would have asked them to pay for the Complainants' current benefits if the reviews had been carried out as scheduled.

The Provider says that to ensure that the Complainants were not disadvantaged in any way by their plan not being reviewed, and to put their plan in the same position it would have been in had it been reviewed correctly, it wrote to the Complainants in March 2016 and confirmed that:

- They were undercharged for the cover that they had benefitted from due to the scheduled reviews not being carried out.
- The Provider had absorbed the undercharge up to this point.
- The Provider would allow this undercharge to continue up to the date of the next review on 1 February 2017 and that the charging structure on the plan would have to be corrected at this stage. The Provider would again absorb the cost of doing so.
- The plan would be reviewed in advance of 1 February 2017 on the assumption that a sufficient premium had been paid to that time.
- The Provider paid a €250 Customer Service Award.

The Provider explains that the size of the undercharge absorbed by the Provider up to the point of its letter dated 27 January 2016 was €4,546.42. The Provider says that a further €8,585.73 was absorbed by the Provider from the date of its letter until 1 February 2017 when the plan was reviewed. The Provider submits that put another way, the life cover that the Complainants benefitted from due to the plan not being reviewed as scheduled cost €13,132.15 more than what they actually paid.

The Provider says that it was its letter dated 27 January 2016 where it provided advance notice of the Plan Review due on 1 February 2017 that gave rise to the complaint.

The Provider states that in the absence of an option being chosen by the Complainants and in order to prevent the plan from terminating, the cover on the plan has been reduced to a level that could be supported by the Complainants' regular payment of €202.09 per month (inclusive of indexation). The Provider's position is that this is in line with the Terms and Conditions plan. The Provider estimates that this payment will maintain the benefits unit the Complainants next plan review due in November 2021.

The Provider states that it is satisfied from its investigations that the Complainants benefited significantly from their plan not being reviewed, as they were undercharged for the life cover that was on their plan. The Provider says that upon realising the error, its action put the Complainants' plan into the same position it would have been in had the reviews been conducted, and under the assumption that a sufficient premium had been paid.

The Provider say that upon review of the Complainants' Complaint Form and supporting documentation submitted by the Complainants to this office, the Provider notes their preferred resolutions is:

- 5 year period at reduced rate.
- Full refund of all payment

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The Provider states that it feels that it has offered generous redress for its oversight in the administration of the plan and regret that it cannot accede to either of these requests.

The Provider submits that as is the case with all unit-linked whole of life protection plans, the cost of providing benefits such as life cover and specified illness cover is linked to the age of the individual. As a person gets older, the cost of providing these benefits increases, as the age related risk to the insurer is greater. The Provider states that it is for this reason that the monthly payment must increase, and it is for that same reason that it is unable to facilitate the Complainants' request to allow a 5 year period at a reduced rate.

It is the Providers position that the Complainants have benefitted greatly due to its error, as the Provider says the Complainants were being undercharged for the cover that they were benefiting from.
The Provider states furthermore, that it would not be in a position to offer a refund of all payments made to the plan since commencement. The Provider states that the plan has provided valuable benefits of life cover and specified illness cover from 1991, and as is the case with all insurances these benefits incur a cost.

The Provider says that in the event of a successful claim the life cover/specified illness benefit would have been made payable to the Complainants. In addition, that in this case, as the Complainants had higher benefits than they were being charged for, a higher claim amount would have been paid in the event of a successful claim.

The Provider submits that while it cannot accede to the proposed resolutions put forward by the Complainants, it would like to offer an alternative resolution.
The Provider says it appreciates the plan was not reviewed as it should have been, in accordance with the Terms and Conditions and in light of this the Provider would like to put forward an offer of €1,000 in respect of the reviews that were not carried out as scheduled.

**Decision**

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 Complainants were 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.

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

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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 23rd August 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.

**Analysis**

The issue for investigation and adjudication is whether the Provider correctly administered the policy, in particular in relation to the carrying out of Policy Reviews and in its communication of the actions on the policy.

The policy that the Complainant took out in 1991 is a unit linked life assurance contract, which has the benefit of being a whole of life policy as long as the premiums continue to be paid and they can support the policy benefits. The main reasoning behind unit linked protection contracts is that it affords the policyholder the chance to pay a premium in the early years that more than covers the cost of the life cover benefit with the balance of the premium remaining invested in the designated investment fund. The purpose of this is twofold, as it allows the policyholders to build up a fund, that is accessible at all times or it can help to supplement the premium paid in future years allowing the policy benefits to be maintained. On this basis the policy is subject to ongoing reviews in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date.

I would point out that even though a unit-linked whole-of-life policy allows the policyholder to build up a cash lump sum over and above what is needed to pay for the life insurance, this usually only happens if the fund performs well. It can be the case that the policy would have a little or no cash value. Such policies are not meant to be a savings plan.

The cost of providing the policy benefits increases as the life assured gets older. In effect, the accumulated fund diminishes the impact of the increasing cost of the policy benefits thereby minimising the increase in premium required at each review date. However, if the premium level and the fund value cannot maintain the policy until the next review date some action needs to be taken (either increase the premium or reduce the sum assured). If the fund value has been completely exhausted the level of the premium increase required may be significant.

The Complainant's policy was to be first reviewed in 1996 (on its 5th Anniversary) in accordance with the policy conditions. The Provider accepts that it did not Review the policy then. The policy was scheduled for review again in 2001, 2006 and 2011. The Provider also

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stated that these scheduled Reviews did not take place. It was not until 2016 that the Provider communicated to the Complainant the results of a review that it had carried out then. The 2016 Review indicated that a substantial increase in premium was required to sustain the existing levels of cover.

From the evidence submitted it is not clear from what date the cost of providing benefits under the policy first exceeded the payments that were being made by the Complainants. In this regard the Provider advised that unfortunately it does not have details of the risk costs deducted from the plan going back to 1991. However, on the basis that the 2016 Review showing a nil surrender value, it is clear that any fund that had been built up over the years was exhausted by the Provider extracting the policy charges.

While I accept that a Provider does not have to notify a policyholder in advance of increasing the annual charges made for mortality rates, I do consider it reasonable that a Provider communicates at the earliest opportunity, be that be at policy anniversary date or at review stage, that the premium being paid is no longer sufficient on its own to cover the cost of providing the policy benefits.

A Policy Review provides the Provider with an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, a Policy Review should give the Provider the information to provide the policyholder with an up to date picture of the level of cover chosen and provide an indication as to how long the premium and policy fund is likely to sustain that cover. Such Reviews are important as they allow the Provider discuss with the policyholder what, if any, action needs to be taken. This is important for the Policyholder.

I find that the Policy document outlined the policy features. The Provider was entitled to Review the policy. However, I consider that there have been major lapses by the Provider in relation to how it has administered the policy over the years, in particular in relation to not carrying out the scheduled Reviews.

Not knowing of the results of a review, a policyholder is denied an early opportunity to decide what action he/she wishes to take regarding the policy. It could, for example, be the case that a policyholder would have wished to exit the policy, after discovering that this is how the policy actually operated in practice (it is one thing to set out in the policy documentation how something is going to be done, but knowing the full implications of a Review process when it happens is another matter). The importance of the Provider carrying out a scheduled Review is to give the policyholder an early insight into the operation and effect of such reviews on their policy. In this complaint, I consider that the Provider's failure to carry out any Reviews, not noticing same, and not communicating same to the Complainants, at an earlier stage, was wholly incorrect and unreasonable.

As stated above the Provider was unable to confirm from what time it was necessary for the Provider to reduce the policy fund to support the benefits, a reduction however, for that purpose appears to have happened, as the fund was exhausted to a nil value. While the policy provisions do highlight that the fund value would be used, in addition to the regular payment, to fund the protection benefits, the Provider did not communicate to the

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Complainants when this had begun to happen or that it was indeed happening for some time.

The importance of having had the policy Reviewed on time and with having some communication of the action of decreasing the fund to pay for the policy cover, was that the Complainants would have had the choice at an earlier date, as to whether to continue with the policy or withdraw from the policy and take the benefit of a higher surrender value. The ability to make alternative arrangements for cover in ones younger years was also lost to the Complainants.

In the above regard, I do not accept that it was reasonable of the Provider (i) not to carry out the Reviews at their scheduled dates (ii) not to tell the Complainants that the cost of cover had exceeded their premium payments, and (iii) that the fund value was being relied upon to cover the excess costs.

I accept that the Policy document outlined the policy features. The Provider was entitled to Review the policy. However, the Provider (a) did not carry out the scheduled Reviews (b) did not notice for some time so as to early communicate to the Complainants that the Reviews were missed or (c) did not communicate when (which appears to be the position) it had begun using the fund value to supplement the premiums that were being paid by the Complainants.

I consider that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is Life Assurance cover.

With regard to the provision of information to a consumer the Consumer Protection Codes state that a regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.

Having regard to the particular circumstances of this case, in particular the failings that have been noted above, it is my Legally Binding Decision to partially uphold the complaint. The Complainants had sought a 5 year period of cover at reduced rate / Full refund of all payments. While the Provider's actions in relation to the administration of the policy, in particular its failure to carry out the scheduled Reviews was unreasonable, I accept that the Complainants did have the benefit of having their level of cover at a reduced cost for longer than they should have had, had the Reviews taken place. This was at a substantial cost to the Provider, and while fortunately it was not tested, the Provider has stated that it would have paid out on that cover, had a claim arisen. Therefore, I consider that the more appropriate remedy here is that the Provider make a substantial compensatory payment to the Complainants.

Having regard to all of the above it is my Legally Binding Decision that the complaint is partially upheld and I direct that the Provider is to pay the Complainants the compensatory payment of €10,000 (ten thousand euro).

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**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)(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 Complainants in the sum of €10,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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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**GER DEERING**
**FINANCIAL SERVICES AND PENSIONS OMBUDSMAN**

19th September 2018

**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.**

**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.**