An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0147
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the Provider's administration and communication on a Whole of Life Policy, which was taken out in 1995. The complaint is that the Provider failed to carry out a policy review in 2010. The later scheduled review of 2015 resulted in the Provider communicating a substantial increase in premium to maintain the then existing level of cover.

The complaint is that the Provider acted incorrectly and unreasonably in relation to the administration of the policy and in regard to the requested substantial increase of premiums.

The Complainants' Case

It is the Complainants positon that the Provider advised in 2015 that it intended to increase the premium almost 10 fold from October 2015. The Complainants say they complained and protested and the Provider failed to provide any answers for nearly four months. The Provider agreed to maintain cover until 2016. The Complainants state that the Provider has now requested an increase of premium from €167 per month to €1625.63 per month.

The Complainants submit that as a temporary measure they have advised the Provider that they will, for the moment, accept the reduced cover of €37,505.00 on the First

Complainant's life and €4,1374 on the Second Complainant's life pending outcome of their complaint.

The Complainants state that they understand that the Provider has a massive liability under the current joint life plan cover but the Provider was the one insisting on a 5% increase in premium and cover for the past 20 years.

The Complainants state that they expected the life cover to continue to at least their 65th birthday. The Complainants say that having said that they can accept a reduction in cover but consider Joint Life cover at €150K to be fair and reasonable and at current premium levels.

The Complainants state that in 2007 they cancelled the serious illness portion of the Policy as with their children grown up they no longer needed that cover. The Complainants state that the Provider quoted the new premium to continue with the life portion of the policy.

The Complainants say that the Provider stated that the growth would be 7% per annum right through the life of the policy and at the same time took 5% increase per annum. The Complainants question how the Provider can justify that the fund does not cover the insurance when the Provider was the one in control of it.

The Complainants consider that they accept they are over insured, but that this is due to the annual index increase in premium and cover for 20 years. The Complainants consider it would be fair to reduce cover to joint life of €150,000 for same premium.

The Provider's Case

The Provider states that when the Complainants applied for their Protection Portfolio Plan in 1995, they also applied for Inflation Protection. The Provider states that this is designed to protect the benefits in place against inflation. Therefore, ensuring that the value of the benefits remain throughout the life of the plan. Under Inflation Protection, the level of payment increases by 5% each year.

The Provider says however, that it is important to note that the level of benefit also increases by 5%. Therefore, while the Provider appreciates that the Complainants have increased their payments over the years; as the benefits also increase at the time rate, these increases have no bearing on the outcome of any Plan Reviews or on the amount of premium that is required in order to maintain the existing benefit until the next Plan Review date.

The Provider submits 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 says 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. Rather, it is deemed 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

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of the benefits in place. The Provider states that it is for this reason that it carries out Plan Reviews on whole of life protection plans.
The Provider says that the risk associated with providing the cover increases as one ages. The Provider states that while it notes the Complainants feels that the Provider is being ageist in charging more for the same level of cover as they age, it feel it is also important to note that such practice is the same across the insurance industry. The cost of any insurance is directly linked to the risk associated with a claim being made. The Provider submits that with life assurance plans, the risk involved is the death of a customer. This in turn, is linked to the customer's age. The Provider says therefore, it does not accept it is being ageist when linking the cost of proposed cover, to the age of the customer to be covered.

The Provider explains that when each regular payment is received, it is used to purchase units in the plan fund. The Provider then encashes units held within the fund in order to meet the costs of the attaching benefits and plan fee, in accordance Terms and Conditions which state, as follows:

Terms and Conditions

"18. Benefit Charges

This section details how the cost of your benefits are calculated and deducted from your benefit fund.

(a) The cost of provision of Benefits shall be recovered by a Cover Charge made monthly in advance from the commencement date.
(b) The amount of the Cover Charge each month shall be based on the Benefits 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) If the permanent disablement option has been selected as shown on the Policy Face an additional factor will be charged related to the cost of this benefit, and
(iii) Such other factors relevant to the mortality risk as were agreed between the policyholder and the Company at the Commencement Date or subsequently.

(c) The cover charge 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 as interest at such other rate as the Actuary may decide, until such time as it may be eliminated by cancellation of units from the Benefit Fund.

The Provider submits that in the early years, the cost of providing the life cover is much lower than the payment being made each month. Therefore a surplus of units remains in the fund each month and begins to build a value.

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The Provider says however, that it is important to note that while the Terms and Conditions state that this value can be withdrawn, either fully or partially, the sole purpose of building a value in the early years is to meet the cost of the benefits in later years, when they increase to a level which is greater than the payment being made. Therefore, withdrawing this value at any stage reduces the ability of the plan to meet the projections provided at both inception and indeed any stage prior to the withdrawal, as these projections are based on the value in the plan, the benefits required and the term over which they are required. The Provider's positon is that this is what happened when the Complainants withdrew the total value, €19,360, from their plan in July 2007. Resulting in any projections provided to them prior the withdrawal, null and void.

The Provider states that as outlined previously, the payments on the Protection Portfolio plan is only set for a certain period. The Provider then conduct reviews on a regular basis, to see whether the payments being made are still sufficient to cover the cost of the benefits in place. Paragraph 19 of the Complainants' Terms and Conditions provide for the plan to be reviewed every five years, and annually from age 65 onwards. The policy provisions state:

"19. Policy Review

(a) *The Sum Assured, Serious Illness Benefit and Premium currently in force under this Policy shall be reviewed by the Actuary on the fifth Policy Anniversary and on every fifth Policy Anniversary thereafter unless and until the Life Assured attains age 65 following which the Review shall be made at each Policy Anniversary. The Benefits will also be reviewed after a claim payment.*

(b) *At the Policy Review the Actuary will determine the maximum Benefits which the Company is willing to allow until the next following Review and in determining such maximum Benefits the Actuary will have regard inter alia to the value of units allocated to the Policy, to whether or not the inflation Protection Option is in operation, to future allocation of units to be made in respect of Premiums payable until the next review and to current rates of mortality. There is no guarantee that the reviewed premium will suffice to meet the cost of the Benefits.*

(c) *If the current Benefits under the Policy shall exceed the maximum as determined by the Actuary at Review the amount of the premium or the level of the Benefits shall be adjusted as the Actuary may determine in accordance with the Company's practice at the time.*

Therefore, as the plan started in 1995, the first Plan Review was due in 2000, then again in 2005, 2010 and 2015, etc. The paln is to then be reviewed annually from when the oldest life covered reaches age 65.

The Provider states that unfortunaely is does not have a copy of the correspondence which would have issued to the Complainants in 2000 when their plan was reviewed. The Provider states however, that the fact that the value of their plan was €7,141.44 by July 2001 and the plan passed its second Plan Reivew in 2005, would have confirmed that their plan had passed its initial review and no change was required at that time.

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The Provider submits that as noted above, the plan was reviewed a second time in 2005. The Provider says that again, the plan passed its review and no change was required. The Provider states that at that time, it wrote to the Complainants confirming that no change was required prior to the next scheduled Plan Review in 2010.

The Provider says that its records show that in 2007, the Complainants contacted the Provider and requested to remove the Serious Illness benefit from their plan. The Provider says that the Complainants also asked to withdraw the total value of €19,360. As a result, two letters issued to the Complainants, one confirmed that their withdrawal had been made and as a result, the benefits had reduced by the amount withdrawn. The second letter confirmed that the Serious Illness benefit had been removed as requested.

The Provider submits that unfortunately, while the plan was due to be reviewed again in 2010, this did not happen. The Provider states that, it was 2015 before the plan was reviewed again. The Provider says that while investigating a complaint raised at that time, it was discovered that the 2010 Plan Review was not carried out.

The Provider states that to ensure the Complainants were not financially disadvantaged in any way by their plan not being reviewed (in 2010), and to put them in a better position than they would have been in had the plan been reviewed as provided for (in 2010), the Provider wrote to the Complainants in 2015 and confirmed the following:

- In July 2007, they received €19,360 from the plan value.

- They were undercharged for the cover that they had benefitted from due to the scheduled review not being carried out in 2010;

- The Provider had borne the cost of the undercharge up to that point (2015);

- The Provider would allow this undercharge to continue up to l October 2016. At that point, it would correct the charging structure on the plan. As before, the Provider would again bear the cost of this extended cover; and

- The plan would be reviewed in advance of 1 October 2016 on the assumption that a sufficient level of payment had been made by the Complainants all along.

The Provider says that the size of the undercharge absorbed by the Provider up until October 2015 was €4,974.84. And that a further €6,122.42 was absorbed by the Provider from October 2015 to October 2016. The Provider submits that put another way; had the Complainants paid for the level of benefits which were in place between October 2010 and October 2016, they would have to have paid €11,110.56 more than that which they actually paid.

The Provider states that in addition to the above and in recognition of the fact that its investigations took almost four months to complete (due to the nature of the information

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required in order to correct that which it had discovered), the Provider also issued a cheque for €250 to the Complainants along with its apologies.

The Provider says that its records show that as a result of the 2016 Plan Review, the Complainants opted to decrease the level of benefits to that which could be maintained with their existing level of payment.

The Provider states however, having carried out a further review of the file and in recognition of the fact that it does not have a copy of the correspondence which would have issued to the Complainants when their plan was reviewed in 2000, the Provider would like to put forward an additional offer of €250.

The Provider's positon is that on the above basis it feels that the complaint should not be substantiated on any of the grounds raised by the Complainants.

Evidence and further submissions from the parties

The Complainants' submission of 26/01/2018

The Complainants point out that in the Provider's summary it makes much of the cash withdrawal from the fund in 2007 but fail to mention in its summary that the fund changed from Joint Life and serious illness cover to just joint life and say that the Provider do not however provide copy documentation for this. The Complainants state that this was a major drop in risk for the Provider. The Complainants say that the premium levels to cover the Joint Life and the level of Joint life cover going forward from 2007 were set by the Provider at that time and the cover value also decreased.

The Complainants submit that the Provider acknowledges that the 2010 review was missed by them and it acknowledges that had a review been carried out at that time then increased payments would have been requested. The Complainants says that had this been done and the review recommended an increase at that time it would not have in any way shape or form taken the level of the premiums demanded in 2016.

The Complainants say that the Provider does not discuss in its summary or cover letter the crux of the matter. The fact that the premiums were to increase from €2,004.60 per annum to €18,632.28 per annum.

The Complainants state that within the Provider's summary it comments that they (the Complainants) accepted the new reduced cover terms of the 2016 review. The Complainants point out that what the Provider did state that it was communicated to it that the Complainants accepted it on a temporary basis while taking the complaint forward.

The Complainants state that the Provider says that it sent them details of alternative plans. The Complainants submit that those details were not received. The Complainants state that they contacted the Provider and requested a quote for straight life cover of 100K, but did not go this route as they felt they were being treated unfairly with the existing policy and decided to *push back on* the Provider.

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The Provider's submission of 26/01/2018 in response to the Complainants' comments

In the Complainants' submission they note that while they withdrew the value of the fund, they also reduced the benefits at the same time. As the Provider set the level of payment after these alterations, the Complainants do not feel that they should now be increased.

The Provider's response is that it is important to note that the terms and conditions of the plan provide for it to be reviewed at regular intervals. Therefore, regardless of when the withdrawal was made / benefits removed, or what the level of payment was reduced to as a result, the payment is always set until the next scheduled Plan Review. The Provider says that therefore, the plan was always due to be reviewed in 2010. And as this was not done as scheduled, the Provider bore the cost of the Complainants being undercharged for their cover, between 2010 and 2016 .

The Provider says that when the plan was reviewed again in 2016, it was done so on the assumption that the Complainants had been making the correct payment for their level of benefits, between 2010 and 2016. Thereby ensuring they were not disadvantaged in any way by the fact that the plan was not reviewed in 2010.

The Complainants feel that had the plan been reviewed in 2010 as planned, the increase required at the time would not have been as much as the increase required in 2016.

The Provider's response to the above is that it is important to again note that any increased cost associated with providing the higher level of cover between 2010 and 2016 was borne by the Provider and not the Complainants. The Provider says that the increase required in 2016, was arrived at, as if the customers had paid the full higher payment required between 2010 and 2016, rather than a portion. The Provider states therefore, that rather than being disadvantaged by the missed review in 2010, the Complainants benefited from the existing cover during these years, for a payment considerably less than the actual cost.

The Complainants are querying the level of increase proposed when the plan was reviewed in 2016.

The Provider's response is that it is important to note the following when considering the level of proposed increase as part of eth 2016 Plan Review;

- The Complainants payment was set at €167.05 in 2007, however, payment due between 2010 and 2016 was much higher than the €167.05 being paid by the Complainants.
- When the payment was set in 2007, the eldest life covered was approximately age 52. Whereas between 2016 and 2020 (the term over which the payment was proposed for in the 2016 Plan Review), the eldest life covered will between 61 and 65.
- The cost of life cover can increase substantially as we age.

<u>Chronology of the Provider's correspondence with the Complainant</u>

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13th December 1996 – Provider to the Complainants

> *"I write to confirm that the premium of £232.26 will sustain cover … for 24 years from November 1996, assuming a growth rate of 7%"*

7 March 2001 – Provider to the Complainants – Current Cash Value €8.856.21

30th July 2001 – Provider to the Complainants

> *"The current Surrender Value of this policy is £5,624.34 (€7,141.44). Please note that this is subject to change in line with unit prices.*
>
> *The approximate total of premiums paid to date are £15,702. This policy was set up on a maximum protection basis. This means that there is the maximum amount of cover for the minimum premium being paid. However, since the premium was increased to £232.26 per month in January 1997, there is more of the premium being invested in the Fund".*

23rd April 2003 – Provider to the Complainants – Current Cash Value €9551.53.

19th April 2004 – Current Cash Value - €13048.02.

8th August 2005 – Current Cash Value - €19380.51

3rd October 2005 – Provider to the Complainants

> *"The Level of Benefits below are projected to be sustained by the current premium for the terms as specified" The current level of benefits were projected to be sustained by the then current premium of €419.33, for 10 years. The following warning was then set out:*
>
> *"Due to the nature of the policy, these figures cannot be guaranteed. Your policy will be reviewed regularly, in accordance with the Policy Conditions, to ensure that it is on track to maintain the benefits requested".*

13th September 2006 – Provider to the Complainants

> *"The current premium of €440.30 per month is projected to sustain the current benefits on this policy for a term of 22 years from inception, assuming 4.8% net growth.*
>
> *Assuming the Serious Illness Cover is removed from the policy, a revised premium of €106.62 per month is required to sustain the policy for its current term of 22 years from inception, assuming 4.8% net growth"*
>
> *Projection Statement*

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"The current premium is projected to maintain the benefits shown above for 22 years, I month from the policy commencement date assuming an investment return of 4.8% per annum".

20th July 2007 – Provider to the Complainant

"Thank you for your recent request to remove the Serious Illness benefits on this policy"

23rd July 2007 – Endorsement to Policy

"Thank you for your partial surrender request. Enclosed is a cheque for €19,360.00…. When you took out this policy the premium was estimated to maintain cover for a specific period of time, based on certain assumptions. However, withdrawing some of the fund value may affect the length of time that the current premium can do this".

31st December 2012 – Annual Statement

Premium amount €144.31

As of 29/11/2012 the surrender value of your policy is €0.00

2nd October 2013 – Annual Statement

As of 30/09/2013 the surrender value of your policy is €0.00

"Policy summary from 01/10/2012 to 30/09/2013
Premiums received €1,731.72
Government Levy (€17.16)
Benefit Charges (€6,317.85)
Policy Fee (€45.10)
Withdrawals (€0.00)
Premium Charges (€68.77)

Closing surrender value as at 30/09/2013 €0.00

Explanatory notes
Benefit charges This is the charge to cover the ongoing costs of the benefits provided by your policy"

1st October 2014 – Annual Statement

"Policy summary from 01/10/2013 to 30/09/2014
Opening surrender value as at 30/09/2013 €0.00

Premiums received €1,818.24
Government Levy (€18.00)

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Benefit Charges (€7,398.81)
Policy Fee (€0.01)
Withdrawals (€0.00)
Premium Charges (€72.20)

Closing surrender value as at 30/09/2014 €0.02"

1st September 2015 – Provider to the Complainants re Review of policy and options for cover going forward.

1st October 2015 – The Provider to the Complainants

"As previously advised, your current payment is insufficient to maintain the current level of benefits under the above plan from 1 October 2015 to 1 October 2020. To prevent your plan from terminating with effect from 1 October 2015 your revised premium will increase from €167.05 to €1,552.69. Your level of benefits will remain the same and are set out below".

1st October 2015 – Annual Statement – Fund Value €-1,567.46

Plan Expense Fund L €-1,567.46

"Important information for your current cash in value and investment fund details

- *The value quoted above in the Plan Expense Fund has arisen because of the costs on your plan".*

21st December 2015 – The Provider to the Complainants

"When your payment is no longer sufficient to cover the cost of maintaining your plan and life cover (due to the increasing cost of providing this cover), we then rely upon the value which had built–up in the fund attaching to your plan. Rather than increasing your payment, we try to keep it as it is for as long as possible by taking the cost of the life cover from the value of the fund each month. This process reduces the value of your fund, until there is no longer a value attached".

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.

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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 10th September 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 policy that the Complainants took out in 1995 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 a unit linked protection contract 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, it allows the policyholder 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 allows for ongoing reviews in order to establish if the premium being paid and the investment fund are 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 better than expected. It can be the case that the policy would have a little or no cash value. Such policies are not meant to be savings plans. The Complainants policy did accumulate a substantial fund, which the Complainants fully encashed in 2007.

The cost of providing the policy benefits increases as the life assured gets older. In effect, the accumulated fund (if any) 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 benefits 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, (as happened here with the Complainants withdrawal of the fund in 2007) or is nearing a nil balance, the level of the premium increase required may be significant.

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The Inflation Protection is different to a Review of the policy. The purpose of the Inflation Protection is to protect the benefits in place against inflation. Therefore, ensuring that the value of the benefits remain current throughout the life of the plan. Under the Inflation Protection, the level of payment increased by 5% each year.

I accept that the documentation sent to the Complainants in respect of their plan did not set any expectation that the protection benefits and payment would remain at the same level throughout the lifetime of the plan. I also accept that the Company has advised the Complainants at all times of the certainty of a policy reviews occurring, albeit missing the 2010 Review.

In response to a query from this office as to when the Provider had begun to supplement the cost of the cover from the policy fund, the Provider advised as follows:

> *"Our records show that the customers withdrew the total value of their plan in July 2007, €19,360. In order for the value to accumulate, it is clear that up until this point, the cost of the benefits and the plan fee was less than the payment being made by them.*
>
> *However, following the withdrawal, the plan did not accumulate a value again until the benefits were reduced in October 2016 and the level of payment once exceeded the cost of the benefits. Therefore, at no stage, did the value of the fund supplement the cost of the plan".*

The fact the premium payments were not meeting the cost of the policy benefits from 2010 to 2016 was not clearly communicated to the Complainants or done so in a timely manner.

Once the Complainants withdrew the full surrender value of their policy in 2007, I consider that it would have been prudent of the Provider to monitor / review the policy more closely as regards the adequacy of the premium being paid over the intervening years. This was particularly so, as there was no longer a fund value to supplement the increasing cost of cover.

It is noted that when the Provider sent the Complainant the surrender value in 2007 it advised that:

> *"When you took out this policy the premium was estimated to maintain cover for a specific period of time, based on certain assumptions. However, withdrawing some of the fund value may affect the length of time that the current premium can do this".*

However, what is noted here is that it was not just a matter of the Complainants ***withdrawing some of the fund value***, but <u>all</u> of the value was withdrawn and this inevitably was going to have an impact on the level of premium payments required to provide cover in the future.

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The Provider's positon is that this is what happened when the Complainants withdrew the total value, €19,360, from their plan in July 2007. Resulting in any projections provided to them prior the withdrawal, null and void.

I consider that a greater warning could have been communicated at this time, or over the subsequent years of the true effect of the full withdrawal of the fund value, in particular that any projections provided to the Complainants prior the withdrawal, were null and void.

The conduct of apparently not monitoring the policy, in the intervening years, in relation to the affect that the full withdrawal had on the workings of the plan, and the then missed 2010 review had an ongoing consequence for the policy. In that regard, a debt was allowed to build up since 2010. I consider what was more detrimental to the Complainants, was the expectation that was created by the Provider as to the adequacy of the premiums being paid by the Complainants over the years. That expectation being that a sufficient payment was being made by the Complainants for their chosen level of cover. However, the opposite was the case.

By missing the 2010 Review, the Complainants were denied the opportunity to fully appraise their life cover needs at an earlier juncture. The Complainants were also denied the opportunity to seek out alternative cover at a time when they were younger and more likely not to have health issues. It is also dissapointing that the Provider was unable to provide a copy of the correspondence which it says would have issued to the Complainants in 2000 when their plan was meant to be reviewed at that time.
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. I accept that there was a continuing failure by the Company to correctly inform the Complainant about how the policy was being administered relative to the contractually required Reviews, the inadequacy of the premium and the reasons for same.

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. I accept that there was a continuing failure by the Company to correctly inform the Complainant about these matters.

Section 51 (5) of the Financial Services and Pensions Ombudsman Act 2017 states that:

"(a) conduct that is of a continuing nature is taken to have occurred at the time when it stopped and conduct that consists of a series of acts or omissions is taken to have occurred when the last of those acts or omissions occurred, and

(b) conduct that consists of a single act or omission is taken to have occurred on the date of that act or omission".

While I accept that there was a lapse by the Company in regard to the administration of the policy Review and communications from the Company, I do not accept that these lapses are

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sufficient to warrant a direction for the Company to maintain the benefits as they were and at their existing lower cost or indeed the alternative cover sought by the Complainants. I accept that the issue here is one of a requirement for greater and better communication / administration of the policy from the Company and for the identified lapses in same I accept that a compensatory payment is merited in this case.

Having regard to the particular circumstances of this complaint, in particular the failings that have been noted above, it is my Legally Binding Decision that the complaint is partially upheld and the Company is to make a compensatory payment of €10,000 (ten thousand euro) to the Complainants. The Complainants must now decide what they wish to do in relation to the cover and premium options that were offered by the Company. In considering the options in relation to the current policy cover, or the alternative policy options, it would be prudent that independent advice be sought by the Complainants.

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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.***

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

3rd October 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.