An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0151
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Failure to advise on key product/service features Delayed or inadequate communication
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a Whole of Life Policy taken out in 1984. The complaint is that the Provider is not correctly or reasonably administering the policy, particularly in relation to the review of the policy and in its communications in respect of the Review.

The Complainant's Case

It is the Complainant's position that in 1984 he took out a Whole Life policy with the Provider (as it then was) through brokers who he says are now no longer in business. The Complainant states that to his knowledge this brokerage held the original policy documents. The Complainant states that at the time he wrote down the original Policy figures which included the sum assured and the monthly premiums. The Complainant states that unfortunately with house moves and clear outs these figures seemed to have disappeared. The Complainant submits that his broker at the time told him that this was the figure that his family would inherit on his death and was also the figure that he would receive on maturity in 2028. The Complainant says that of course he is now aware that none of this was true and would be altered over the years beyond all recognition. The Complainant states that from 1991 on, the Provider seemed to index link this policy by 5% p.a. In February 1999 the Complainant enquired about the encashment value of this policy and was quoted a figure of €6,150.36.

The Complainant states that whenever questioned the Provider maintained that the original figure assured was €99,441 which he knew to be incorrect. The Complainant states that when questioned regarding any of the figures quoted he remained sceptical as to their

veracity. The Complainant says that to this end he asked the Provider if it could furnish him with a signed copy of the original agreement. The Complainant says the Provider claimed that this was not to hand whilst at the same time seemed to be quite capable of quoting figures verbatim. The Complainant submits that the fact that the Provider's figures were so complicated and made no sense at all to him, he says he even began to think that the problem arose from conversion of pounds to Euro.

The Complainant submits having studied all of the figures that the Provider furnished him with over the last 32+ years he felt it prudent to query the figures and their origins and once again asked for an update on the encashment value of this Policy only to be told that this value had been "absorbed" into his policy, without any notification to, or agreement by him, in any shape or form either written or verbal. This the Complainant felt was way beyond any legal rights that the Provider felt that it may have held. The Complainant says that this action in itself, in his opinion required further investigation.

The Complainant states that at all times the Provider has maintained that the figure of €99,441 was the assured figure from 1984 and have re-iterated this "fact" in a number of its correspondences to him. The Complainant says that if this figure had been correct and taking into consideration the annual 5% increases from 1993 to 1998 this figure should have been €133,260. The Complainant states that in fact this €99,441 figure only came about on 5th April 1998 when he increased his policy level by a further 5% from £74,586 to £78,316 which on conversion to Euro becomes €99,441. The Complainant states that he does not know how the Provider now explain this error. He states that for him it brings into question all of the past figures including the absorbing of his policy encashment figure into the fund. The Complainant submits that the Provider has never satisfactorily answered any of his questions as to how this was achieved. He gave as an example that over the period 1999 to 2016, it would have added an extra €30.15 per month to the already inflated premium that was being charged over the 7 years. The Complainant says that also during this period his cover was reduced to less than 50% of the original cover for a much larger premium, and that is without this extra €30.15.

The Complainant says that basically he feels that, when asked for clarification of figures, the Provider has hidden behind what he would call "Insurance-speak", that it is less than transparent with its answers and has used his encashment figure without his permission.

The Provider's Case

The Provider states that the Complainant took his plan out through an independent financial intermediary and say that Independent financial intermediaries are regulated separately from the Provider by the Central Bank of Ireland. The Provider would not be responsible for any alleged act or omission of an independent intermediary.

The Provider states that as product provider it simply put the plan in place in line with the application received from the Complainant's independent Financial Intermediary.

It is the Provider's positon that the plan documentation issued to the Complainant at the time was clear on the nature of his chosen plan.

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The Provider states that it is worth mentioning that overtime the Complainant amended the managing agency on his plan from and to a number of other independent financial intermediaries. The Provider submits that it would be its expectation that the Complainant would have spoke with each of his nominated independent financial intermediaries over the years and as such would have had a full understanding about the nature of his plan and how it works.

The Provider states that the plan had accumulated a value of €6,150.36 by February 1999. The Provider states that in order to explain how this value was used it has set out a detailed explanation to demonstrate the relationship between the regular direct debit payment, the plan fund and how the plan fund is used to pay for the plan costs.

The Provider states that the plan is a reviewable whole of life protection plan. The Provider explains that each time a monthly direct debit payment was collected from the Complainant's bank account this payment purchased new units in his plan fund. Separate to this unit buying process units in the fund equivalent in value to the monthly costs are cancelled to pay for the plan charges. This includes the charges to provide the plan benefits.

The Provider says that this is the purpose of the plan fund and this is the mechanism by which payments to the plan are made and plan charges collected.

The Provider states that any units remaining in the fund after the deduction of the monthly plan charges make up the value of the plan at any given time. The Provider submits that the cost of providing protection benefits increases as one gets older and when the value of the plan fund, to which new units are being added each month by the recurring direct debit payment, reduces to a level where it is no longer sufficient to meet the plan charges going forward a plan review is necessary.

The Provider states that this process of units being cancelled each month from the plan fund to meet the plan charges is as set out by paragraph seven of the Complainant's plan terms and conditions, a copy of which was provided to him when his plan started.

Paragraph 7, states:

After the end of the deferred period, there is a mortality charge made each month by deduction from the units allocated to the policy. The amount of the charge is obtained by applying the mortality factor appropriate to the life assured's attained age to the excess of the sum assured over the value of the units allocated to the policy. For the purpose of this condition units are valued at their bid value.

The mortality factors adopted for the purpose of this condition will be determined from time to time by the company acting on the advice of the actuary.

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The Provider states that in line with paragraph seven of the plan Terms and Conditions any value that the Complainant's plan had accumulated was correctly used over time to meet his plans costs including the cost to pay for his valuable life cover benefit. The Provider states that this is why the value of his plan over time reduced to zero.

The Provider submits that it is worth highlighting that its correspondence of 18 February 1999, which confirmed that the current value at this time was €6,150.36, also provided an estimated future value for 1 April 2004 in addition to providing the estimated costs to maintain the plan over the period 1999 to 2004.

In February 1999 it was estimated that the value in April 2004 assuming a growth rate of 7.0% would be €5,971.58 (IR£4,703). The Provider states that this estimated value for April 2004 was approximately €178 less than what it actually was in February 1999 despite the fact that the payments to the plan increased from €9,511.61 (IR£7,491) to €14,524.53 (IR£11,439) over the period 1999 to 2004 — difference of approximately €5,013.

It is the Provider's position that this estimation clearly demonstrated how the plan fund is used to collect new payments into the plan in addition to paying for the plan charges which increase with age.

The Provider states that the current level of life cover (€44,535) on the Complainant's plan is correct and accurate.

The Provider states that Plan reviews are provided for by paragraph ten of the Complainant's plan Terms and Conditions. The Provider explains that when a review is conducted it looks at factors such as the value of the fund (if any), the benefits on the plan, age of the life assured and current mortality and morbidity rates. From this the Provider establishes the highest level of cover that can be obtained by continuing with the current payment and what payment is required in order to maintain the current benefits on the plan to the next review date.

The Provider says that all money paid into the plan is allocated to the plan fund and all plan charges due are deducted from the plan fund. When the value in the fund is no longer sufficient to meet the plan charges a review is conducted. The Provider submits that this is how the plan was designed to operate.

Paragraph 10 of the plan Terms and Conditions provide for it to be reviewed after its first ten years, every five years after that and annually once over the age of 70.

Paragraph 10 states:

"Ten years after the policy date and every five years thereafter and on each policy anniversary after the life assured has attained age 70 years the policy will be reviewed.

(i) *If at a review date the actual policy reserve is higher than the theoretical policy reserve the sum assured will be increased or, at the grantees request, the premium will be reduced.*

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(ii) *If at a review date the actual policy reserve is less than the theoretical policy reserve the premium will be increased or at the grantees request the sum assured will be reduced.*

The Provider's submits that as the Complainant's plan started in 1984 reviews were scheduled to be conducted in 1994, 1999, 2004, 2009, 2014 and annually going forward.

The Provider states that in 2004 it identified that reviews had not been carried out in 1994 or 1999. The Provider says to acknowledge that the Complainant's plan had not been reviewed in 1994 or 1999 it placed his plan on what are known as "term or preferential rates" going forward resulting in him being charged a significantly lower charge for his life cover than what he would have otherwise paid on the plans normal "contract rates".

The Provider states that this change at this time had the effect of allowing the Complainant to maintain the same level of cover on his plan until it became due for review again in 2010.

The Provider's position is that the amending of the Complainant's plan to term rates at this time was following consultations with then the Insurance Ombudsman of Ireland office on similar cases where plan reviews had not been carried out.

The Provider states that while it is satisfied that it has already paid for reviews not being conducted in 1994 or 1999 (by putting the plan on to term rates) it would like to offer the Complainant a €500 Customer Service Award for no communication being issued to him at these times in 1994 or 1999 (€250 per review).

The Provider submits that it reviewed the Complainant's plan in 2008 and again in 2009 and at these times wrote to him to confirm that his current payment would maintain his level of cover until the plan is reviewed again in 2010.

The Provider says that the 2010 review identified that an increase in payment was required at this time to maintain the same level of cover on the plan until its next review in 2015. The Provider gave options to the Complainant in late 2009. The Complainant at this time opted to reduce his cover to an amount that could be supported by the current payment that he was making. At this time the Complainant's payment remained at €72.71 per month with his cover reducing from €99,441 to €44,535.39.

The Provider states that it reviewed the Complainant's plan again in 2015 and at this time an increase in payment was required in order to maintain the cover until his next review in 2016 (annual reviews going forward as the Complainant was over the age of 70). The Provider submits that at this time the Complainant opted to maintain his level of cover by increasing his monthly payment.

The Provider states that from 2015 all reviews going forward were due on an annual basis as the Complainant was over the age of 70.

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The Provider reviewed the Complainant's plan again in 2016 and 2017 and at these times he opted to increase his payment in order to maintain the same level of cover on his plan until his next review in 2018.

The Provider says that the 2018 review options were issued to the Complainant on 5 February 2018. The Provider submits that in order to maintain the same level of cover until his next review in 2019 the Complainant would need to increase his payment from €104.15 to €112.39 per month. In addition the Provider has offered the Complainant the option to take out a new guaranteed whole of life plan which is not subject to future review. The payment on this plan is fixed for the rest of his life and there is no underwriting needed.

It is the Provider's positon that the increase required in each of the Complainant's reviews from 2010 have been quite modest and that this is as a direct result of the Complainant's plan being placed on term rates in 2004.
The Provider concludes that while it appreciates the Complainant's concerns at now being reviewed on an annual basis this is a feature of his plan as set out by paragraph 10 of his plan Terms and Conditions.

Further submissions from the parties

30th March 2018 - The Complainant's response to the Provider's submission:

The Complainant states that in or around 1984 he took out a number of policies, including the one in dispute, with the Provider (as it then was). It is the Complainant's position that all of these policies were taken out through the Provider's agents. The Complainant states that since taking out these policies he has never had any communication with the Intermediary and has only dealt and communicated with the Providers (original Provider and the Provider now in place). Over the years all monies paid in respect of this policy were collected by these bodies. The Complainant states that in fact in their original "Policy Conditions" the Provider describe themselves as "the Company to whom all premiums are to be paid". The Complainant submits that as the Intermediary is only agents or Sub Contractors to the Provider and no further contact is made or comes from them the onus must fall on the Provider as being the "Main Contractors" of this policy for any assistance or support and he cannot accept the Provider's claim to act as nothing but bankers and controllers of his policy. It is the Complainant's positon that in taking out this policy he was assured by the Intermediary that his life was covered to the figure in excess of £50,000 later to be converted to Euro payable on his death or in 2028 (age 85) whichever came first. The Complainant states that at that time there was never any question of this amount being altered or lowered as the years progressed. The Complainant says that the figure stated above of £50,000 is certainly the minimum quoted at the time by the Intermediary and could in fact have been considerably more.

The Complainant states that as the Provider has over the years issued him with varying figures of life cover he has always been at odds as to the actual amount covered. The Complainant says that the confusion that this caused has led him to believe that in fact errors had been made on conversion to Euro and to date it has not been fully explained.

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The Complainant states that in his own notes at that time he reflected that: *"I would not be surprised in the least if they claim that they are not to hand as the original figure has always been in dispute"* and a cause of confusion. The Complainant submits that predictably the Provider claims that it did not have the original Policy Document, but surprisingly, did have the original terms and conditions. Which would have been standard format at that time. The Complainant says that over the years he has had policies with various other companies all of whom retained perfectly detailed records.

On 18th February 1999 the Provider informed the Complainant that there was an encashment figure on the policy of €6150.36.

The Complainant state that the Provider claims that from the inception date he has had cover of £78,316 (€99,441) and yet he has furnished this office with documents (all furnished by the Provider) clearly showing cover of, £50,483 October 1989 and figures ranging from £58,440 in February 1992 through £74,586 in April 1997 to £78316 in April 1998. The Complainant states that on changeover to Euro just happens to covert to €99,441.11.

The Complainant submits that in April 2010 the Provider decided to either reduce his cover to €44,535 a massive 55% or to more than double his monthly premium from €72.71 to what he says is *an unbelievable* €159.23. The Complainant states that as his policy had been indexed since 1991 and suffered an increase of 5% p.a. until 1998 and he felt that he had paid dearly to have built it up to € 99,441, this reduction to him was illegal. The Complainant states that as he was extremely unhappy with this huge depletion and rise. He decided to query it with the possible intention of cashing it in completely, to that end he asked for a current encashment figure (believing that it would be considerably greater than the figure quoted in 1999) only to be informed that the Provider had taken *the whopping* €6,150.36 encashment figure and added it to its already inflated premium figure. It is the Complainant's position that he was never informed *in any way shape or form* of this *unauthorised* transfer and was never made aware of it. The Complainant's position is that this action was outside the Provider's remit and bordered on the illegal. The Complainant states that to put this move in context, over this 7 year period, his cover was reduced by 55%, his monthly premium rate was greatly increased and a massive €30.15 per month was added to his premium unknown to him and without his permission. The Complainant says that when he asked the Provider for an explanation of all of this it *"swamped"* him with *"Insurance speak"* and denial of any wrong-doing.

The Complainant submits that after these bizarre events of disputed figures, massive premium rises, denials of responsibility, and general evasion of all forms he no longer had any faith in the Provider or its evasive ways and decided to complaint to the Financial Services and Pensions Ombudsman. The Complainant says that to his mind none of the figures quoted or statements made by the Provider could have any credibility, credence or reliability.

The Complainant's positon is that he would agree that he feels that this policy was mis- sold to him as the Intermediary made certain claims at the time of sale that were utterly false and misleading. The Complainant submits that the Intermediary did not inform him at any

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time that the Intermediary and not the Provider, were wholly responsible for all aspects of this policy. The Complainant says that any correspondence relating to this policy came under the letterhead of the Provider. The Complainant states that he never received any communication in writing from the Intermediary. The Intermediary is said to have told the Complainant that his life would be covered to a figure in excess of £50,000 (which at a later stage would convert to Euro) and that he would receive a similar lump sum if he survived until his 85th birthday. It is the Complainant's position that he was never sent any Policy details either from the Intermediary or the Provider. The Complainant states that as far as he was, and is still, concerned the Intermediary was either employed by or sub-contracted to sell policies for the Provider as a Tied Agent.

The Complainant submits that he was extremely unhappy that the Provider quoted him an encashment figure of €6150.36 in February 1999 only to discover that over a 7 year period, unknown to him and without informing him, the Provider claims to have infused this figure into his account.

The Complainant says that as set out above, lack of original information at the time of sale led him to believe that, if he paid his monthly premiums the Provider kept him covered. The Complainant's says he will agree that as time progressed he did accept a rise in premiums but certainly not to the extent that they rose from 2010 onwards.

The Complainant submits that the Provider also mention the documentation issued at the time of his plan. The Complainant says that no such documentation was ever issued to him and the Provider itself acknowledge that it has no knowledge of such documentation.

The Complainant submits that the Provider also deals comprehensively with Assurance Levels and Premium Rates from 2010 onwards whereas there is little or no mention of the figures before this time. The Complainant says that significantly the Provider neglects any mention of the figures from 1991 to 1998 where in documentation submitted previously it clearly shows an anomaly between the claimed assurance figures and the true figures of that time.

The Complainant states that in the illustration submitted by the Provider which it states is "correct and accurate" the Provider:

> *"[S]hows the cover of £78,316/€99,441 as being the figure from inception, yet in other documentation (already submitted) this figure varies from £40K through £74 ½ K through the 1990s. Page 5 goes on to quote more figures and quite specifically singles out the years 1994 and 1999 where they claim that NO reviews had been carried out where my documentation clearly shows reviews BUT NOT ON THEIR FIGURES SHOWN IN THEIR ILLUSTRATION. The first paragraph on page 6 again clearly shows that they have no idea of the "state of or level of cover at this time. Again page 6 paragraph 3 this is reinforced where [the Provider] have no idea what they are about and are prepared to offer me compensation for? I have no idea. The rest of this section continues with figures which certainly cannot be relied upon"*

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The Complainant refers to the Policy conditions which he says he only received from the Provider during the latter part of the dispute. The Complainant states that the Provider does not have the Original Policy Document and he does not accept that an extremely important document such as this has not been retained on his file.

The Complainant explains that in 2003 he was a member of the National Guild of Master Craftsmen. Part of the Guild's service was to advise on investment and insurance matters. In December 2004 the Guild looked at the Complainant's various policies and sent him out a schedule. The Complainant states that the only advice that he can remember receiving from the Guild at that time was to cancel some of the policies taken out with the original Intermediary in 1984 as *they were a waste of money*. The Complainant states that over the ensuing years "The Guild" seemed to change agents but to his knowledge he never sought or received any meaningful advice.

The Complainant notes that the Provider did not produce or include any documents dated from 1984 to 1999.

The original Provider was taken over and it is the Complainant's opinion that all the original records of his policy have either been lost or mislaid and that the Provider has no records of his policy before 1998. The Complainant states it is his belief that any queries about his account prior to 1998 are not available to the Provider, hence the Provider seems to pluck their figures out of the sky.

The stated reasons for the Complainant's assumptions:

> *" [The Provider] maintain that his life cover has been £78,316 / €99,441 since 1984*
>
> *No reference to this figure of £78,316 / €99,441 can be found on any [Provider] document dated before 1998.*
>
> *This figure first came to light on [a Provider] document dated 9th February 1998 on an annual Indexation Notice, being a 5% increase on £74,587 from year 1997 culminating in a figure of co-incidentally £78,316 / €99,441.11*
>
> *Why has no reference whatsoever been made to these indexation notices in [the Provider's] comprehensive dossier?*
>
> *This was the 8th of 9 Indexation Notices taken up over the previous 8 years, the 9th notice was not taken up, which begs the question, If I had taken it up would the original 1984 [Provider] figure on their table have shown £82,232 / €104,413 as shown in their 9th Indexation Notice I / We shall never know.*
>
> *In a letter to me from [the Provider dated 24th February 2016, on page 6, paragraph 3 it is stated that "Had you passed away in the earlier years of your plan, for example 2009,]the Provider] would have paid out the life cover of € 99,441" they go on to say "if you had paid in €15,000 before 2009, [the Provider] would still have paid out €99,441 life cover" stating that this was "part of their risk". This is a clear indication*

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that they maintain that my life cover is and always has been €99 441. All of this statement is completely at odds to all of the figures shown on their Indexation Notices and begs the question of how can any of the figures quoted by [the Provider] be anyway credible.

If their 1984 figure £78,316 were correct then they would have been completely wrong of them to have somehow reduced this figure from £ 78,316 in 1984 to £ 55,657 in 1991. That is an unbelievable cut of £32,660 / €41,470 in 7 years.

Either way it is obvious that [the Provider] figures are totally unreliable and based on completely false and fictitious assumptions. This in turn has got to bring into question (a) the amount that I may have been overcharged or lost over the years (b) whether they were in any way justified in reducing my level of cover in 2010 (c) if they had any right to use my encashment figure along with my premiums, especially without consultation and (d) what they plan to do to correct this blunder".

9th April 2018 - The Provider's response to the above:

"Having reviewed [the Complainant's] correspondence we are satisfied that we have already responded in significant detail to all of the issues in our submission of 9 February 2018.

As such we have no further comment to make only to clarify again that [the Complainant's] benefits index linked from inception to an amount of IRL£78,316 which correctly converted to €99,441 on 1 January 2002. [The Complainant's] most recent letter includes his indexation notices showing his death benefit indexing over the years to this amount of IRL£78,160.

As a result of plan reviews in 2010, 2015 ,2016, 2017 and 2018 the cover on [the Complainant's] plan reduced to its current sum assured of €44,535. This sum assured is correct and accurate and I refer [the Complainant] again to the table set out on page 4 of our Explanation of conduct complained of dated 9 February 2018. The purpose of this table was simply to illustrate the reduction in cover from its conversion in euros to its current amount".

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 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.

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 22nd October 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.

The Complainant acknowledged receipt of the Preliminary Decision on 27th October 2018 and advised that he had no further submission to add. There was no further correspondence from the Provider.

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 1984 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 Policy was sold by an Independent Intermediary. The Provider would not be answerable for any alleged act or omission of an Independent Intermediary. The fact that the sale occurred in 1984 is also noted, and the passage of time would impact on an examination of same.

While the sale of the policy in 1984 is not being examined here, a key point is that conduct of an ongoing nature allows in certain circumstances a consideration by this office of conduct which might initially have started or been caused by conduct that occurred beyond the 6 year limitation period, but which continues up to a more recent point in time which brings aspects of this complaint within the jurisdiction of this office. I accept some of the conduct of the Provider was of a continuing nature. I also accept that the Complainant only became aware in recent years of some of the Provider's conduct, the subject matter of the examinable aspects of the complaint here.

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

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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 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 1994 (on its 10th Anniversary) in accordance with the policy conditions. The Provider accepts that it did not Review the policy in 1994, nor in 1999. The policy was scheduled for review again in 2004, 2009, 2014 and annually thereafter, as the Complainant had turned age 70yrs in 2013. It was not until 2004 that the Provider communicated to the Complainant the results of a review that it had carried out then.

The Provider acknowledges that the Complainant's plan had not been reviewed in 1994 nor 1999 and because of this, it placed his plan on what are known as "term or preferential rates" going forward. The Provider says that this resulting in him being charged a significantly lower charge for his life cover than what he would have otherwise paid on the plans normal "contract rates".

The Provider states that this had the effect of allowing the Complainant to maintain the same level of cover on his plan until it became due for review again in 2010.

The Provider's position is that the amending of the Complainant's plan to term rates at this time was following consultations with then the Insurance Ombudsman of Ireland office on similar cases where plan reviews had not been carried out.

However, I find no evidence in the documentation of the Provider communicating to the Complainant in 2004 that it had missed the previous reviews or that it was adjusting the term rates going forward. This information was not communicated to the Complainant in 2004 or in the subsequent years. The first time that the Complainant was made aware of this was in the Provider's response to this complaint.

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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 the 2009 Review correspondence, the Provider advised that: *"we anticipate that your payments will not be enough to maintain your current level of benefits from 05/01/2010.* On the basis that the 2010 Policy Statement showed 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 from the fund, in addition to the premium payments being made.

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 gives the Provider 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 to 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 and not communicating same to the Complainant over the years. I also consider that the Provider could have communicated in a clearer and earlier manner that the premiums being paid by the Complainant were not sufficient on their own to provide the cover under the policy. It is clear that for some time that this was the position and the policy fund was being used in addition to the premium payment to cover the cost of the policy benefits.

Not knowing the full position of what the Provider was doing i.e. using the fund in addition to the premium payments, 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 the 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 the fund deduction process when it happens is another matter). In this complaint, I consider that the Provider could have been clearer in its communication of the position, particularly in the 2009 communication and in later Reviews where it is clear that the fund had been exhausted, without any communication that the premium payments alone were no longer sufficient.

As stated above it is not clear from the information to hand, from what time it was necessary for the Provider to reduce the policy fund to support the premium payments. A reduction however, for that purpose appears to have happened, as the fund was exhausted to a nil value in 2010. While the policy provisions do highlight that the fund value would be used,

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in addition to the regular payment, to fund the protection benefits, the Provider did not communicate to the 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 being informed of the action of decreasing the fund to pay for the policy cover, was that the Complainant 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 his younger years was also lost to the Complainant.

In the above regard, I do not accept that it was reasonable of the Provider not to communicate over the years that it had failed to carry out some reviews at their scheduled dates (ii) that reduced rates were being applied to reflect the missed reviews (iii) that the cost of cover had exceeded the premium payments, and (iv) that the fund value was being relied upon to pay for the life cover 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 all of the scheduled Reviews (b) did not early communicate to the Complainant that the Reviews were missed or (c) did not communicate when (which appears to have been the position for some time) it had begun using the fund value to supplement the premiums that were being paid by the Complainant.

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.

The Complainant also questioned the Sum Assured figures submitted by the Provider. While I am satisfied that the figures submitted by the Provider reflect the cover that was provided by the policy over the years, I do consider that there could have been a clearer communication by the Provider in its submissions on this matter. The Sum Assured was index linked for a time, and would have been reduced as part of the options selected by the Complainant over the years. The mis-communication in the complaint responses by the Provider, was that the value of €99,441 was available from when the policy was taken out in 1984. This is not correct.

An example of where the Provider has confused matters is where it states in its letter of 4th March 2016 that:

> *"You have paid €24,444.06 to [The Provider]. In return, you have been provided with life cover of €99,411 until 2009 and €44,535.39 since then. You have been paying [the Provider] to provide you with life cover, in the event of your passing.*
>
> *You have had the benefit of life insurance on your life for the past 32 years that would have been paid out to your estate or next of kin had you passed away. You paid €24,444.06 for this insurance"*

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This implies that the €99,411 was the life cover that had been in place from 1984 to 1999, when in fact a lower sum would have been available at different stages up to that point. The original sum assured had increased on a number of occasions up to 1999, due to the implementation of the indexation option. Therefore, it was incorrect of the Provider to communicate that the Complainant was provided with life cover of €99,411 throughout that entire period.

The Provider further confused matters by submitting (on 9th August 2018) a table of information showing that in 1984 the sum assured was £78,316 which converted to €99,411 in 2010, when in fact it was not until 1998 that the sum assured had reached that figure through the implementation of the indexation option over the intervening years.

For example, it is noted that in 1992 the sum assured was £58,440, in 1993 the sum assured was £61,362, and in 1977 the sum assured was £74,586.

I accept that the above lapses by the Provider were unreasonable and incorrect. However, the position is that the Complainant had life cover in place and that the life cover had to be paid for. Therefore, I do not consider that a refund of premium is required here. However, I do consider that a substantial compensatory payment is merited. Having regard to all of the above it is my Legally Binding Decision that the complaint is partially upheld and I direct the Provider to pay the Complainant the compensatory payment of €8.000 (Eight thousand euro). This compensatory payment is in addition to the €500 already offered by the Provider. The Complainant must now decide what cover options he wishes to maintain with the Provider. If he keeps the current policy in place, it is inevitable that increases in premium will occur over the years. The Provider has offered another option which would provide certainty as to the payments that have to be made. Ultimately it is a decision that the Complainant must make himself, and the assistance of an independent advisor may be prudent.

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 make a compensatory payment to the Complainant in the sum of €8,000, 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

14th November 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.