An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0162
Sector:	Investment
Product / Service:	Pension
Conduct(s) complained of:	Fees & charges applied
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant took out an initial unit contract in May 1992 called a Private Pension Plan. It is the Provider's position that the policy was sold to the Complainant by independent financial advisors / Financial Consultants. The Complainant disputes that the Financial Consultants were his advisor.

The complaint is in regard to the policy fees and charges applied to date. The Complainant is not happy with the:

> *"exorbitant charges — the sum invested verses the charges applied. The total lifetime charges exceed the sum invested by approx. 75% and the annual charges equate to approx. 65% of the policy growth".*

The complaint is that (i) the Provider is incorrectly and unreasonably deducting excess charges from the policy fund, and (ii) the Provider is incorrectly stating that there was an Independent Intermediary in place.

The Complainant's Case

The Complainant's complaint is that the administration charges applied to a dormant pension fund are exorbitant, exceeding the growth and final projected fund value. The Complainant says that the policy does not represent anything like value for money, nor the

interest of the customer. The Complainant states that the policy history summary is as follows:

The Complainant states that the sum invested (€11,329.23) is less than the charges applied to the policy (€19,849.37). That the current value of the policy (€5,543.46) is significantly less than the sum invested. The Complainant says that the projected final value of the policy (€10,227.86 - €10,531.79) is less than the sum invested and approximately 50% of sum of the charges applied. The Complainant submits that the total lifetime charges exceed the sum invested by approx. 75% and that the annual charges applied equate to approx. 65% of the policy growth.

The Complainant wants the Provider to:

- stop applying exorbitant annual administration charges
- refund a large proportion of those applied.
- enable the transfer value of this policy to equal its current fund value.
- enable him to extract value from this investment.

The Provider's Case

Overall the Provider's position is that:

- The Complainant was or ought to have been aware of the charges applicable to his policy when it was taken out.

- The Provider was not a party to the sale.

- In 1992 the documents at outset (i.e. the policy schedule, policy terms and conditions etc) were sent to the Complainant's Broker who would have been obliged to give these documents to their customer.

- The Provider has not acted outside the terms and conditions.

- The Complainant took out a policy that was intended to pay in premiums until retirement (long term investment). The fact that the Complainants circumstances changed so soon into the policy term (2 years and 4 months) has impacted on the overall value and charges. It was the Complainant's decision to stop paying his premiums.

The Provider states that it is satisfied that it has administered the policy in line with the policy terms and conditions.

Submissions from the parties

It is the Provider's position that its terms and conditions allow it to deduct the future charges should the policy be surrendered prior to age 70. The Provider says that this is confirmed under the policy terms and conditions as follows:

/Cont'd…

"Section 2 — Phased Retirement (b) The proposer may by notice in writing to the Company elect to receive benefits under any one or more of the Retirement Policies ("The Surrendered Policies"), while deferring receipt of benefits under the remaining Policy or Policies. On receipt of this election and subject to the provisions of paragraphs 3(b), 3(d), and 3 (f) the units applicable to the Surrender Policies shall be applied (after due allowance for the full value of the Supplementary Management Charge as described in paragraph 10 by the Company in the provision of benefits".

Section 10 — Management charges

(a) *— The Company shall be entitled to deduct from the fund a management charge as may be determined from time to time by the Company.*

(b) *— The Company shall be entitled to deduct from the Fund at monthly intervals a Supplementary Management Charge equal to 0.45 percent of the value of the units allocated in respect of the first 2 years premiums due under the retirement policies and any associated policies. The supplementary management charge will be applied only to the specified units and will cease at age 70.*

(c) *The supplementary management charge will be applied only to the specified units and are written to age 70. This charge is deducted at surrender regardless of the customer's age".*

The Provider states that the risk benefits below also applied to the policy while it was in force from May 1992 to August 1994. The Provider says however these risk benefits lapsed from September 1994 as no more premiums were being paid.

Benefit	Life Cover
Decreasing Term Assurance	€419,966 (£330,750)
Permanent Health Insurance	€16,753 (£13,194)
Personal Accident (PA)	€16,753 (£13,194)
Waiver of Premium	€5,371 (£4,230)

The Provider points out that the risk benefits above were the amounts when the risk benefits lapsed in September 1994. They weren't the original amounts from the outset. The Provider says that the reason is because this policy had indexation. The sum assured automatically increases by 5% on each policy anniversary date without the need for the increase in sum assured to be medically underwritten.

The Provider outlines how the policy works as follows.

"Year 1 & 2

The policy was set up to use the first 2 years contributions to invest in initial units and on any premium increase thereafter.

These initial units differ from normal units by carrying an additional management charge in this case an extra monthly charge of 0.45% per month (5.4% per annum). The initial units on the product are written to age 70. This is also known at the

/Cont'd…

supplementary management charge mentioned in our Annual Benefit Statements and terms & conditions.

This charge was outlined in the policy terms and conditions given to the Complainant at outset. The booklet is called Private Pension Plan, Policy Booklet. It's outlined under Part Section 10 (a) — Management charges as mentioned above.

Year 3

After the second year the premiums were invested in accumulation or normal units. The same would apply on any premium increase.

In May 1994 we received a letter from the Complainant looking to postpone his May premium. We confirmed to him in July 1994 that the May premium was skipped.

We received premiums for June, July and August 1994. From June 1994 to August 1994 (3 months) the Complainant purchased accumulation or normal units.

In October 1994 the Complainant wrote to us again asking us to postpone payments on his policy indefinitely. We altered the policy to a "paid-up" status from September 1994. This resulted in the risk benefits (outlined above) lapsing as no more premiums were being paid".

Current position

The Provider states that the initial amount of units that would be deducted is 499.52. This it says accounts for the extra 0.45% a month up to age 70. This outstanding charge results in the difference between the current value and the surrender value.

The Provider states that the debt of €855.13 on the policy is as a result of the risk benefits that were attached to the policy when it started in 1992. The Provider explains that the cost of the risk is taken by unit deduction. It says however the risk benefit charges (mentioned above) cannot be deducted from the initial units. The Provider states that unit deduction can only be taken from accumulated units. As there were not enough accumulated units to cover this cost of the risk (only 3 months), the outstanding cost was then added to the debt. The Provider states that the same applies to the pension levy. The Provider submits that as this policy was made paid up since 1994, the policy never cleared the cost that was added to the debt.

The Provider states that if premiums continued to be paid the debt would disappear during the course of the policy. However, because premiums were stopped in 1994 the accumulation units for the 3 months were immediately wiped off to cover the debt that had built up on the policy (i.e. to cover the mortality charges (risk benefits) that had accrued for the first 2 years).

/Cont'd…

The Provider says that therefore the outstanding charge value is currently €7,719.58, in addition to the debt of €855.13.

This the Provider states was confirmed in the policy terms and conditions called the Private Pension Plan, Policy Booklet. It's outlined as follows:

Part 1, Section 2 — Phased Retirement (b) as previously mentioned above.

Part 1, Section 5 — The funds —

> *"The company shall be entitled to deduct from a fund, or from the income of a fund, such amounts as shall be determined by the Company in respect of:*
> *(i) Amounts in respect of management charges as described in paragraph 10".*

Part 1 Section 9 —

> *"Unit Allocation & Unit switching (b) — Units allocated in respect of the first 2 years' premiums due under the retirement policies shall be subject to a supplementary management charge as detailed in paragraph 10".*

Part 1, Section 10 — Management charges (a) a (b) as previously mentioned above.

Part 1, Section 11 —

> " Cancellation of Units (b) — *if at any time, there are insufficient units attaching to the Retirement policies to meet the costs detailed above then such costs will be carried forward as negative units to be applied in cancelling or reducing future allocations of units to the Retirement Policies until all negative units are expended".*

It is the Provider's positon that the 2015 Annual Benefit Statement shows the current value and the surrender value. The current value includes outstanding initial unit charges that are yet to be deducted. This along with the outstanding debt on the policy led to the difference between current value and the surrender value on the Annual Benefit Statement

The Provider states that in June 2016 the Complainant confirmed he was not happy with how his policy has performed and did not view the product anything like what you would call *"value for money".*

The Provider's letter of 28 June 2016 stated that the information that it provided the Complainant over the course of the complaint was correct.

Total premiums paid:	€11,329.29
Total charges:	€19,849.37
Surrender Value:	€5,446.77

The Provider submits that in essence, the Complainant is contesting the policy charges.

/Cont'd…

The Provider states that the Complainant is contesting the chargeable nature of the policy when he was clearly informed of its charging structure when he took out the policy. The Provider says that the Complainant is seeking that it waive these charges and transfer the current value. The Provider's positon is that unfortunately it is unable to offer this as it says this policy has been administered as per the policy terms and conditions.

The Provider states that it did not sell this product to the Complainant, but that the Policy was originally sold to the Complainant in May 1992 by an independent financial adviser.

The Provider's position is that at outset, the Independent Intermediary (no longer in operation) acted on the Complainant's behalf in arranging this policy. The Provider says that the Intermediary is responsible for the financial advice it provides to its clients pre and post the inception date of a policy. The Provider states that the Intermediary was also responsible for explaining both the workings and features of the product prior to the Complainant completing the application form.

The Provider submits that its role was to establish the policy based on the completed and signed application form received, and administer it in accordance with the policy terms and conditions. The Provider says that it was the administrators of the policy and that it did not provide financial advice to the Complainant in relation to any of its policies or the options available. If the Complainant required financial advice at any time, the Provider says he needed to seek the services of the Independent Intermediary. The Provider submits that it is happy to address any aspect of the complaint relating to the administration of the policy, however it cannot comment on any discussion which took place between the Complainant and the Complainant's Financial Advisor on the suitability of the product.

The Provider states that an onus also rested with the Complainant to ensure that he was familiar with both the workings and features of the policy in particular the policy fees and charges. The Provider says that that the Complainant was also responsible for monitoring his own policy. The Provider states that the Complainant also had a responsibility to seek the services of his financial advisor if he required financial advice at anytime.

The Provider states that it issued the 2015 Annual Benefit Statement to the complainant on 04 April 2016. On 28 April 2016, the Complainant telephoned to complain about the policy fees and charges detailed on his Statement. On 06 May 2017, the Provider telephoned the Complainant to explain the workings of this pension product and how the charges apply. The initial unit charging structure was also explained at this stage.

The Complainant requested that this information be provided in a letter, along with a full explanation of how the product works.

In its letter dated 10 May 2016, a full explanation of the product and charges was given by the Provider:

/Cont'd…

> *"The above policy is an initial unit policy. The initial units are bought with the premiums paid in the first 2 years of the policy and on any premium increase thereafter. The premiums after this period are invested in accumulated units. The initial units carry an extra monthly charge of 0.45% per month (5.4% per annum). The initial units on your product are written to age 70."*

The Provider's position is that this is confirmed in its policy terms and conditions given to the Complainant at outset

The Provider's letter then goes on to state that:

> *"The debt on the policy is as a result of the risk benefits that were attached to the policy when it started. The pension levy was also added to the debt. The cost of the risk is taken by unit deduction. Unit deduction can only be taken from accumulated units. As there were not enough accumulated units to cover the cost of the risk, the outstanding cost was then added to the debt. The same applies to the pension levy. This debt would then be cleared over time when the policy starts to invest in accumulated units. As your policy was made paid up in 1994, the policy never cleared the cost that was added to the debt".*

It is the Provider's position that again this was confirmed in its policy terms and conditions.

> *"Part 1, Section 11 (b) — Cancellation of Units*
>
> *If, at any time, there are insufficient units attaching to the Retirement Policies to meet the costs detailed above then such costs will be carried forward as negative units to be applied in cancelling or reducing future allocations of units to The Retirement Policies until all negative units are expended".*

The Provider states that its system calculates the initial unit charge that is applicable to the policy over its term. This charge is applied to the policy as an initial unit discount. This discount is then drawn from the policy by way of unit deduction every month. The Provider says that if the policy is transferred before age 70, the remaining initial units are withdrawn from the policy at claim stage. This it says was confirmed in its policy terms and conditions:

"Section 2 — Phased Retirement (b) of the policy terms & conditions:

> *"The proposer may by notice in writing to the Company elect to receive benefits under any one or more of the Retirement Policies ("The Surrendered Policies"), while deferring receipt of benefits under the remaining Policy or Policies. On receipt of this election and subject to the provisions of paragraphs 3(b), 3(d), and 3 (f) the units applicable to the Surrender Policies shall be applied (after due allowance for the full value of the Supplementary Management Charge as described in paragraph 10 by the Company in the provision of benefits".*

Section 5 — the Funds (e)

/Cont'd…

"The company shall be entitled to deduct from a fund, or from the income of a fund, such amounts as shall be determined by the Company in respect of: (i) amounts in respect of management charges as described in paragraph 10".

Section 9 — Unit Allocation & Unit switching (b)

"Units allocated in respect of the first 2 years' premiums due under the retirement policies shall be subject to a supplementary management charge as detailed in paragraph 10".

In May 2016 the Complainant requested further information from the Provider. Its response was outlined in its letter of 18 May 2016.

On 19 May 2016 the Complainant asked if the charges in the letter were correct.

On 24 May 2016 the Provider stated to him that they were correct.

A further request was received from the Complainant on 24 May 2016 for a projection of the charges to be applied to age 65. This projection was sought from the Provider's Actuarial team and was sent to the Complainant by email on 31 May 2016.

In response to the Provider's email of 31 May 2016, the Complainant contacted the Provider on 21 June 2016 to advise that he was unhappy with how the policy had performed and that he did not view his policy as value for money.

A more detailed explanation was given by the Provider in relation to the projected charges to age 65 (as requested in the Complainant's email of 24 May 2016) as this had been misinterpreted and deemed to be a policy projection and not a charges projection.

In the Provider's response, issued on 28 June 2016, it stated that the total premiums paid, total charges and surrender value were as follows:

Total premiums paid: €11,329.29
Total Charges: €19,849.37
Surrender Value: €5,446

The Provider states that these are projections only and are based on fund performance and are not a reliable guide to the future performance of the investment.

The Provider's correspondence outlined the total charges at the time of issue as €19,849.37, with the projected charges to age 65 reducing to €10,227.86.

On 22 December 2015 the Provider wrote to the Complainant to advise him that it was closing some of its existing funds and would be switching in to alternative funds. The Complainant was invested in the Provider's Retirement Managed Fund and it was going to switch into the Dynamic fund.

The Provider advised the Complainant that if he was happy with the new fund choices he did not need to do anything. However, if he wanted to switch into different funds, he could

/Cont'd…

do so if the funds were available on his product. The Provider recommended that he speak with his financial advisor before making any changes.

On 10 November 2016 the Provider wrote to the Complainant advising that it had now closed the Retirement fund and switched him into the Dynamic Series fund with effect from 14 October 2016.

The Provider's position on the issues raised by the Complainant

The Provider states that from the start of the policy, the policy fees and charges have been outlined in the policy terms and conditions and the Provider is satisfied that the it has been administered correctly.

As regards the Complainant's assertion that the transparency and language of the alleged terms and conditions is very low, the Provider states that its terms and conditions state that the policy is subject to supplementary management charges to the specified units and will cease at age 70.

The Provider says that there was an onus on the Complainant to make sure that he knew how his policy worked and that the workings of the policy was tailored towards a long term investment for retirement.

The Complainant states while the policy update statements point to reasonable growth, the majority of the annual appreciations go to the Provider for example the change in policy value from December 2014 to December 2015 was €1,238.48 of which €824.58 was applied as a policy fee and charge.

The Provider's response is that the figure of €824.58 charge outline in the Annual Benefit Statement 2015 is the monetary amount of the initial units that were drawn off the policy for that calendar year (2015). The Provider says that its system calculates the initial unit charge that is applicable to the policy over its term. This charge is applied to the policy as an initial unit discount. This discount is then drawn from the policy by way of unit deduction every month. If the policy is transferred before age 70, the remaining initial units are withdrawn from the policy at claim stage.

The Provider states that there is also an annual management charge of 0.50% - this charge is an annual management charge and is taken in the daily unit price and does not affect the unit holding.

The Complainant's position is that the pattern is repeated annually, guaranteeing that the Provider charges to date exceed the original sum invested by almost a factor of 2, and will increase over the remaining years of the policy.

The Provider's response is that this is a long term investment however premiums ceased to be paid since August1994 and that this has impacted on the overall value and charges. The Provider states that from the outset that its terms and conditions outline how this policy worked and that there was an onus on the Complainant to make sure that he knew how the policy worked. The Provider says that if the Complainant was unsure about anything he needed to speak to his financial advisor.

/Cont'd…

The Complainant states that the clear predominate beneficiary from this policy, and any others like it, is the Provider.

The Provider's response is that it was the Complainant's decision to stop paying his premiums. This policy is a retirement policy and was designed as a long term investment. It is a frontend charge plan because most of the charges are made at the "front" or beginning of the policy. The Provider states that it is unfortunate that the Complainant decided to stop his premiums so early into this investment.

The Provider states that its Actuarial Department carried out a high level calculation based on assumptions that this policy was not stopped in 1994 and continued to pay premiums (for simplicity they assumed level premium rather than indexing premium). This calculation showed that if the Complainant had continued to contribute into the policy, it would have a surrender value in the region of €215,000 versus premiums paid in of €128,000.

The Complainant states that the Provider has been unable/unwilling to supply copies of documents showing his agreement to or transparency of the terms and conditions from the time the policy commenced.

In response the Provider submitted 2 copies of the same application form and advise that the reason is the first copy has only the first page. The second copy has the 2 pages but it is a very poor copy. The Provider states that it must be noted that it could not have started this policy without the Complainant's signature.

The Provider submits that on 17 January 2017 it issued the Complainant with copies of his policy schedule, policy terms and conditions, his instructions to make the policy paid up and confirmation that policy was made paid up.

The Provider accepts that the wrong terms and conditions were issued to the Complainant in January 2017 and apologises for the inconvenience caused.

It is the Provider's positon that if the Complainant had requested any information on his policy it would have provided it at any time.

The Complainant submits that in his efforts to date the Provider has acknowledged most of the simple facts of this scenario but have not moved an iota towards meeting any of the mitigations suggested in his original complaint as submitted to the Financial Services Ombudsman.

The Provider states that it is unable to waive the charges because it is satisfied that this policy has been administered as per the policy terms and conditions. Also it would be unfair to other customers who are invested in a similar policy.

Provider's explanatory note on factors that affect policy charges.

<u>Factors that affect the charges</u>

> *"Cost of Life Cover*
>
> *The policy has accumulated debt. This is as a result of the risk benefits that were attached to the policy when it started. The pension levy was also added to the debt. The cost of the risk is taken by unit deduction. Unit deduction can only be taken from*

/Cont'd…

accumulated units. As there were not enough accumulated units to cover this cost of the risk, the outstanding cost was then added to the debt. The same applies to the pension levy. This debt would then be cleared over time when the policy starts to invest in accumulated units. As the policy was made paid up in 1994, the policy never cleared the cost that was added to the debt.

Fund performance

The initial unit charge is 5.4% per annum (of the initial units bought). The overall charge is directly linked to the fund performance. As the unit price has grown substantially, this has increased the value of the units that have been drawn off the policy with respect to the initial unit charge.

For information: The bid price of the Retirement Managed Fund on 15 May 1992 was €4.336 and the bid price at 16 May 2016 (before the fund switch in November 2016) was €23.664"

The Complainant's response of 7th September 2017 to the Provider's submission is as follows:

Relationship with the Provider

The Complainant states that the assertion is repeated that the Provider did not have a direct relationship with him and therefore either cannot supply certain documents or account for some correspondence, advice etc. The Complainant says that this contrasts directly with his experience. The Complainant submits that he discussed and agreed the policy and cessation of premiums with an employee of the Provider and that recently this employee confirmed this. The Complainant states that he had no dealings with the Intermediary.

The Complainant says that any communications about the policy were with the Provider's employee FG directly either in person or through a Provider address. The Complainant's position is that he had a direct relationship with the Provider and therefore it is fully responsible for communications and the relationship.

The Complainant submits that the Provider has not shown any evidence that the policy was sold to him by an independent adviser. The Complainant states that he can recall the places he discussed and agreed to the policy with FG. The Complainant says he has no recollection of dealing with anyone from the named Intermediary nor where they were located etc.

On the point of "having a responsibility to have a financial adviser" the Complainant questions whether the Provider is suggesting that its customers require a financial adviser to understand or to get fair terms from a pension provider.

Supplying Relevant Documents

The Complainant states that the core dispute issue relates to policy charges, value to the customer and related communications. The Complainant submits that while the Terms & Conditions may contain wording that explains these in the view of the Provider, he can confirm that at no point were they explained to him in terms of real life charges and value, either at policy take up or when premium payments ceased. The Complainant says that if

/Cont'd…

they had been, he would not have taken out such a policy, nor would he be surprised when he reviewed most recently supplied statements - because it would not represent a sensible investment.

Fairness to Other Clients

The Complainant states that he notes the Provider's suggestion that if it addressed his concerns about value etc. that this would be unfair to other clients. The Complainant submits that the point should be that if this process results in action being taken in his favour, it should be of course applied to anyone else with similar circumstances and policies with the Provider. That would be fair and reasonable.

Supplied Documentation and Correspondence

The Complainant says it is notable that there are significant gaps in supplied correspondence dealing with policy commencement, cessation of payments etc. between 1995 and 2004 and between 2004 and 2008. The Complainant questions why is this when there is reference to annual statements being issued.

The Complainant states that Annual statements outlining charges etc. only applied from 2012. The Complainant states that therefore, despite the Terms & Conditions relevance/accuracy issue outlined above, it's also clear that meaningful communications around annual value, fees and transfer value only commenced in 2012.

The Complainant says that the point that the Provider was not involved in the sale of this product is incorrect if it is taken that the Provider was operating under another name previously.

The Complainant questions even if he dealt with a broker, should that exempt the Provider from any responsibility when its name is on all the policy documents and there is no reference to the broker.

The Complainant says that the application form completed in section 8 refers to a retirement age of 60 and asks how does this relate to other statements that the policy runs to age 70.

The Complainant questions why is it that in some years i.e. 2009, 2010 and 2011, no management charge is noted in the annual statement despite the 0.45% monthly charge clause referred to elsewhere and why were charges applied from 2012.

The Complainant states that he notes the difference in detail between pension statement correspondence in 2009 and those from e.g. 2016. He says while it shows a loss of funds (*unsurprising in the prevailing financial markets at that time*) it makes no reference to other ongoing charges, or encashment value.

The Complainant submits that there is no document supplied by the Provider which demonstrates a known relationship between him and the alleged, now defunct broker.

The Complainant states that the issue here is that if the Provider was to agree with him it would be unfair and unreasonable for it to not look at other similar policies which are paid up and not follow up based on the outcome of this dispute.

/Cont'd…

The Complainant states that the issue of an indirect relationship involving a broker was not detailed in response to his initial 2016 queries.

The Complainant submits that while the Provider alleges that more recent consumer protection legislation did not apply in the early-mid 1990s, he considers that the principal of fair terms is applicable in both Irish and European law.

The Complainant states that the core issue remains namely: *is it reasonable that the charges on a policy should exceed the premiums paid by such a large factor and should the transfer value of a paid-up policy be so meagre relative to the current value*.

The Provider's response of 21st September 2017 to the above submission:

The Provider submits that Mr G's role as a sales consultant for the Provider was to give information in relation to the product. The Provider says that its sale consultants do not give advice to customers directly, and that their role is to engage with brokers. The Provider states that it cannot comment on alleged conversations that Mr G may have mentioned in his communication with the Complainants.

The Provider's positon is that all customers require a financial broker to ensure that the product they are selecting is suitable for their own individual circumstances & needs. The Provider says it was the underwriter on this policy. On the first page of the proposal form it states "this cover is underwritten by [Provider's name]". The Intermediary is named as the agent/broker on 4th page of the policy schedule part D. Their agent number was C***.

The Provider submitted copies of screen prints showing that the introductory agent on the policy was agent number C***. It says that they were the brokers on this policy from May 1992 until they were cancelled on 7 December 2004. It is the Provider's position that the Broker was responsible for the financial advice they provide to their clients pre and post the inception date of a policy.

The Provider states that its role was as underwriter and policy administrator and to establish the policy based on the completed and signed application form received, and administer it in accordance with the policy terms and conditions.

The Provider says that an onus also rested with the Complainant to ensure that he was familiar with both the workings and features of his policy and to seek the services of his financial advisor if he required financial advice at any time. The Provider submits that it cannot comment on any discussion which took place between the Complainant and the financial broker on the suitability of the product.

As regards supplying relevant documents, the Provider states that in 1992 the policy schedule and policy terms and conditions were sent to the financial broker who had an obligation to give these documents to the Complainant.

As regards fairness to other clients, the Provider states that the policy was effected through a broker. The Provider submits that the policy charges and structure should have been discussed at point of sale (which it says it was not party to). The Provider states that any issues on the suitability of the product must be referred back to the broker. It is the Provider's positon that it has administered the policy in line with the policy terms and conditions. The Provider clarifies what it meant by its previous statement here was that it

/Cont'd…

cannot override the policy terms and conditions for one customer just because they are unhappy. The Provider says it does not agree with Complainant's assertions.

As regards the supplied documentation and correspondence, the Provider explains that this is a historic policy sold in 1992. The Provider states that it endeavours to disclose its charges through its Annual Benefit Statements. The Provider says that it has developed and improved these throughout the years and that it is always an area that it is looking to improve.

The Provider states that under the Consumer Protection Codes (CPC) it was only obliged to send Annual Benefits Statements from 2012 on policies set up prior to 2001. It says however it did issue Annual Benefit Statements on this policy from 2009. These were improved after CPC 2012.

As regards the condition of the policy document, the Provider states that it has tried to get a better copy of the proposal form but unfortunately these are the only copies it has.

The Provider states that the Complainant can retire at any time after age 60, it is his decision. The Provider says that the Complainant's chosen retirement age was age 60 as per the first page of the policy proposal form. The Provider states however that in the policy terms and conditions the charges are written to age 70. Therefore, whenever the Complainant decides to retire the charges are calculated up to age 70 and taken when he surrenders the policy (at retirement). The Provider submits that its terms and conditions allow it to deduct the future charges should the policy be surrendered prior to age 70. This, it says, is confirmed under the policy terms and conditions.

The Provider states that Charges were not only applied from 2012. They applied on this policy from the start. The Provider says that all the charges were explained in the policy terms and conditions. The annual benefit statements were improved over the years. The Provider’s position is that with the passage of time it has endeavoured to provide the Complainant with as much information as possible regarding the performance and operation of the policy.

The Complainant has stated there was no reference to an encashment value or charges in the previous statements. The Provider’s response is that this is not true. These statements outline each year the current unit position and value and charges. The older statements outlined the closing balance and the realisable value. All of these statements confirm a 'REALISABLE VALUE' which is significantly lower than the fund value. The Provider says that as mentioned above more detailed statements were issued from 2012.

The Provider states that it also issued values to the customer on request on 13 December 2004 and 26 August 2010.

The Provider states that the policy schedule does note the agent/broker as the named Consultants. The Provider says that the broker is not mentioned on any correspondence since December 2004 as the broker's agency was terminated from 7 December 2004.

The Provider says it realises that this is not what the Complainant wants to hear but it must reiterate again that this policy is a pension policy. It was intended to pay in premiums until retirement (long term investment). The fact that premiums were stopped after 2 years and

/Cont’d…

4 months has impacted on the overall value and charges. It was the Complainant's decision to stop paying his premiums. The Provider states that it is satisfied that it has administered this policy as per the policy term and conditions.

The Complainant's submission of 11 October 2017 in response to the Provider's above position, is as follows:

"I dispute the relationship [named Financial Consultant] in so far as my relationship was with [the Provider], via a [Provider] employee and no one has produced any evidence of a direct relationship or communication between [the named Financial Consultant] and myself. Screen shots of [the Provider's] software systems make no difference to this.
I still contend that there was no adequate explanation of ongoing charges when the policy was paid up. I doubt if anyone would have invested in a scheme where paid up status was going to result in charges that exceed either the original investment amount or the ultimate policy value. Maintaining the right to extending charges to age 70, even where retirement could e.g. be at 60 is staggering.

No pension policy should be designed so that its paid up status before retirement age is punitive. Why wouldn't it clearly state for example that the policy was fixed term instrument? People move jobs, change schemes etc. This is normal behaviour.

Despite the fact that timing of this policy predate certain legislation, there has been lack of transparency until very recently".

Evidence

6th October 1994 – The Complainant wrote to the Provider asking to postpone the payments for his pension plan, as follows:

> *"Following a discussion with FG on the matter yesterday, he advised me to formally ask you that I wish to postpone my May premiums for the above policy".*

The Provider then altered the plan with effect from 15th September 1994.

6th October 1994 – The Complainant to FG (Provider employee)

> *"This is to confirm that I would like to postpone the payment for my policy / pension indefinitely due to the fact that my new employer will be providing the cover I require"*

13th October 1994 – The Company to the Complainant

> *"We refer to your recent request regarding the above numbered policy and enclose herewith an endorsement schedule noting same. This should be kept safely with the Policy Document.*
>
> *Please note that all benefits are cancelled".*

/Cont'd…

The enclosed Endorsement Schedule stated as follows:

"The policy schedule is altered with effect from the 15 September, 1994 as follows:

Benefits
A Retirement Benefit Fund payable on survivance of the proposer to 15 May, 2021 (the specified date) of an amount equal to the value of the investment funds on the valuation date immediately following the specified date, to be applied towards purchase of an Annuity Benefit"

13th December 2004 – Provider to the Complainant

> *"Thank you for your recent contact with our office regarding the above plan.*
> *The information requested is as follows:*
> *Surrender value: €2,974.02*
> *Estimated maturity value @ 6% age 60: €6,859.70*
>
> *Notes:*
> 1. *The surrender value assumes no further premiums are paid.*
> 2. *Values are not guaranteed as unit prices can fall as well as rise. In the event of a claim the value payable will be determined by the bid price at the close of business on the day, [the Provider] receive all requirements.*
> 3. *Estimated values are not guaranteed and may be greater or less than shown and assume no further contributions will be paid.*
> 4. *Investments are assumed to grow at the annualised growth rates shown.*
> 5. *The value of the Unitised With Profit fund if applicable reflects any Market Value adjustment (MVA) factor applying due to adverse market conditions. This has the effect of reducing the pension (UWP) fund value on surrender or transfer. The MVA does not apply to claims on maturity or death.*
> 6. *Values are issued errors and omissions excepted".*

The letter is cc'd to the Financial Consultants with the following handwritten note in brackets (*not current agent!)*

14th January 2005 – Provider to the Financial Consultants

> *"Thank you for your recent telephone call.*
> *The above policy was set up in 1982 under the agency of … Financial.*
> *Please note that further information cannot be issued as the … Financial agency with [the Provider] has been cancelled".*

Annual Benefit Statement 2009

> *"The statement of account summarises the contributions received, charges applicable and any fund growth or loss on your policy in the last year and gives the closing value of your fund".*

/Cont'd…

In the statement the Provider refers to a Closing Balance of €10,091.34, but state:

"Please note that the closing balance above is the Fund Value at 24/04/09. The current Realisable Value is €2,290.62"

26th April 2010 – a draft Annual Statement of Account letter is on file – to be sent to the Broker, but is headed "Agent is Terminated".

26th April 2010 – Provider sends Annual Statement of Account to the Complainant directly:

May 2013 – Annual Benefit Statement sent to the Complainant

"Important Notes
If your policy is paid up, no future premiums will be collected. However, it is important to note that we will continue to deduct charges as applicable".

30 November 2015 – The Provider contacts the Complainant.

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

Important Notes

"If your policy is paid-up, no future premiums will be collected. However, it is important to note that we will continue to deduct charges as applicable".

From 2015 the following Pension policy update was provided to the Complainant.

Section 2 *"How much your policy value has changed since your last statement*
..
If you decided to transfer your policy, because of the way your policy works, there are some changes we have to make to the value.

- *Initial unit discount charge €8,273.25*
- *Debt €855.13*

On 23 December 2016 the transfer value was €5,543.45

..
Key Assumptions for Projected Values
To calculate your projected fund value and projected income we've assumed:

- *Investments earn a return of 5.52% a year*
- *The effect of charges reduces the expected investment return by 0.50% a year*
- *Your contributions will not increase.*
- *Inflations is 3.00% a year.*
- *..*
- *Any contributions unpaid as of this statement date have since been paid".*

/Cont'd…

Glossary

- *Debt – where the value of units (excluding initial units) is not enough to cover any charges owed.*
- *..*
- *Initial unit discount charge – initial units are a special type of unit that we use to take charges from your policy. The charges we take are for the expenses we have administering your policy (such as the cost of setting it up). If you cancel the policy before the maturity date then we need to take the remaining charges from the initial units.*
- *Transfer value – the amount of money you can transfer to another policy or arrangement subject to certain rules. This is the value of your policy after we take off any charges or add on any final bonuses due to you. The actual value will be calculated on the day after we receive all our requirements. Some individual funds may have a deferral period".*

..

Notes

Your policy is paid up. This means you're not currently making any payments into it. However, we will continue to take charges in line with your policy terms and conditions".

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.

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 5th November 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.

/Cont'd…

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

The issues for investigation and adjudication is whether (i) the Provider is incorrectly and unreasonably deducting excess charges from the policy fund, and (ii) whether the Provider correctly advised about the Intermediary that was said to be in place.

Analysis

There is an issue between the parties as to who was providing, or should have been providing advice to the Complainant over the years. The Provider's position is that there was an Independent Intermediary in place. It is the Complainant's position that he had all his dealings with the Provider. While it appears that there was an Intermediary in place at the outset, this position changed along the way, at what point the Intermediary went off record is unclear. From the evidence submitted the Complainant had made all his contacts from October 1994 on the policy directly with the Provider or its employees. Likewise the Provider sent communications directly to the Complainant from this time.

There is a letter on the Provider's file dated 13th December 2004. This letter was sent directly to the Complainant, by the Provider. This letter is cc'd to the Financial Consultants with the following handwritten note in brackets (*not current agent!)*.

On 14th January 2005 the Provider wrote to the Financial Consultants, as follows:

"Thank you for your recent telephone call,
The above policy was set up in 1992 under the agency of … Financial.
Please note that further information cannot be issued as the … Financial agency with [the Provider] has been cancelled".

It is not until 10 years later on 30 November 2015 that the Provider contacts the Complainant to advise, as follows:

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

The evidence shows that the Complainant requested in 1994 that the policy premiums cease, and the Provider made the Policy Paid-up. The request for ceasing of premiums was made directly to the Provider by the Complainant, and confirmation of same came directly to the Complainant, from the Provider.

On the basis of the above evidence, I must accept that it was reasonable for the Complainant to consider and expect that any advice he was to receive on the policy would come directly from the Provider. At no stage prior to 2015 was the Complainant advised by the Provider that the Intermediary that was in place from the outset was no longer recognised as such by the Provider. At no stage prior to 2015 was the Complainant advised by the Provider to have an alternative Intermediary provide him advice on the policy.

/Cont'd…

While I accept that the Provider was allowed to apply the charges in the manner it did, and deal with the debt on the policy in the manner it did, I do consider that greater and better communication should have been made by the Provider to the Complainant about how such matters were going to be dealt with by the Provider.

While I accept that there were greater requirements placed on Providers at different times over the intervening years, from 1994 to 2015 with regard to the level of information that should be supplied to a policyholder, the evidence shows that it was not until 2015 that the Complainant was alerted to the fact that there was a debt on the policy, and as to the level of charges that would be taken from the policy value.

As regards the provision of information to the Complainant over the years the Provider states that:

> *"With the passage of time we have endeavoured to provide the Complainant with as much information as possible regarding the performance and operation of the policy. We feel we have achieved this through the Annual Benefit statements that we have issued which we have improved over the years in terms of the provision of information in relation to the performance and how the policy works".*

While I accept that the above position is an accurate reflection of the level of information that has been supplied to the Complainant by the Provider, I consider that such information could have been supplied earlier.

I consider that there were many opportunities over the years for the Provider to communicate to the Complainant (i) the positon that existed in relation to the Intermediary and (ii) the position that existed in relation to the debt that was on the policy, and of the level of charges that were going to be taken from the policy value. Unfortunately, the Complainant was not so well informed on these matters.

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 up to 2015 to correctly inform the Complainant about the debt and the charges that would be deducted from the fund in accordance with the policy provisions.

Section 51 (5) of the Financial Services and Pensions Ombudsman Act 2017, allows for the examination of conduct of a continuing nature.

As regards the allegations in relation to the sale of the policy in 1992, that is that the policy was mis-sold, or mis-advised upon, this is not being examined due to the passage of time.

However, the key point is that conduct of an ongoing nature allows in certain circumstances a consideration of conduct which might initially have started or been caused by conduct that occurred beyond the 6 year period, but which continues up to a

/Cont'd…

more recent point in time which brings the complaint within my jurisdiction. I accept some of the failings by the Company outlined above were of a continuing nature.

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".*

I accept that there was a continuing failure by the Company up to 2015 to adequately inform the Policyholder about how the policy charges and policy debt was going to affect the value of the policy. The Provider could also have better informed the Complainant about the status of the Intermediary that it says was representing and advising the Complainant on the workings of the policy.

As I accept that the Provider has administered the policy in accordance with the policy provisions in relation to the debt that arose and the charges that were to be taken from the policy value, I cannot direct that the Provider undo what it has done or is doing in relation to this. However, on the basis that I find there was a requirement for greater communication from the Provider over the years in relation to the debt and in relation to the agency situation, I consider that a compensatory payment is merited. I consider that the need for such clear communications on this type of policy is vital as a policyholder such as the Complainant would plan his future pension needs based on what funds he had available to him in the future. For the Complainant, the amount he thought he had available to him was much less than expected or communicated to him prior to 2015. Therefore, it is my Legally Binding Decision that this complaint is substantially upheld and I direct that the Provider make a compensatory payment of €3,000 (three thousand euro), to the Complainant.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially 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 Complainant in the sum of €3,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant/s 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

28th 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.