An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0176
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Dissatisfaction with customer service Maladministration
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants, who are husband and wife, incepted a whole of life assurance policy with the Company on 1 March 1994, which at that time provided them with life cover in respect of each life in the amount of IR £6,106 (€7,753.02) for a then monthly premium of IR £30 (€38.09).

Following the 2015 Policy Review, the Company wrote to the Complainants on 21 January 2015 to inform them that their then premium amount was no longer sufficient to sustain their chosen level of life cover until the next scheduled policy review in March 2016. As a result, the Company outlined a number of options to the Complainants to choose from at that time, namely, *a)* to increase the premium to an amount that would sustain their then level of life cover, *b)* to maintain the then premium amount but reduce the life cover to a level that the premium could sustain or *c)* to contact the Company in order to obtain a quote for a different premium amount or level of life cover of their choice.

Following receipt of these 2015 Policy Review options, the Complainants contacted the Company on 22 January 2015 to raise a formal complaint about the changes required to maintain their policy. The Company wrote to the Complainants to explain the reasons for the policy review options on 26 January 2015. The Complainants contacted the Company on 2 February 2015 to make inquiries as to how they could surrender their policy, but did not then pursue this course of action. The Company later wrote to the Complainants on 26 May 2015 to inform them that in the absence of a voluntary increase in their quarterly premium

as set out in the 2015 Policy Review notification, their level of life cover had been reduced in line with the policy terms and conditions.

The Complainants then contacted the Company and requested that it reinvestigate the complaint that they had made on 22 January 2015 as they remained dissatisfied with the matter.

As a result, the Company wrote to the Complainants on 7 July 2015 explaining how their whole of life assurance policy works and the reasons for the policy review options. In the absence of receipt of the quarterly premium since March 2015 and with the next quarterly premium due as of June 2015, the Company wrote to the Complainants on 24 July 2015 to advise that their policy was cancelled due to the non-payment of premiums. The Company further advised the Complainants on 7 August 2015 that its position regarding their policy review options remained unchanged and referred them to the then Financial Services Ombudsman Bureau if they wished to escalate their complaint.

Following a complaint being submitted to this Office, the Company made an offer to the Complainants through the Bureau on 9 March 2016 in order to settle the dispute. In this regard, the Company agreed to suspend the 2015 Policy Review options until the next scheduled policy review with a view to then offering better terms and the expectation of the introduction of a new guaranteed whole of life product in 2017, which may better suit the Complainants' needs. In addition, the Company offered to reinstate the Complainants' lapsed policy and cover one year's premium payments in order to bring the policy up to date. The Complainants accepted this offer and withdrew their complaint.

The Complainants' Case

The Complainants incepted a whole of life assurance policy with the Company on 1 March 1994, which at that time provided them with life cover in respect of each life in the amount of IR £6,106 (€7,753.02) for a then monthly premium of IR £30 (€38.09). By January 2017, the Complainants' policy was providing them with life cover in respect of each life in the amount of €8,547 for a quarterly premium of €146.50 (inclusive of 1% Government Levy). The First Complainant is now age 88.

Following its review of their policy in January 2017, the Company wrote to the Complainants on 4 January 2017, as follows:

> *"We have recently conducted a review of your plan in accordance with the terms of your contract, to calculate if your combined payments and plan fund are still enough to cover the cost of your level of benefits. In this case, we anticipate that your payments will not be enough to maintain your current level of benefits from 1 March 2017. It is therefore necessary to make some adjustments to your plan.*
>
> *In the plan review a number of options (which are based on current mortality assumptions and a fund growth rate of 3.40% gross per annum before management charges):*

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(a) You can increase your payments in order to maintain your current level of benefits

OR

(b) You can reduce your level of benefits in line with the payment you are making

OR

(c) You can reduce your level of benefits by a smaller amount for an increased payment

We have enclosed a form that outlines the options available to you from 1 March 2017".

The enclosed 'Your Options and Consent Form' advised the Complainants that *a)* if they wanted to maintain the then current level of life cover in respect of each life the quarterly premium would need to increase to €714.47 (inclusive of 1% Government Levy), or *b)* they could maintain the then current quarterly premium of €146.50 (inclusive of 1% Government Levy) by reducing the level of life cover in respect of each life to €1,182, or *c)* they could reduce the level of life cover in respect of each life to €4,849 for an increased quarterly premium of €430.48 (inclusive of 1% Government Levy).

The Complainants contacted the Company on 19 January 2017 to query why the policy review options were not more favourable, in accordance with the aforementioned settlement agreed with the Company in March 2016.

Having investigated the circumstances of the 2017 Policy Review options provided, the Company wrote to the Complainants on 24 January 2017, as follows:

"I understand from my review of your file that you are unhappy with the recent Plan Review that was carried out on your [policy] *as you state that you were previously advised by* [the Company] *that your next Plan Review would provide you with more favourable terms.*

Having reviewed your file in full, I would now like to clarify [the Company's] *position on the matter…*

Upon review of your file, I note that on 24 June 2015 you raised a complaint with [the Company] *about the Plan Review that had been carried out on your plan. We provided you with our response on 7 June 2015. You raised a further complaint with* [the Company] *on 6 August 2015 and we provided you with our response on 7 August 2015. I also note that on 11 January 2016 we received communication from the Office of the Financial Services Ombudsman.*

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Having carried out a thorough review of your file, I note that we wrote to you on 9 March 2016 following communication with the Office of the Financial Services Ombudsman and explained in detail how your [policy] *works. I have enclosed a copy of this letter for your convenience. We also stated the following:*

> *"As long standing and valued customer of* [the Company] *as a gesture of goodwill we have reinstated your cover without the need for any underwriting. We have also applied one year's payments (€586) to take your plan to 1 June 2016. Your next quarterly payment of €146.50 will be due from this date.*
>
> *In addition we are in the process of increasing your cover back to its original level of €8,547. Your payment of €146.50 per quarter will maintain this level of cover until 1 March 2017. At this time we hope to be in a position to offer similar favourable terms to you".*

As you can see from the above extract, we offered to extend the period of time whereby you paid your normal quarterly payment of €146.50 for the higher benefit of €8,547 until your next review date of 1 March 2017. We also confirmed that we hoped to be able to offer similar favourable terms to you at that time.

I note that we received your completed Consent Form on 16 March 2016, confirming your agreement to proceed with the aforementioned offer.

The next review due to take place on your plan is 1 March 2017. I can confirm that the options outlined in our letter dated 4 January 2017 are correct should you wish to maintain your Protection Portfolio plan.

However, we are now offering a new, Guaranteed Whole of Life plan where payments are set (i.e. fixed) from the start of the plan and will never be reviewed. This is the more favourable option we were referring to in our letter of 9 March 2016.

I have set out below quotations for this new plan. Please note the quotations provided are only valid until 1 February 2017; however new quotations can be provided upon request:

Option A - Maintain Benefits		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€8,547	€8,547
Revised Payment	€177.36 per month (inclusive of 1% Government Levy)*	

*approximately €532.08 per quarter

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Option B – Maintain Payment		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€2,170	€2,170
Revised Payment	€48.80 per month (inclusive of 1% Government Levy)*	

*approximately €146.40 per quarter

We strongly recommend that you seek financial advice prior to making any decision".

The First Complainant telephoned the Company on 30 January 2017 to complain about the policy review options and the Agent advised that she would send the options back to the Actuaries for review and that the Company would write when it received information back.

As a result, the Company wrote to the Complainants again on 2 February 2017, as follows:

"I understand that you remain unhappy with our response as set out in my previous letter dated 24 January 2017, and the Plan Review options that you received on 4 January 2017.

While we appreciate that any increase in payment or reduction in cover (as a result of a Plan Review) is unwelcome, I can see from reviewing our file that we have explained in detail how your plan works, and why a Plan Review is needed.

Your Terms and Conditions provide for your plan to be reviewed, and you will note that we have never set any expectation that your benefits and payment would remain at the same level throughout the lifetime of your plan and that we have advised you at all times of the certainty of a Plan Review occurring.

However, having reviewed the file in full, I can confirm that unfortunately the figures quoted in our letter of 4 January 2017 were incorrect. I apologise for this error, and any inconvenience that it may have caused you. I have set out below the correct Plan Review options available to you at this time:

Option A - Maintain Benefits and Increase Payment		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€8,547	€8,547
Revised Payment	€588.27 per quarter (inclusive of 1% Government Levy)	

Option B – Maintain Payments and Reduce Benefits		
Life Covered	[First Complainant]	[Second Complainant]

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Life Covered	€2,943	€2,943
Revised Payment	€146.50 per quarter (inclusive of 1% Government Levy)	

Option C – Alternative Option		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€5,682	€5,682
Revised Payment	€367.39 per quarter (inclusive of 1% Government Levy)	

In order to proceed with any of the options above, we require a written instruction, signed by both of you. Please note that if we do not hear from you, in order to prevent your plan from terminating your benefits will be amended as set out in Option B with effect of 1 March 2017.

I am sorry that you are unhappy with the Plan Review process; and appreciate that any increase in payment or indeed reduction in benefits is unwelcome; however you will note from our previous responses that Plan Reviews formed a feature of your plan from the very beginning.

I am sorry that the options provided to you in our letter of 4 January 2017 were incorrect, and trust that providing you with the correct options which are more favourable to you is to your satisfaction".

The Company wrote to the Complainants on 1 March 2017 to inform them that in the absence of a voluntary increase in their quarterly premium as set out in the revised 2017 policy review correspondence, their level of life cover had been reduced to €1,182 in respect of each life for the quarterly premium of €146.51, as provided for by the policy terms and conditions. Later, following the absence of receipt of the quarterly premium since December 2016 and with the next quarterly premium due as of 1 March 2017, the Company wrote to the Complainants on 22 April 2017 to advise that their policy was cancelled due to the non-payment of premiums.

The Complainants are *"unhappy with premium increase/benefit reduction"*. In this regard, this complaint relates to the 2017 Policy Review. As a result of a prior complaint to this Office which was settled without the need for a Finding being made by the then Financial Services Ombudsman, the Company decided in March 2016 to, among other things, suspend the 2015 Policy Review options until the 2017 Policy Review with a view to offering at that time more favourable terms. However, the Complainants are dissatisfied with these terms, that is, the 2017 Policy Review options. In this regard, the Complainants seek for the Company to *"restore original cover and premium"*, that is, life cover in respect of each life of €8,547 for a quarterly premium of €146.50 (inclusive of 1% Government Levy).

In addition, the Complainants note that the Company erred in its correspondence dated 4 January 2017 when setting out the 2017 Policy Review options, resulting in it having to issue

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them with corrected policy review options by way of correspondence dated 2 February 2017. The Company acknowledges that it made an administrative error in its correspondence dated 4 January 2017 and has offered the Complainants a Customer Service Award of €500 as a token of its regret for its error. The Complainants have declined this offer.

The Complainants' complaint is that the Company wrongly administered their policy by way of carrying out a policy review in January 2017 and also that it provided them with poor customer service during this policy review.

The Provider's Case

Company records indicate that the Complainants incepted a whole of life assurance policy with the Company on 1 March 1994, which at that time provided them with life cover in respect of each life in the amount of IR £6,106 (€7,753.02) for a then monthly premium of IR £30 (€38.09).

Following the 2017 Policy Review, the Company wrote to the Complainants on 4 January 2017 to inform them that their then premium amount was no longer sufficient to sustain their chosen level of life cover until the next scheduled policy review in March 2018.
As a result, the Company outlined a number of options to the Complainants to choose from at that time, namely, *a)* to increase the premium to an amount that would sustain their then level of life cover, *b)* to maintain the then premium amount but reduce the life cover to a level that the premium could sustain or *c)* to reduce the level of life cover in respect of each life for an increased quarterly premium. The Company further advised that the option chosen by the Complainants would apply from 1 March 2017 and remain in place until the next review date on 1 March 2018.

The Company wrote to the Complainants on 1 March 2017 to inform them that in the absence of a voluntary increase in their quarterly premium as set out in the 2017 policy review correspondence, the Company had applied option *b)* to their policy, that is, their level of life cover had been reduced to €1,182 in respect of each life for the quarterly premium of €146.51, as provided for by the policy terms and conditions. Later, following the absence of receipt of the quarterly premium since December 2016 and with the next quarterly premium due as of 1 March 2017, the Company wrote to the Complainants on 22 April 2017 to advise that their policy was cancelled due to the non-payment of premiums.

With the exception of certain regrettable omissions and errors associated with the 2017 Policy Review notification, which were subsequently corrected, the Company is satisfied that it has administered the Complainants' policy in line with its terms and conditions. In this regard, the Company notes that Paragraph 19, 'Policy Review', of the terms and conditions of the Complainants' policy allows for periodic reviews of their policy, with the implied possibility that either the premium may need to be increased or the life cover reduced, in order to maintain the policy into the future. The Company confirms that it conducted regular policy reviews in line with these terms and conditions.

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The 2001 Policy Review notification and the 2004 Policy Review notification indicated to the Complainants that their policy had passed each of these reviews and outlined for how long it was estimated that the then current premium would be sufficient to sustain their then chosen level of life cover until, using an assumed future fund growth rate. Each of these policy review notifications also provided the Complainants with the option to voluntarily increase their premium or decrease their level of life cover to allow for an extension of the date to which it was estimated that the chosen premium or level of life cover would be sufficient to maintain their policy until, using an assumed future fund growth rate.

Following receipt of the 2004 Policy Review notification, the Complainants decided voluntarily to increase their premium from €126 per quarter to €145.05 per quarter, in order to sustain their chosen level of life cover for a further 10 years, that is, up to 2014. The Company notes that this projection was based on an assumed future fund growth rate of 5% per annum. As they had voluntarily increased their premium, all subsequent policy reviews up to 2014 merely confirmed to the Complainants that their policy had passed each review without any additional options needed.

However, by 2015, as their 10 year term for the guaranteed premium had expired, the Complainants were provided by way of the 2015 Policy Review notification dated 21 January 2015 with a number of options to maintain their policy going forward, namely, *a)* keep their then existing level of life cover of €8,547 in respect of each life for a revised premium of €492.08 per quarter, *b)* retain their then quarterly premium at €146.50 for a decreased level of life cover of €4.424 in respect of each life or *c)* contact the Company to receive an alternative quotation for a different level of cover and/or benefits.

Following receipt of the 2015 Policy Review options the Complainants raised a formal complaint with the Company about the changes required to maintain their policy. The Company reviewed its administration of the Complainants' policy with regard to the policy review process and concluded that it had correctly administered the policy in line with its terms and conditions and wrote to the Complainants to confirm this. Despite a number of further contacts and explanations, the Complainants remained dissatisfied with the Company response and referred a complaint to the then Financial Services Ombudsman's Bureau.

In the meantime, the Complainant's policy lapsed and went out of force on 24 July 2015 due to the non-payment of the two previous quarterly premiums.

During a review of the complaint, prior to responding to the submission request from the then Financial Services Ombudsman Bureau, senior management in the provider took the decision to make the Complainants an offer in order to resolve the matter. In this regard, the Company offered to suspend the 2015 Policy Review options until the then next scheduled policy review in 2017, with a view to then offering better terms and the expectation of the introduction of a new guaranteed whole of life product in 2017, which may better suit the Complainants' needs. In the meantime, the Company offered to reinstate the Complainants' lapsed policy and cover one year's premium payments in order to bring the policy up to date. The Complainants accepted this offer and withdrew their complaint from the then Financial Services Ombudsman Bureau.

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Following the 2017 Policy Review, the Company wrote to the Complainants on 4 January 2017 to inform them that their then premium amount was no longer sufficient to sustain their chosen level of life cover from 1 March 2017. As a result, the Company outlined a number of options to the Complainants to choose from at that time, as follows:

Option A - Maintain Benefits and Increase Payment		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€8,547	€8,547
Revised Payment	€714.47 per quarter (inclusive of 1% Government Levy)	

Option B – Maintain Payments and Reduce Benefits		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€1,182	€1,182
Revised Payment	€146.51 per quarter (inclusive of 1% Government Levy)	

Option C – Alternative Option		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€4,849	€4,849
Revised Payment	€430.48 per quarter (inclusive of 1% Government Levy)	

The correspondence advised that all options would only hold until the next policy review date on 1 March 2018.

Following receipt of these 2017 Policy Review options, the Complainants contacted the Company to query why the options provided were not more favourable compared to the 2015 Policy Review options, in line with the agreed settlement offer accepted in March 2016. Upon investigation of the circumstances of the 2017 Policy Review options provided, the Company advised the Complainants that unfortunately due to administrative errors that not only had the calculations needed to provide the more favourable terms promised as per the agreed Settlement Offer not been incorporated in the quotations for the standard options but also that the promised new guaranteed whole of life product option had not been included.

As a result, the Company subsequently offered the Complainants the following revised more favourable options in respect of their 2017 Policy Review by way of correspondence dated 2 February 2017, as follows:

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Option A - Maintain Benefits and Increase Payment		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€8,547	€8,547
Revised Payment	€588.27 per quarter (inclusive of 1% Government Levy)	

Option B – Maintain Payments and Reduce Benefits		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€2,943	€2,943
Revised Payment	€146.50 per quarter (inclusive of 1% Government Levy)	

Option C – Alternative Option		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€5,682	€5,682
Revised Payment	€367.39 per quarter (inclusive of 1% Government Levy)	

In addition, the Company also provided the Complainants with the following 'Fixed for Life' Guaranteed Whole of Life Plan Options by way of correspondence dated 24 January 2017, as follows:

Guaranteed Whole of Life Plan Option A – Maintain Benefits		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€8,547	€8,547
Revised Fixed Payment	€532.08 per quarter (inclusive of 1% Government Levy)	

Guaranteed Whole of Life Plan Option B – Maintain Payment		
Life Covered	[First Complainant]	[Second Complainant]
Life Covered	€2,170	€2,170
Revised Payment	€146.50 per quarter (inclusive of 1% Government Levy)	

The Company notes that the Complainants were not prepared to accept any of the above options offered.

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The Company wrote to the Complainants on 1 March 2017 to inform them that in the absence of a voluntary increase in their quarterly premium as set out in the revised 2017 policy review correspondence, their level of life cover had been reduced to €1,182 in respect of each life for the quarterly premium of €146.51, as provided for by the policy terms and conditions. Later, following the absence of receipt of the quarterly premium since December 2016 and with the next quarterly premium due as of 1 March 2017, the Company wrote to the Complainants on 22 April 2017 to advise that their policy was cancelled due to the non-payment of premiums.

The Company understands that it is the view of the Complainants that they were never warned of the magnitude of future possible premium increases arising from a policy review. However, the Company states that due to the long term nature of these whole of life policies that there was never any practical way of being able to predict what the cost of providing the chosen level of life cover would be in 20 or even 30 years' time. It is for this very reason that these whole of life policies were designed with a supporting investment fund, which would help maintain the chosen level of life cover for the longest possible period. However, inevitably at some point in the future, depending on how long the policy lasted, a premium increase would be required in order to maintain the chosen level of life cover until the next scheduled review. The Company notes that the quantum of this premium increase was always going to be an unknown quantity at the time of the commencement of the Complainants' policy, in March 1994.

While the Company states that it understands that no policyholder welcomes the need for either an increase in their premiums or a decrease in their level of life cover, these options were necessary in order to maintain the policy going forward and the changes were a true reflection of the cost to the Company for providing the life cover attaching to the policy until the next scheduled review. The Company is of the view that it has also gone to great lengths to provide more favourable and additional options to the Complainants than those that would have been available to other policyholders under similar circumstances. The Company states that it is satisfied that it has administered the Complainants' policy in accordance with its terms and conditions.

Finally, in recognition of the fact that due to administrative oversights the Company failed to provide the Complainants with the promised more favourable terms as part of the original 2017 Policy Review notification dated 4 January 2017, it is prepared to offer the Complainants a €500 Customer Service Award as a token of its regret for these errors.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties 16 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.

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

The complaint at hand is, in essence, that the Company wrongly administered the Complainants' policy by way of carrying out a policy review in January 2017 and also that it provided them with poor customer service during this policy review.

In this regard, the Complainants incepted a whole of life assurance policy with the Company on 1 March 1994, which at that time provided them with life cover in respect of each life in the amount of IR £6,106 (€7,753.02) for a then monthly premium of IR £30 (€38.09). By January 2017, the Complainants' policy was providing them with life cover in respect of each life in the amount of €8,547 for a quarterly premium of €146.50 (inclusive of 1% Government Levy).

Following a review of the Complainants' policy in January 2017, the Company wrote to the Complainants to inform them that their then premium amount was no longer sufficient to sustain their chosen level of life cover from 1 March 2017 and outlined a number of options to the Complainants to choose from at that time. The Complainants are *"unhappy with premium increase/benefit reduction"* options proposed by the Company following this policy review and seek for the Company to *"restore original cover and premium"*, that is, life cover in respect of each life of €8,547 for a quarterly premium of €146.50 (inclusive of 1% Government Levy).

With regard to the first element of the Complainants' complaint, that is, that the Company wrongly administered the Complainants' policy by way of carrying out a policy review in January 2017, I note that Section 19, 'Policy Review', of the Policy Conditions document (January 1994) applicable to the Complainants'' policy provides:

> ***"This section details what happens when the Policy is reviewed.***

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

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

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

I accept therefore, that the Complainants' policy provides for policy reviews to be carried out by the Company.

In this regard, the Complainants' policy is a flexible unit-linked whole of life protection plan, providing life cover payable in the event of death. With policies of this nature, the cost of providing the life cover increases according to the ages of the policyholders and this cost depends on a number of factors, including gender, age and current mortality rates. As a person grows older, the cost of providing life cover increases as the age-related risk to the insured is greater. A positive policy value may be built up in the earlier years when the cost of the life cover is less than the premiums, but where the cost of life cover in later years becomes higher than the premium amount, the fund subsidies this difference. In due course, the fund is exhausted, resulting in the need for a policy review, which will result in either an increase in premium or a reduction in life cover.

Policy reviews are an integral part of a unit-linked whole of life policy. The purpose of these reviews is to assess whether the value of the policy and the on-going premium payments will be sufficient to sustain the cost of life cover until the next review date. The premium calculation takes into account, among other things, the level of life cover provided and the ages of the lives assured, hence it may be necessary for the policyholders to make an additional provision to maintain the level of life cover by way of an increased premium. Alternatively, the policyholder may choose to maintain the life cover by increasing the premium.

The second element of the Complainants' complaint, that is, that the Company provided the Complainants with poor customer service during its policy review in January 2017, I note that following receipt of the 2017 Policy Review notification dated 4 January 2017 the Complainants contacted the Company on 19 January 2017 to query why the policy review options were not more favourable, in accordance with a previous settlement agreed with the Company in March 2016.

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In this regard, the Company accepts that due to administrative errors the 2017 Policy Review options that it initially presented to the Complainants in its correspondence dated 4 January 2017 did not incorporate the calculations needed to provide the more favourable terms promised as per the previous agreed settlement and also that the promised new guaranteed whole of life product option had not been included.

As a result, the Company presented the Complainants with the 'Fixed for Life' Guaranteed Whole of Life Plan Options by way of correspondence dated 24 January 2017 and then the revised more favourable options in respect of their 2017 Policy Review by way of correspondence dated 2 February 2017.

Conclusion

I accept that the Complainants were made aware from 2014, that the premium being paid was no longer, on its own, enough to sustain the cost of cover. From that time the policy fund was supplementing the cost of cover. It is not clear how long the fund had been used to supplement the cost of cover in addition to the premium being paid, but it is noted that in 2005 the Provider had advised the Complainants that if they made a surrender of €1,000 from the fund their premium would substantially increase. This would indicate that the fund had subsequently been used in addition to the premiums for some time prior to 2014.

Overall I am satisfied that the Provider was timely with its reviews and in its communication of how the policy was performing over the years. However, I consider that clearer and better communication was required of the need to supplement the cost of cover from the policy fund. I also consider that given that the policy was being reviewed on a yearly basis for many years the Provider could have better prepared the Complainants for the eventuality of higher premiums in later years.

I accept that the Provider made reasonable attempts at providing affordable cover for the Complainants, when the complaint first arose in 2015. However, the Provider had indicated then that upon a review of same in 2017, it would offer similar favourable terms. Unfortunately, when those new terms were communicated to the Complainant they were not correctly set out, and were not so favourable. The Provider did acknowledge soon after that there had been an administrative oversight in relation to the communication of the new terms, and then gave alternative options for the Complainants to choose from. In addition, the Provider did make an offer of a customer service payment of €500 in recognition of this administrative oversight. While I accept that the Provider acted in a timely manner in correcting its administrative oversight and in offering a customer service payment, I do consider that this oversight was an understandable breaking point for the Complainants in their dealings with the Provider and that they reasonably wanted the matter fully investigated.

This breakdown of trust caused by the Provider's actions I consider, merits a more substantial compensatory payment than that offered by the Provider. Therefore, I partially uphold this complaint and direct the Provider to pay the Complainants a compensatory payment of €4,000, instead of the Provider's €500 customer service payment.

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I also direct the Provider to keep open its offers of cover set out in its letter of 2 February 2017 (without the need for further underwriting of the Complainants for same) for the Complainants' further consideration for a period of 4 weeks from the issuance of this, my Legally Binding Decision. The Complainants must now consider whether they wish to avail of the alternative options and may need to seek independent advice on same before making that decision. Regardless of their choice to avail or not, of one of the Provider's policy options, they are to receive the €4,000 compensatory payment.

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)(b) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct (i) that the Respondent Provider make a compensatory payment to the Complainants in the sum of €4,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider, and (ii) that the Provider keep open its offers of cover set out in its letter of 2 February 2017 (without the need for further underwriting of the Complainants for same) for the Complainants' further consideration for a period of 4 weeks from the issuance of this, my Legally Binding Decision.

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.***

/Cont'd…

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

9 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.