Decision Ref:	2018-0178
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Dissatisfaction with customer service Failure to provide product/service information
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint is being brought by the executors of the late Policyholder's estate. The complaint concerns the administration of the Policyholder's Whole of Life Policy and the advices that were / were not given to him in 2014 when he sought alternative cover.

The complaint is that that the Provider did not correctly or reasonably administer the policy over the years and that the Provider did not correctly or reasonably advise the Policyholder in 2014 when he sought alternative cover.

The Complainants' Case

The Policyholder passed away on 27th November 2015. The Complainants state that upon contacting the Provider to notify of the Policyholder's passing, the Provider informed that the Policyholder requested to encash his policy over a year prior (August 2014) and as a result he had no existing life insurance policy and hence, it had no liability. The Complainants state that after several telephone calls, emails and finally lodging a formal complaint, they learned from the Provider the following:

Up until August 2014, the Policyholder had routinely paid monthly premiums for the previous 31 years to his whole of life insurance policy. His policy anniversary date was April of each year.

Above the age of 70, the Provider was to conduct annual policy reviews, and at the policy anniversaries of February 2013, 2014, no increase in premium was incurred.

In August 2014 however, the Policyholder was contacted and told that his premium from April 2015 onwards was going to increase by over 100%. This was supposedly in order to cover costs of continued insurance with a guaranteed death benefit of approximately €101,000.
The Policyholder felt the premium increase was outrageous and unaffordable and looked for options to reduce it - with a policy offering a reduced death benefit.

The Policyholder's primary concern (as noted at the time by the financial advisor, Mr. C) was to ensure some form of death benefit for his dependant wife in the event he died.

The Provider states that the Policyholder had an issue with the review clause of his existing policy - and this appears to have taken priority in the Provider advising him to get off his existing policy and apply for a new Lifelong Cover policy (which he was unlikely to ever be approved for) rather than simply electing to reduce the death benefit associated with his existing policy (which the terms explicitly state is allowed and which the Provider since confirmed was an option).

In the time between the first call from the Provider representative (Aug 24th) and mid September, the Policyholder had encashed his existing policy (yielding him just under €1,100), writing a very angry letter to the Provider where it is clear he was disgusted at the outcome and most unhappy with what he appears to have viewed as his only choice.

The Complainants state that the Provider contends that the Policyholder did this entirely of his own accord, and that he wrote to the Provider (as it told him to) to encash his policy, so it had no choice but to execute his wishes. The Complainants say that the Provider also suggest the adviser attempted to get in touch with the Policyholder, but he never returned the calls, and so the adviser did not pursue the matter for fear of being seen to harass the Policyholder.

The Complainants contend that the adviser had an obligation to the Policyholder as his advisor, to not just passively inform him of other options on the table, but of advising him in his best interests.

The following month, the Provider wrote to the Policyholder, denying him coverage on the new plan proposed by the advisor - based on medical grounds.

The Complainants contend that given the Policyholder's many health issues were all known up front, that the adviser would have had a very good idea at the time of the application as to the likelihood of the Policyholder ever being approved - and should have advised him that it was highly unlikely if not impossible. The Complainants state that the Provider informed the Policyholder he: *"would not be automatically approved"* - but this the Complainants state, is a very watered down version of what was more likely the truth - i.e. that it was highly unlikely that he would be approved at all.

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The Complainants contend, that yet again, the adviser did not act in the Policyholder's best interests and suggest that had this likely outcome been stated to the Policyholder, he would have chosen to stay on his existing policy at reduced death benefit.

The Complainants state that upon review of the Policyholder's original policy - there are two clauses that in particular apply, namely:

i) the Optional Variation clause, which states that the Policyholder was entitled to stay on his existing policy and reduce the associated death benefit with resulting reduction in monthly premium.

ii) Conversion Option clause which states that in the event the Policyholder encashed his existing policy, he was entitled to open a new, similar policy up to the difference between the previous death benefit and the encashed amount - regardless of the condition of the life being insured.

The Complainants suggest that the Policyholder's primary concern was to have a policy that did not require annual reviews - and all his decisions stemmed from that.

The Complainants contend that a man who had paid his premiums for 31 years and as noted specifically by the Provider's advisor in August 2014, his chief objective was to ensure some form of death benefit for his wife in the event he died. The Complainants contend that since the Provider had noted this, all advice should have been towards achieving this aim and obtaining the best possible outcome for him. It is the Complainants position that this clearly did not happen.

The Complainants contend that it is more than a coincidence that the worst possible outcome for the Policyholder (i.e. cancellation of all life insurance) was the best possible outcome for the Provider (i.e. removing any financial obligation to him from it's books) - and this motivated the Provider's *lack-lustre approach* to advising him. The Complainants question the financial advisor's motivation and think that there is a clear conflict of interest. The Complainants question both the timeliness and the quality of the advice provided and believe it directly contributed to this worst outcome being realised.

The Complainants state that they understand that the unit-linked funds of the Policyholder were sorely underperforming. The Complainants question the Provider's responsibility to better manage funds in a conservative fashion, assuring limited growth, given the known purpose for these investments is a life insurance policy with guaranteed death benefit. The Complainants further question why, upon two previous reviews of the policy (in 2013, 2014) the Provider failed to mention the *pending fiscal cliff* his policy was going to fall off, instead choosing to only tell him when the money had all but ran out. The Complainants consider that this is further evidence, of a firm not operating in their client's best interest - and only further demonstrates the pattern of professional neglect in responsibilities to inform the Policyholder in a timely manner so that he had all the information necessary to make a properly informed decision.

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The Complainants contend that the Policyholder would clearly have been better off sticking to his original policy, at even half the original death benefit - even if he was to have ongoing yearly reviews. The Complainants state that this has to be a better outcome than ending up with no policy and no death benefit. The Complainants state that the Provider refuses to accept any responsibility in this decision making process, claiming it was all the Policyholder’s decision. The Complainants submit that by definition, as "advisor", the advisor was obliged to be more forthcoming with the true nature of his situation.

15. The Complainants state that as a result of the Provider’s actions, after 31 years of paying premiums (approx €55,000), the Policyholder ended up with a total encashment less than €1,100 the Policyholder’s widow ended up with nothing, since the original policy guaranteeing €101,000 was no longer in force.

The Complainants state that they want:

1. The Provider to be found negligent in their advice to the Policyholder and to acknowledge there is a conflict of interest that affected the quality and timeliness of the advice provided.

2. The terms relating to death benefit of the original life insurance policy to be enacted, as they believe this policy was encashed under duress and based on poor advice from the financial advisor.

3. The original death benefit to be paid to the Policyholder’s widow, less any monthly premiums that would have been paid had the policy remained in place from September 2014 through to November 2015.

<u>The Provider’s Case</u>

The Provider states that the complaint relates to the policyholder’s (the Complainant’s late father’s), decision to cancel his Whole of Life Policy in September 2014. The Complainant attributes his father's decision at this time to advice that he received from the Company’s financial adviser Mr C.

The Provider says that by way of some background to the conduct complained of and to demonstrate that the Provider played no part in the late Policyholder’s decision to cancel his Policy, the Provider sets out the background on the cancellation of the plan itself and the Policyholder’s interactions with the adviser before this time.

The Provider states that the Policyholder contacted the Provider by telephone on 29 September 2014 requesting to cancel his Policy.

During this call the representative confirmed to the Policyholder the Provider’s requirements in order to do this. These requirements being a cancellation request signed by the Policyholder and because his plan had a value attaching a copy of photographic identification and a recent utility bill as proof of address in order to comply with Anti Money Laundering Requirements.

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On 30 September 2014 the Policyholder drafted a cancellation letter in respect of the Policy. It is the Provider's position that the Policyholder did this in the full knowledge that the cancellation of his existing Policy would bring an end to the cover that was being provided by the Policy.

On 1 October 2014 the Provider received the Policyholder's cancellation instruction and his plan was cancelled as requested the following day. The Provider says that separate to the Policyholder's phone call of 29 September 2014 and written correspondence to the Provider at this time, in order to ensure that no further payments were made he contacted his own bank in order to stop his direct debit further demonstrating his intent for his cover to be cancelled.

The Provider submits that following the Policyholder's phone call and signed cancellation instruction it wrote to him on 2 October 2014 confirming that his plan had been cancelled as requested. In this letter the Provider set out:

> *...I am pleased to enclose a cheque for €1,115.08. This amount represents the full value of this plan, which, following this payment, is now finished.*

The Provider says that at the time that the Policyholder cancelled his Policy he was very unhappy with the fact that his plan was subject to annual reviews in line with paragraph 16 of his plan Terms and Conditions. He had raised this discontent with the Provider's adviser Mr C when they met on 25 August 2014.

The Provider states that the Policyholder had sought a meeting with Mr C at this time to discuss the reviewable nature of his plan after listening to a radio program which was discussing whole of life plans which are subject to review.

The interactions between the Provider's adviser Mr C and the late Policyholder prior to the decision to cancel the Policy in October 2014, is stated by the Provider to be as follows:

The Policyholder telephoned the Provider's Customer Services Team on 19 August 2014.

The Policyholder highlighted his concern about potential increases in payments when plans become subject to review. The Provider submits that while reviews are a feature of his plan its representative explained that his plan was not subject to review until the following year (April 2015) and for illustration only he gave the Policyholder an estimation of what he could expect his payment to increase to at this time. The Provider representative informed the Policyholder on expressing his concerns about his plans reviewable nature that if he stopped making his regular plan payment he would no longer be on cover and in the event of his death claim there would be no death benefit due.

The Provider states that the Policyholder later spoke with Mr D of the Provider who Informed him that he had moved to another area in the business and as such was no longer looking after his plan. Mr. D informed the Policyholder that the adviser Mr C had been

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appointed as his new adviser. The Policyholder contacted the Provider for Mr C's number and an appointment was later arranged for 25 August 2014.

The Provider states that the Policyholder had prior to this time been dealing with Mr D and he sought his telephone number as he wished to speak to him about his plan. The Policyholder was provided with the representatives' mobile number.

The Provider submits that the adviser Mr C and the late Policyholder met at the Policyholder's home on 25 August 2014 as agreed. The Provider states that the Policyholder during this meeting expressed his unhappiness that his plan was subject to annual review and that it was likely that an increase in payment would be required each year in order to maintain his plan into the future.

The Provider's positon is that its adviser explained to the Policyholder in detail how his plan worked, setting out that his plan was now subject to annual reviews in line with his plan Terms and Conditions as he was now over the age of 70. He is said to have explained that the cost of life cover increases as one gets older and he discussed with the Policyholder if he still had a financial need for the level of cover on his plan at his stage of life as the need for significant sums assured for a lot of people reduce as they get older, (at this time the Policyholder's life cover benefit stood at €101 ,855).

The Provider says that the Policyholder explained that he had a need for the level of cover as his wife was incapacitated and as such he required cost certainty into the future as he was not prepared to pay any more than what he was paying at present for his Policy each month.

The Provider submits that the Policyholder's Policy did not provide him with the cost certainty that he needed as it was subject to annual reviews and as such its adviser first and foremost discussed the Provider's Life Long Insurance plan as a possible solution to his need of removing the cost uncertainty that comes with policy reviews.

The Provider says that its Life Long Insurance plan is a whole of life protection plan similar to Policyholder's policy with the exception that the payment on the Life Long Insurance plan is not subject to review. The Provider states that as such a plan of this nature would eliminate the upset that the cost uncertainty of maintaining the Whole of Life Policy into the future was causing for the Policyholder.

The Provider states that the adviser discussed the application process with the Policyholder setting out very clearly that it was very likely that more medical information such as a Private Medical Attendants Report (PMA) or medical would be required from its Underwriters and he set his expectation that it was very likely that his application could be loaded or declined.

It is the Provider's positon that the Policyholder agreed with the adviser that the application process would not be straightforward but at least when the underwriting decision was arrived at he would have certainty about his next steps. The Provider says that in the event that his application was not successful the next step was to consider reducing his level of cover on his existing Policy despite the fact that this cover would still be subject to annual reviews.

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The Provider states that first and foremost the Policyholder agreed to apply for a new Life Long Insurance Plan. The Provider stressed in its response that at no time was the Policyholder advised to cancel his Policy and states it is evident from the Life Long Insurance application and the notes recorded in the late Policyholder's Personal Finance Review Report that his Policy was only to cancel in the event that his Life Long Insurance application was successful.

The Provider refers to the copy of the Policyholder's Personal Finance Review Report completed by its adviser Mr C with the Policyholder when they met on 25 August 2014. A copy of this report was posted to the Policyholder in the days after their meeting. In particular the Provider refers to the free text notes recorded by the adviser which it says fully support the fact that the Policyholder required cover into the future because he was dependent on this, but that he wanted certainty on its cost. The Provider states it is also noted from the notes that it was only in the event that the Policyholder's Life Long Insurance Application was successful that his existing plan would then be cancelled.

From Page 2 of the Personal Finance Review Report it states:

"[The Policyholder] had no one else present at the meeting. His wife was in the house at the time but not in the room".

From Page 4 of the Personal Finance Review Report it states: *"Your wife [name] is solely dependent on you and is [a wheelchair user]"*

From Page 6 of the Personal Finance Review Report it states:

"[Policyholder's name] you are very unhappy with the [Policy] you have and are looking to replace this plan with a life long cover plan. You are looking for certainty with your life cover plan especially since your wife is solely dependent on you".

From Page 10 of the Personal Finance Review Report it states:

"[Policyholder's name] you wish to apply for a life long cover plan that gives you certainty on the amount you pay but also the amount of life cover that will be paid out. You wish to replace the existing cover you have which is [Policy number] with a new plan once all the requirements are in. Once you are on cover and the premium is paid your cover will be guaranteed not to be reviewed into the future".

It is the Provider's positon that the late Policyholder proposed for a new Life Long Insurance plan on 25 August 2014 with life cover of €50,241 at a monthly payment assuming acceptance at standard rates of €392.31 per month. In his application it was requested that his existing Lifesaver plan would cancel only when new plan started. The Provider again states that the Policy was only to cancel in the event that the new plan issued.

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The Provider states that on 26 August 2017 it wrote to the Policyholder's GP asking him to complete and return a Private Medical Attendants Report (PMA). The Policyholder's report competed by his GP was received by it on 29 September 2017. The Provider states that coincidently on the same day the Policyholder phoned its Customer Services Team. The Provider says that on that day he raised two queries:

1) He is said to have requested an update on the progress of his Life Long Insurance application. The Provider says that its Customer Service Representative informed him that his PMA has been received that day and was currently with the Underwriting Department. A decision was expected in the following 24 hours.

2) The Provider says that regarding his existing Policy the Policyholder confirmed that he wished to cancel the plan and that he did not wish for any further payments to be collected on it. The Provider states that as the plans next payment was already in progress with the Policyholder's bank its adviser confirmed that he would need to cancel with the bank directly to ensure that it did not collect. Regarding the cancellation the representative confirmed that the Provider required a signed cancellation instruction in addition to a copy of photographic identification and a copy of a utility bill as proof of address. The Provider says the adviser again referenced the fact that the plan was subject to review which the Policyholder was very unhappy about before the call ended.

The Provider submits that on 30 September 2014 its Underwriting Department having reviewed the medical information received from the Policyholder's GP made the decision that the Provider was unable to offer terms to the Policyholder on medical grounds. The Provider says that a text message was sent to the Policyholder to notify him that a decision had been made on his application and that his financial adviser would be in touch with further details.

The Provider says that on the same day the Policyholder drafted a cancellation instruction for the existing Policy. He also cancelled his direct debit to the Provider with his own bank to ensure that the next payment which was in progress was not paid. The Provider says that the Policyholder did this in the full knowledge that the cancellation of his existing Policy would bring an end to the cover that was being provided by this plan.

The Provider states that its Adviser Mr C contacted the Policyholder to discuss his Life Long Cover application. The Provider states that the Policyholder was naturally very unhappy with the decision not to accept him for the proposed Life Long Insurance cover and its adviser offered to get quotations for reduced levels of cover and premium on his existing Policy and to meet again to discuss. The Provider states that the Policyholder informed Mr C that he did not want to meet again and he did not engage with Mr C again.

The Provider's positon is that the Policyholder's cancellation correspondence was received on 1 October 2014 and the Policy was cancelled as requested. The Provider says it wrote to the Policyholder the next day to confirm that his plan has been cancelled and it attached a cheque to the value of €1115.08. This cheque is said to have represented the final value of the Policyholder's Policy.

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The Provider's position is that the decision to cancel the Policy was made by the Policyholder alone and that it is not responsible for the Policyholder's decisions.

Evidence

Submissions after receipt of the Providers response to the complaint

The Complainants' response to the Provider's submission is that:

The Complainants state that upon reviewing the Provider's response they noted that the Policyholder's Policy contained a "**Conversion Option**" which states that:

- *Provided all premiums due have been paid under the Policy the Proposer shall have the option to encash the Policy and to effect on the life of the Life Assured an Endowment Assurance or Whole-of-Life Assurance plan assuring a sum not greater than the amount by which the Death Benefit exceeds the encashment value. This option is available irrespective of the Life Assured's then state of heath".*

The Complainants state that in the schedule of evidence returned by the Provider, it categorically states:

"[The Policyholder's] plan did not provide him with the cost certainty that he needed as it was subject to annual reviews and as such our adviser first and foremost discussed the [Provider's] Life Long Insurance plan as a possible solution to [the Policyholder's] need of removing the cost uncertainty that comes with policy reviews.

Our Life Long Insurance plan is a whole of life protection plan similar to [the Policyholder's Policy] with the exception that the payment on the Life Long Insurance plan is not subject to review. As such a plan of this nature would eliminate the upset that the cost uncertainty of maintaining [the Whole of Life Policy] into the future was causing for [the Policyholder]".

The Complainants say however, that the Provider declined the Policyholder's application for this policy in September of 2014 - which appears to them to be contractually opposed to what the Provider had guaranteed in the original Policy. The Complainants say that this new policy was a whole of life plan also. The Complainants state that the Provider has not once commented on this clause and they would like to understand the Provider's view on this and how it determined it was not legally bound and contractually obliged to approve his new policy. The Complainants question that in the event that a technicality somehow meant the clause did not apply to the particular policy it advised him to apply for, then why did the Provider not advise him towards a policy that would be guaranteed by this clause. The Complainants state that they see no mention of this in the entire schedule of evidence from either the Provider or its representative.

The Complainants state that their contention is not that the Provider or any representative explicitly advised the Policyholder to cancel his existing policy, but they are concerned that the Provider repeatedly appear to have been *bad actors*. The Complainants submit that

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while there clearly is an element of *caveat emptor* in this dispute - at no time did the Provider or it's representatives appear to present the Policyholder with vital information that could have materially swayed his decision in a direction that was financially beneficial for the Policyholder.

It is the Complainants positon that the Provider was:

- Delinquent in its policy reviews (e.g. from 01/04/95 to 01/04/03) up to the point that the policy was practically worthless.
- Incorrect in directing the Policyholder to apply for a policy it must have expected he would never be approved for.
- Incorrect in not providing the Policyholder with any figures to illustrate the possibility of remaining on his existing policy at a lower death benefit - in parallel with his application for the new policy.
- Incorrect in not advising the Policyholder of the conversion option clause in his old policy and how that could have potentially benefited him.

The Provider's response to the Complainants observations on its submission was that the Policyholder's option to convert to another whole of life plan under paragraph 15 of his plan Terms and Conditions allowed him to convert to another reviewable whole of life contract only. The Provider's position is that it was not possible for the Policyholder to convert to a non reviewable Life Long Insurance plan as the Provider does not allow conversions under this clause to be made to non reviewable whole of life contracts. The Provider says that in summary the Policyholder could only convert to another whole of life reviewable product under this clause. The Provider say that as demonstrated in its submission the Policyholder did not want a reviewable whole of life product.

The Complainants responded to the Provider's further submission as follows:

The Complainants state that had the option of another policy requiring the underwriting on health grounds been eliminated from the outset then the choice would have been very simple - either stay on the current policy with reduced death benefit (the Policyholder could have halved his benefit to be at the same level as he was applying for in the new policy) - or end up with no policy at all. The Complainants state that they do not think there is doubt in anyone's mind as to which of these options the Policyholder would have preferred. The Complainant states that the Provider mentions that presenting the Policyholder with the Optional Variation on his existing policy was plan B - but question, given the reality on the ground, why was this not presented as plan A. The Complainants state that it does not matter if this is what the Policyholder would have preferred if there was no possibility of doing so. The Complainants say that they believe that producing the data indicating the success rate for similar clients with similar health issues on a similar product would validate this contention.

The Provider's response to the Complainants' submission of 20 November 2017 is as follows:

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- *It is not unusual for a financial adviser to provide the option of moving to a Life Long (non-reviewable) plan, when a customer wishes to have a whole of life plan, but for the plan to not be subject to regular plan reviews.*
- *[The Policyholder] was not happy with the fact his plan was subject to reviews and as such, the premium would continue to increase as he got older.*
- *Deciding to apply for a Life Long Plan was [the Policyholder's] decision only. You will note from the Personal Financial Review report, [Mr C, the advisor] actually recommended a Life Term Plan. However, [the Policyholder] choose the Life Long Plan based on its whole of life / level payment conditions*
- *A financial adviser is not a medical professional, rather, it is their role to set out the options available to a customer, who in turn must then decide on which option (if any) to take. Therefore, a financial adviser cannot determine (regardless of what medical information is provided by the customer), whether they will be accepted for cover (at either Normal Rates or Special Terms) or declined cover. Rather, it is the role of the financial adviser to gather the appropriate information and pass this to the medical professionals who in turn, make the decisions on behalf of the company. It is not possible to determine whether or not an applicant will or will not be accepted on cover, until the application has been fully medically underwritten by those in the appropriate field. [Mr C, the advisor], would not have been able to make this decision, regardless of what medical information was provided by [the Policyholder].*
- *[The Policyholder's] new application was arranged as Business Replacement. That is, the existing plan and cover, would not be cancelled until such time as the new plan (and cover), was in place. However, [the Policyholder] took separate steps to ensure that the existing plan was cancelled, in that he wrote to [the Provider] to cancel the plan (on 30 September 2014), on the same day that [the Provider] sent a text message to him, advising that cover had been declined on the new plan.*
- *Had this letter been drafted prior to him receiving the text message, it would be my expectation that he would have contacted [the Provider] (by telephone or letter), in the days after, to ensure that the old plan was not cancelled, if this was his intention. However, our records show that this was not the case. Rather, [the Policyholder] wrote to us on 7 October 2014, setting out why he decided to cancel his plan (the instruction for which was in his letter dated 30/09/2017).*

I understand from [the Complainants'] email, [they] feel there is no doubt, that had [the Policyholder] been advised that he had the option to remain in his existing plan with reduced life cover, this is what he would have done. However, it is important to note that had [the Policyholder] reduced the life cover on his existing plan, it would still have been subject to future plan reviews. Whereas, it is clear from the notes recorded during his meeting with [the advisor], that [the Policyholder] was seeking a plan on which the level of future payments, remained unchanged. It is my belief from reviewing the file, that this would also have been the case regardless of whichever order the plan review options were set out in our correspondence".

The Complainants' response to the above (of 4th December 2017) was that:

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"I think we can all agree that [the Policyholder] wanted the most cost-effective policy that would ultimately pay money to his sick wife when he died. Historical facts prove the only policy that would ever have done that is the one he was on & that no other policy would work. If [the Provider] produced empirical evidence of similar clients in similar health advised similarly to [the Policyholder] where a different, positive outcome was achieved – then I would rest my case and say that yes, [the Policyholder] took a chance based on the best advice he could possibly get. However, [the Provider's] continued refusal to produce any such evidence leads me to believe that there aren't any examples of a positive outcome in similar circumstances, because [the Provider] are a business, and no rational business would take on any such clients, given they constitute definite loss-makers.

If [the Policyholder] had been advised that at the time – then his choice would have been very clear (and certainly more accurate). Either reduce his current policy or end up with no policy. I think again, all parties can agree which choice would have been made in that case".

The Provider's response to the above was set out in its e-mail of 11th January 2018, as follows:

"While I appreciate that the customer wishes the Provider to confirm whether or not we have records of [the advisor] suggesting a similar plan to an individual of similar age and health to his father, the Provider does not accept that such information is relevant to this specific complaint and would not change the decisions made by his late father (or indeed the reasons for his decision),when applying for the plan. …

I understand from [the Complainant's] email, he feels there is no doubt, that had his father been advised that he had the option to remain in his existing plan with reduced life cover, this is what he would have done.

However, it is important to note that had [the Policyholder] reduced the life cover on his existing plan, it would still have been subject to future plan reviews. Whereas, it is clear from the notes recorded during his meeting with [the advisor], that [the Complainant] was seeking a plan on which the level of future payments, remained unchanged.

It is my belief from reviewing the file, that this would also have been the case regardless of whichever order the plan review options were set out in our correspondence."

In the Complainants' response submission of 16th January 2018 they expressed their disappointment that the Provider continued to fail to provide evidence of other policyholders with such medical history as their father receiving cover from the Provider. The Complainants also question how this information would not be relevant. The Complainants further stated, as follows:

- *If [the Provider] never approve such cases, then the very act of advising [the Policyholder] to pursue such a policy is entirely misleading. Given that [the Provider] themselves have indicated in previous communication that pursuit of the new policy was the first option agreed with [the Advisor] and exercising the optional variation clause would be pursued next if the first option did not work. Given this background,*

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I don't think it's a stretch to suggest that if [the Policyholder] understood his only option was to stay on his existing policy and exercise the variation clause - that is what he would have done. Instead, he was given the impossible hope that he would be accepted on the alternate plan.

- *The last point they repeatedly make is that [the Policyholder's] sole concern was to get a plan where the level of future payments remained unchanged. Yes, this was a priority, but let's please not lose track of the chief reason for this policy in the first place as noted in the application - i.e. to provide a source of financial support for his sick spouse who depended solely upon him in the event of his death. He wanted to provide for his wife in the event of his death. Two facts are now clear: He couldn't have done so on the suggested policy. He could have done so on his old one, reduced to the same benefit level".*

A further submission was received from the Provider on 7th February 2018, reiterating its position. The Provider further stated:

- *A financial adviser is not a medical professional, rather, it is their role to set out the options available to a customer, who in turn must then decide on which option (if any) to take. Therefore, a financial adviser cannot determine (regardless of what medical information is provided by the customer), whether they will be accepted for cover (at either Normal Rates or Special Terms) or declined cover. Rather, it is the role of the financial adviser to gather the appropriate information and pass this to the medical professionals who in turn, make the decisions on behalf of the Company.*
- *It is not possible to determine whether or not an applicant will or will not be accepted on cover, until the application has been fully medically underwritten by those in the appropriate field. [The advisor], would not have been able to make this decision, regardless of what medical information was provided by [the Policyholder] during their meeting.*
- *Having reviewed the original application and the information provided by the customer at the time, [the Provider] would like it noted that the terms under which [the Policyholder] was declined cover (as referred to in the letter to which the Complainant refers), are not all in fact disclosed on the signed application. Rather, the decision was based on information received by the Company, in the Private Medical Attendants Report from his GP. This was requested by the Company's Underwriter after the application was received.*

I also note that [the Complainant] has again asked why his father was not advised to reduce the life cover on his existing plan, rather than apply for new life cover plan.

As outlined previously, had [the Policyholder] reduced the life cover on his existing plan, it would still have been subject to future plan reviews. Whereas, it is clear from the notes recorded during his meeting with [the advisor], that [the Policyholder] was seeking a plan on which the level of future payments, remained unchanged".

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The Complainants' response to the above of 9th February was to note that the Provider was still unwilling or unable to produce a single instance of someone in similar condition as the Policyholder ever being accepted from a similar product as was suggested to him.

Policy Provisions

"Paragraph 1
(l) The "Policy Review Date" means the twelfth anniversary of the date of Commencement of the Assurance and thereafter every sixth anniversary thereof provided always that where the Life Assured has attained age 70 and the Policy has been in force for twelve years the Policy Review Date shall mean every anniversary of the Date of Commencement".

"Paragraph 13. Variation in Guaranteed Minimum Death Benefit
- *(a) Optional variation – The Proposer may elect with effect from any monthly anniversary of the Date of Commencement of the Assurance to increase the Guaranteed Minimum Death Benefit … or to reduce it to an amount which shall not be less than fifteen times the premium payable in a policy year".*

"Paragraph 15. Conversion Option – Provided all premiums due have been paid under the Policy the Proposer shall have the option to encash the Policy and to effect on the life of the Life Assured an Endowment Assurance or Whole of Life Assurance assuring a sum not greater than the amount by which the Death Benefit exceeds the encashment value".

"Paragraph 16. Policy Review – At each Policy Review Date the Company's Actuary will:
- *(a) Review the Policy Fee and may adjust it to the level compatible with the scale then being charged by the Company for similar policies or if such policies are no longer being issued by the Company to such level as the Company's Actuary deems appropriate.*
- *(b) Determine the maximum Guaranteed Death Benefit the Company is willing to allow under the Policy until the next following Policy Review Date and is determining the said maximum Guaranteed Minimum Death Benefit the Company's Actuary will inter alia take into account the Accumulated Fund on the said Review Date, future options under the Policy, future allocations of Units to the Policy up to the next Policy Review Date assuming all due premiums are paid and then current mortality rates. If on a Policy Review Date the Guaranteed Minimum Death Benefit under the Policy exceeds the permitted maximum as determined by the Company's Actuary then the Guaranteed Minimum Death Benefit under the Policy will be reduced to the maximum or at the option of the proposer the amount of premium payable in the future will be increased to such amount as the Company's Actuary shall determine".*

30th September 2014 – Letter from the Policyholder to the Provider

"As discussed with your customer care assistant on Mon 29th September. I have cancelled the above plan which is now rather worthless. To sell such plans is nothing short of criminal. Please reimburse me any remaining surplus".
1st October 2014 – Provider to the Policyholder

/Cont'd…

"I have passed your letter to our Encashment Team who will be in contact with you regarding the surrender of your plan.

In regard to any complaint you may have about the sale of this plan, please contact us with details of your complaint and we will pass this on to our Complaints Management Team".

13th October 2014 – The Policyholder to the Provider

"I understand from your financial adviser a review should have taken place every 5 years and [at age] 70 an annual review. None ever happened, if they had I may have cancelled earlier. As said earlier to sell such plans is nothing short of criminal".

Financial Review

"[Policyholder's name], you wish to apply for a Life Long cover plan that gives you certainty on the amount you pay but also the amount that life cover will be paid out. You wish to replace the existing cover you have which is … with a new plan once all the requirements are in. Once you are on cover and the premium is paid, your cover will not be reviewed into the future".

In response to this Office's request for details of charges and fees that were applied, the Provider advised that:

"[The Policyholder's] plan was amended from normal contract rates (death benefit charge) to more favourable term rates when we conducted his plan review in 2002. We made this change at this time following consultations with the then Office of the Insurance Ombudsman about plans where reviews prior to this time had not been conducted as scheduled.

As a result of this very favourable change for [the Policyholder's] plan he paid significantly less for his level of cover going forward than he would have otherwise have paid had his plan remained on its normal contract rates".

21 October 2002 – Provider to the Policyholder

"We are writing to tell you that, as outlined in your … policy terms and conditions, your policy review was scheduled for 01/04/1995 has been deferred and is now due on 01/04/2003".

"In your policy review we calculate if your combined payments and policy fund are still enough to cover the cost of your level of life cover. In your case, next year on 1/04/2003 we anticipate that your payments will be insufficient to maintain your level of life cover".

Alternative options for life cover were offered to the Policyholder and he accepted Option A which was to maintain the level of cover by increasing the monthly payment. The Policyholder was advised that the next review date was 1st September 2013.

Annual Statement 2007 – Then current value was €16,834.64

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"Plan Review
Assuming a future growth rate of 4.80% and our charges for benefits do not change, we estimate your payments will maintain your benefits until 1 June 2016. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time".

Annual Statement 2008 – Then current value was €15,410.99
"Plan Review
Assuming a future growth rate of 4.80% and our charges for benefits do not change, we estimate your payments will maintain your benefits until 1 September 2015. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time".

Annual Statement 2009 – Then current value was €9,891.18
"Plan Review
Assuming a future growth rate of 4.80% and our charges for benefits do not change, we estimate your payments will maintain your benefits until 1 October 2013. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time".

Annual Statement 2010 – Then current value was €11,400.46

"This is a protection plan, so the value is not extra savings. This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan".

Annual Statement 2011 – Then current value was €11,116.87

"This is a protection plan, so the value is not extra savings. This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan".

Annual Statement 2012 – Then current value was €8,867.75

"This is a protection plan, so the value is not extra savings. This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan".

Annual Statement 2013 – Then current value was €6,650.84
"This is a protection plan, so the value is not extra savings. This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan".

Annual Statement 2014
"Your current cash in value at 05 February 2014 €3765.14. … Opening cash in value of your plan at 5 February 2013 €6,650.84.

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Payments received since 5 February 2013 €4,049.65

Charges applied
Protection benefit charges €7,378.47.
The current value represents a reduction in your plan of €2,885.70 since your last statement".

Decision

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

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

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

A Preliminary Decision was issued to the parties on 10th 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.

A correspondence 15th October 2018 was received from the Complainants, which acknowledged the Preliminary Decision and outlined how the Complainants wished the compensatory payment to be paid. This correspondence was exchanged with the Provider for its information.

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

Analysis

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

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The policy that the Complainant took out in 1983 is a unit linked life assurance contract, which has the benefit of being a whole of life policy as long as the premiums continue to be paid and they can support the policy benefits. The main reasoning behind unit linked protection contracts is that it affords the policyholder the chance to pay a premium in the early years that more than covers the cost of the life cover benefit with the balance of the premium remaining invested in the designated investment fund. The purpose of this is twofold, as it allows the policyholders to build up a fund, that is accessible at all times or it can help to supplement the premium paid in future years allowing the policy benefits to be maintained. On this basis the policy is subject to ongoing reviews in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date.
I would point out that even though a unit-linked whole-of-life policy allows the policyholder to build up a cash lump sum over and above what is needed to pay for the life insurance, this usually only happens if the fund performs much better than expected. It can be the case that the policy would have little or no cash value. Such policies are not meant to be a savings plan.

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

The Policyholder's policy was to be first reviewed in 1995 (on its 12th Anniversary) in accordance with the policy conditions. The Provider accepts that it did not Review the policy then. The policy was scheduled for review again in 2001, 2007 and yearly from 2010.

From the evidence submitted it is not clear from what date the cost of providing benefits under the policy first exceeded the payments that were being made by the Policyholder. However, on the basis that the decreasing surrender value, it is clear that any fund that had been built up over the years was being exhausted by the Provider extracting the policy charges.

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

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

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I find that the Policy document outlined the policy features. The Provider was entitled to Review the policy. However, I consider that there have been major lapses by the Provider in relation to how it has administered the policy over the years, in particular in relation to not carrying out the scheduled Reviews and its handling of the matter when the required substantial increase in premium became an issue in 2014.

From the evidence submitted the following points have been noted

- The Whole of Life Policy was taken out in April 1983.

- The Policyholder was born in 1940 and at the time that he experienced difficulties with the Provider in 2014 he was aged 74 years. His concern in 2014 (as per his 2014 Financial Review) was primarily to have certainty with his life cover especially since his wife was in ill health and dependant upon him.

- It was not until receipt of the Annual Statement in 2014 that the Provider alerted the Policyholder to the fact that the benefit charges were exceeding the premium payment that were being made by him.

- It was not until 2014 that the Policyholder was alerted to the fact that the Provider was deducting the excess cost of cover from the policy fund.

- The Policy was due to be first Reviewed on or about its 12th anniversary in April 1995. The next Reviews were due in 2001, 2007, and yearly from 2010.

- In the Policy's 30 year history there does not appear to have been a full and timely policy review carried out on the Policyholder's policy. In this regard it is noted that in 2002 the Policyholder was advised by the Provider that the scheduled reviews were not carried out, but that concessionary measures were taken in that regard. The Policyholder was also advised that the scheduled review of the policy would happen in 2003. With the 2002 letter the Provider set out options for the Policyholder. The Policyholder chose the first option which was to increase the premium to maintain the policy cover until 2013.

- No full contractual review took place in 2003. There is no evidence of the Provider advising the Policyholder that there would not be a further review in 2003.

- The Provider did <u>not</u> carry out the yearly reviews from 2010, following the Policyholder's 70 birthday, as required by the Policy Provisions.

- The Provider again did not contact the Policyholder in 2013 for the full contractual review of his policy that had been promised in the Provider's 2002 letter.

- When alternative cover was sought by the Policyholder from the Provider in 2014, the Provider failed to set out the full options available to him at that time. Neither the Conversion Option nor the Optional variation were fully advised to the

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Policyholder in 2014. The only cover that appears to have been recommended was a Life Long Policy which required underwriting based on his state of health. The Complainants argue that given the Policyholder's age and health circumstances, it was unlikely that the Provider would have underwritten cover for him.

The Provider argues that the only type of cover that the Policyholder wanted was a non reviewable policy and it states that the Conversion Option did not provide such cover. However, I am not satisfied that the Conversion Option clause in the policy provisions was clear on that point.

- The Policyholder raised a complaint in 2014 which does not appear to have been responded to by the Provider then. In a letter dated 1st October 2014, the Provider advised the Policyholder that in regard to any complaint he may have about the sale of the plan, he was to contact the Provider with details of his complaint and the Provider would pass this on to its Complaints Management Team.

  On 13th October 2014 – The Policyholder duly wrote to the Provider in relation to a complaint, stating:

  "I understand from your financial adviser a review should have taken place every 5 years and [at age] 70 an annual review. None ever happened, if they had I may have cancelled earlier. As said earlier to sell such plans is nothing short of criminal".

  The above letter was received by the Provider, but does not appear to have been answered or further actioned in relation to the Policyholder's complaint.

- The Policyholder died one year later on 27th November 2015.

- It is clear from the Policyholder's letter of 13th October 2014 that had he known of the missed reviews he would have cancelled earlier. The missed opportunity of not being able to exit the policy earlier when in younger and healthier circumstances when he may have been able to avail of alternative cover, was lost to the Policyholder. Not knowing that the premium payments alone were no longer sufficient to provide the life cover under the policy was not communicated by the Provider over the years and this too would most probably have earlier influenced the Policyholder's decision about the policy.

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

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While the policy provisions do highlight that the fund value would be used, in addition to the regular payment, to fund the protection benefits, the Provider did not communicate to the Policyholder when this had begun to happen or that it was indeed happening for some time.

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

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

I accept that the Policy document outlined the policy features. The Provider was entitled to Review the policy. However, the Provider (a) did not carry out the scheduled Reviews, or (b) did not communicate when (which appears to be the position) it had begun using the fund value to supplement the premiums that were being paid by the Policyholder, but to the contrary, up to 2013 it indicated that the premium payments alone were sufficient (c) did not fully set out the alternative cover options available to the Policyholder when sought new cover, and (d) did not progress the Policyholder's complaint when raised by him in October 2014.
I consider that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is Life Assurance cover.

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

I accept that there was a continuing failure by the Company up to 2014 to correctly inform the Policyholder about how the policy had been administered relative to the Reviews provided for in the Policy Document and as to the adequacy of his premium payments to purchase the life cover. Section 51 (5) of the Financial Services and Pensions Ombudsman Act 2017, allows for the examination of conduct of a continuing nature.

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 more recent point in time which brings the complaint within the jurisdiction of this office. 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:

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"(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".

The Complainants state that they want the original death benefit to be paid to the Policyholder's widow, less any monthly premiums that would have been paid had the policy remained in place from September 2014 through to November 2015. While I have found unreasonable lapses by the Provider in this complaint, it has to be accepted that the Policyholder did take the action of cancelling the policy himself. It is unfortunate that matters were not further pursued at the time, and if they had, the outcomes that could reasonably have been achieved are not so certain. I also accept that the Policyholder did have the protection of the policy for many years. That said, I do consider that the most beneficial remedy here is a substantial compensatory payment.

Having regard to all of the above it is my Legally Binding Decision that the complaint is substantially upheld and I direct the Provider to pay the Complainants (the estate of the deceased policyholder) the compensatory payment of €50,000 (fifty thousand euro). The Provider is to liaise with the personal representatives of the deceased estate in relation to their required method of payment of the compensatory payment.

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Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is 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 Complainants in the sum of €50,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

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GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

5th 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.