An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0193
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Maladministration (life) Delayed or inadequate communication Dissatisfaction with customer service Results of policy review/failure to notify of policy reviews Fees & charges applied (life)
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to a Whole of Life Insurance Policy taken out in 1995.

The Complainants are unhappy with a perceived lack of 'transparency' in the Provider's administration of the policy, and in particular, the Provider's failure to communicate in a 'clear' and 'effective' manner with the Complainants as to how their policy operated.

They cite in this regard the following examples:

1. They state that they were unaware that the policy was a '*flexible one*' until April 2017 upon receipt of the Provider's Final Response Letter whereupon, they submit, they became aware for the first time that it was possible to '*vary the term of the policy*'. The Complainants believe that the Provider's alleged lapse in notifying them before this time as to the nature of their policy, resulted in them not being *'fully apprised as to what the policy was.'*

2. The Complainants are also unhappy that '*prior to the involvement*' of this Office, they were never given *'the specifics as to the application of the premium paid'* or an *'actual breakdown of the cost of the life cover for each of them'* or confirmation of the applicable *'policy fee[s]'*.

The Complainants appear to be unhappy generally with recent premium increases applying to their policy, calling them '*exorbitant'*.

The Complainants raised specific grievances in relation to the sale of the policy in 1995. The Complainants have been informed that this Office is not investigating this aspect of their complaint owing to the passage of time.

The complaint is that the Provider did not correctly administer the policy, in particular in relation to making clear over the years how the policy operated by way of transparent communications.

The Complainants' Case

In 1995, the Complainants took out a Whole of Life Insurance Policy with a third party Provider. The aforementioned Provider, which is the subject of this complaint, subsequently took over the policy.

The Complainants submit that the Provider *'owes [the Complainants] a duty to communicate clearly, effectively and transparently as to how it is applying [their] money and it singularly failed to do that prior to the involvement of your office.'* This Office received the complaint on 21 July 2017. The Complainants are of the view that if communication on the part of the Provider had been clearer, '*[they] would have had full information with which they could have made decisions'* in respect of their policy.

The Complainants contend that: *'it was not until [the Provider] wrote to [the Complainants in] letter … dated 06.10.2017 … that an actual breakdown of the premium paid, cost of life cover for [the First Named Complainant], cost of life cover for [the Second Named Complainant] and policy fee was actually broken down …'*

The Complainants reference in this regard the Provider's annual statement dating from February 2017 by way of illustration: *'On [this] annual statement… it is specified that we paid premium €3853.32. Policy charges (excluding annual management charge) is specified as -€4576.90. This on the face of it, at least, would appear to suggest that none of our premium paid is being applied to the purchase or funding of units. This, to us, seems to be in breach of the terms of the policy schedule, regarding unit allocation etc [second schedule]'.*

They continue by stating: *'We do not accept that [the Provider] has a right to apply the entirety of our premiums to policy charges, and most certainly not to the extent that there is a shortfall between its charges and the premium paid. Does this mean that [the Provider] is eating into the policy fund value to finance this shortfall … We do not accept that [the Provider] has the right to do this, without at the least giving us clear unambiguous notification that this is what it is proposing to do and seeking our written agreement in advance.'*

The Complainants also feel particularly aggrieved over the content of the Provider's Final Response Letter dated 13 April 2017. Up until receiving this letter, they state that they were *'unaware that the policy … was a flexible policy'*. They refer specifically to that part of the

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Provider's letter as a result of which, they state that they learnt '*for the first time ever'*, the following:

> *'This is a flexible policy, You can choose alternative levels of premium, life cover or even length of time to which the policy is to be maintained and we can calculate the resultant policy information'.* [underscore emphasis my own]

The Complainants contend as follows: '*If we had been told at any time that we could have changed the term of the policy from whole of life to specified term of years, we could have made an informed decision as to term of years which we now understand would have had an impact on the premium payable. We were not told this until 13.04.2017. The policy document does not say that the term of the policy could be changed or altered.'*

The Complainants are also unhappy with the premiums increases applying to their policy, calling them '*exorbitant*'.

The Complainants '*are advancing in years and they require resolution of this matter as it is causing them stress and distress.*' They are seeking the following by way of redress:

1. A '*written breakdown … of all monies paid into this policy … since its inception'.*
2. A breakdown as to *'allocation by it and its predecessors of all monies paid in by it to this policy, as allocated between units, policy charges, management charges on a year by year basis.'*
3. *'Reimbursement … of the amount paid by us from year 11 to date that is in excess of the initial monthly premium paid ... for year 1 through to 10.'* (The Complainants submit that their premium '*stayed the same for the first ten years'* of the policy).

It is noted that the Provider states that the policy *'was cancelled with effect from 1st March 2018 at [the Complainants'] request.'*

The Provider's Case

The Provider explains that the Complainants had a Living Insurance policy. It states that the purpose of this policy is to provide life cover in the event of death.

The Provider submits that the premium for the policy *'is affected by the 'Policy Review' section of the Complainants' policy document'.* The Provider states that it is satisfied that it has correctly administered the policy *'in line with its terms and conditions'* and adhered to the Consumer Protection Codes. It is also satisfied that *'charges have been applied correctly'.* The Provider submits that the '*the fees and charges [were] being deducted in line with the Policy Document'* and goes on to state that *'the amounts deducted are shown in the annual statements since 2014.'*

The Provider submits the following explanation as to how the Complainants' policy operates:

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> *'The cost of the life cover plus the policy fee is deducted from the policy investment account. Where the cost of life cover, together with the policy fee is less than the premium being paid, the balance of premium paid remains in the investment account. Thus, an encashment value may accumulate. As the cost of life cover, together with the policy fee, increased with age it became greater than the premium being paid and so a combination of both the premium and the investment account was used to cover the cost of the life cover amounts. The additional amount deducted from the investment account meant that the investment account value on the policy was gradually eroded due to the cost of the life cover benefits being greater than the premiums paid. This was in line with the Second Schedule of the Policy document.'*

In respect of its Final Response letter dated 13th April 2017, the Provider has since clarified the wording in its letter: *'The references to 'length of time' in that letter are not relating to an end date for the policy. They are relating to how long a certain level of premium would be able to maintain a certain level of cover. Beyond those points, it would be necessary to increase the premium or reduce the levels of cover.'* The Provider has apologised '*if the phrasing in [its] letter … caused some misunderstanding'* in respect of the term of the policy. The Provider asserts its view that the policy '*is not and never was a term policy.'*

Evidence

Policy Provisions

I have reviewed the Policy document. The **First Schedule** confirm that the date of commencement of the policy was '01/03/1995' and that the premium was payable *'MONTHLY by DIRECT DEBIT from the Date of Commencement and during the lifetime of the last survivor of the Lives Insured but subject to the Provisions of the Fourth Schedule'.*

The **Second Schedule** of the policy document references in part unit allocation and unit apportionment.

Section 4 refers to Unit Allocation and states:

> *'During the first year of the policy and during the first year of each policy increase, forty percent (unless otherwise specified in the First Schedule) of each Unit-Linked Premium paid or the Unit-Linked portion of any Increase shall secure units and during the second year of the policy and during the second year of each policy increase, sixty per cent (unless otherwise specified in the First Schedule) of the Unit Linked Premium paid or the Unit-Linked portion of any increase shall secure units.*
>
> *Thereafter one hundred percent (100%) of each Unit-Linked Premium paid (unless otherwise specified in the First Schedule) shall secure units.*
>
> *Units are secure at the offer price on the Premium Due Date or at the discretion of the Company in the event of the Total Premium not being paid on its Premium Due Date, on the first day of the month following receipt of the premium.'*

Section 5 refers to Unit Apportionment and states:

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'The number of units in any Fund allocated to this policy on payment of a Unit-Linked Premium will be in accordance with the current apportionment instructions of the Policy Owner and will be determined by dividing each Funds proportion of the Unit Allocation … by the offer price of the units appropriate to that Fund on the Premium Due Date …

Future premiums may be apportioned to any Fund which the Company has created and to any Fund which it may create in the future subject to any legal or Revenue restrictions.'

The **Fourth Schedule** of the policy document relates to policy reviews, and is set out as follows:

"1. At a Policy Review the Total Premium payable under this policy shall be recalculated by the Actuary taking account inter alia of the Sum(s) Insured, the value of the Policy Account and the age of the Life or Lives Insured. The recalculated premium, if greater, shall replace the Total Premium until the next Policy Review the date of which shall be determined by the Company.

2. When a Policy Review takes place:
(a) Immediately prior to the tenth anniversary of the Date of Commencement. Should a Maximum Review Term apply to this policy the Policy Owner may elect to leave the Total Premium unchanged after this Policy Review until the expiry of the Maximum Review Term.

(b) Following the exercise of any option contained in Paragraph 5, 7, 16, 17 of the Sixth Schedule, on the death of the First Life Insured (if there are two Lives Insured), and on receipt of an instruction to redirect any future premiums from the CAPP account.

The Policy Owner may elect to leave the Total Premium unchanged provided that the First and Second Life Sum(s) Insured under this policy would not then exceed such maximum Sum(s) Insured as the Actuary shall determine. The Actuary shall then recalculate the Guaranteed Encashment Value and the Maximum Review Term (if any).

(c) In any event, at the expiry of the Maximum Review Term (if any).

The **Fifth Schedule** of the policy document relates to annual policy increases, and is set out as follows:

'1. Increase in Sum Insured

At each Policy Anniversary date, the Sum(s) Insured shall be increased proportionately to the increase in the Consumer Price Index during the preceding year, without any evidence of the continue good health of the Life or Lives insured, unless the Policy Owner elects to take a lesser or no increase.

2. Increase in Premium

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The Total Premium shall be increased in the same proportion as any increase in the Sum(s) Insured under this Schedule. However, the Company may, at its discretion, increase the Total Premium by a greater amount to be calculated by the Actuary on the basis of applying to the increase in Sum(s) Insured the rate of premium which in his opinion is appropriate to a new policy, having regard to the age of the Life or Lives Insured at the anniversary date and the ratio between Sum(s) Insured and Total Premium under this policy immediately prior to the said increase.

3. Premium Unchanged

The Policy Owner may elect within one month of the anniversary date to accept the increase in Sum(s) Insured under the provisions of this Schedule and leave the Total Premium unchanged providing that the increased Sum(s) Insured does not exceed the maximum Sum(s) Insured determined by the Actuary. The Actuary shall then recalculate the Guaranteed Encashment Value and the Maximum Review Term, (if any), under this policy.'

Review Communications

February 2018 Review
'We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2018 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2017 Review
'We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2017 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2016 Review
'We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2016 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2015 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2016 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2014 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2016 … We will in future review

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your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2013 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2014 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2012 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2014 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2011 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2013 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2010 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2013 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2009 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2012 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2008 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2011 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2007 Review
"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2010 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2006 Review

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"We have again reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2009 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

February 2005 Review
"We have now reviewed your policy and can advise that your current premium is expected to maintain your current protection benefit(s) until 1st March 2009 … We will in future review your policy on a regular basis which will ensure gradual premium increases to help maintain your protection benefit(s) for whole of life".

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, including audio 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 9th August 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

The issue for investigation and adjudication is whether the Provider correctly and reasonably administered the policy, in particular in regard to reviews and overall clarity and transparency in respect of communication with the Complainants re the cost of maintaining benefits, associated charges and length of policy term.

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Analysis

The policy that the Complainants took out in 1995 is a unit linked life assurance contract, which has the benefit of being a whole of life policy as long as the premiums continue to be paid and they can support the policy benefits. The main reasoning behind unit linked protection contracts is that it affords the policyholder the opportunity 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 allows for ongoing reviews in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date.

I would point out that even though a unit-linked whole-of-life policy allows the policyholder to build up a cash lump sum over and above what is needed to pay for the life insurance, this usually only happens if the fund performs well. It can be the case that the policy would have a little or no cash value. Such policies are not meant to be a savings plan. Where encashments are taken from the policy by the Policyholder, this will have an impact on what fund is available in the later years. I note the Provider's confirmation that '*no encashments*' were made by the Complainants during the lifetime of the policy and that no submission has been made in this regard by the Complainants.

I note that the Complainants are unhappy that their premium has increased *'from €641.76 per annum in 1995/6 to €3815.16 in 2016/17.'* They state that *'this exorbitant premium … is putting [us] under financial pressure'.*

It is appropriate to point out that 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. In this regard, I note that the Provider states that the Complainants *'chose not to accept the recommended premium increases in 2010, 2012, 2014, 2015 and 2016.'* The Complainants therefore, appear to have accepted the recommended premium increases in the years 2011, 2013 and 2017 respectively. I note that the Complainants are particularly unhappy with the 2017 premium increase calling it *'exorbitant.'*

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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The Fourth Schedule of the policy document clearly states that policy reviews apply from the tenth anniversary onwards. The Provider submits that *'annual reviews commenced on [the] policy from March 2005'.* Having examined the review correspondence on file, I am satisfied that reviews took place every year from 2005 (tenth anniversary) up to 2018.

The fact that the reviews were to take place in respect of the policy, is not a matter which is specifically contested by the Complainants. Indeed the Complainants acknowledge, with reference to the policy terms and conditions, that *'the Fourth Schedule relates to policy review of the premium payable'*.

Though I find that the Provider was contractually entitled to review the policy, and did so in accordance with the policy terms and conditions, I am not satisfied with the overall clarity and transparency of the Provider's communications in respect of the policy as a whole.

For instance, in response to the Complainants' contention that charges are being applied incorrectly, the Provider states that the annual statements which issued to the Complainants from 2014 onwards, show that '*the fees and charges [were] being deducted in line with the Policy Document.'* I note that annual statements issued to the Complainants every year from 2012, in accordance with the provisions of the 2012 Consumer Protection Code. In respect of the 2012 and 2013 annual statements, I note that the cost of cover is not disclosed however as and from the year 2014, the annual statements do disclose the amounts deducted by way of charges. That being said, the annual statements which issued from 2014 onwards still require a degree of calculation on the part of the Complainants in order to deduce the actual interaction between the fund and the cover, that is, this information is not manifestly evident from reading the annual statements first hand. I appreciate that the figures displayed are comprehensive however I am of the view that the figures have not been put into an appropriate context.

I am cognisant that the Complainants believe that it was not until correspondence dated 6th October 2017 that they received '*an actual breakdown of the premium paid, cost of life cover for [the First Named Complainant], cost of life cover for [the Second Named Complainant] and policy fee …'* from the Provider. In its Company File to this Office dated 19 April 2018, the Provider submitted a '*Breakdown of premiums paid & policy charges.'* It also provided confirmation of the *'fund value of the policy [for] each year'*. I have reviewed both these submissions (compiled retrospectively by the Provider), in tandem with the annual statements and review correspondence sent to the Complainants (prepared contemporaneously by the Provider). It appears that the cost of life cover first exceeded the premium being paid in or around the policy year 1 March 2012 – 28 February 2013. However, looking at the content of the review correspondence issued to the Complainants along with the annual statements, I am not satisfied that the Provider had made the Complainants fully aware, in these communications, of the implications of the interaction between the fund and the cover at the material time.

It is not clear from the annual statements/review correspondence what date the cost of providing benefits under the policy first exceeded the premium payments that were being made by the Complainants. However, on the basis that the 2017 annual statement shows a '*NIL*' encashment value, it is clear that any fund that had been built up over the years was

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exhausted by the Provider, extracting the policy charges. However, this again required some degree of calculation on the part of the Complainants, in order to comprehend that this was the case.

While I accept that a Provider does not have to notify a policyholder in advance of increasing the annual charges made for mortality rates (as this is provided for in the policy terms and conditions), 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 and that it was necessary for the Provider to reduce the policy fund to support the premium payments to cover the benefits. It is not immediately evident from the annual statements and/or policy review correspondence sent by the Provider to the Complainants, the period of time from which it was necessary for the Provider to reduce the policy fund to support the benefits. A reduction however for that purpose appears to have happened, as the fund was exhausted to a '*NIL'* encashment value in 2017.

So while the annual statements from the latter stages of the policy did highlight that the fund value had been used, in addition to the regular payment, to fund the protection benefits over the years, it is my view that the Provider did not adequately communicate to the Complainants the date from when this had begun to happen or when it was happening in the intervening periods. Indeed, the opposite advice was given to the Complainants by the Provider in many of its communications. The review correspondence sent to the Complainants over the intervening years (copy extracts of which are set out above) specifically advised that the premium payments the Complainants were making were sufficient to maintain the Complainants' current protection benefits.

Bearing the above in mind, I do not accept that it was reasonable of the Provider to merely advise the Complainants from year to year that their premium payments were sufficient to cover the cost of benefits, without telling them that the cost of cover had exceeded the premium payment, and that the fund value was in fact being relied upon to cover the excess cost. While the policy provisions do highlight that the fund value would be used, in addition to the regular payment, to fund the protection benefits, I am satisfied that the Provider did not communicate to the Complainants when this had begun to happen or that it was indeed happening for some time. As a result, I find that the correspondence was somewhat misleading and I therefore consider that there have been significant lapses by the Provider in relation to how it communicated with the Complainants as to its administration of the policy.

I am cognisant that the Complainants feel aggrieved that as a result of poor transparency on the part of the Provider in its overall communications, they were prevented from making *'an informed decision'* about continued involvement in the policy. I am also cognisant that they believe that they did not have *'full information'* concerning their policy '*with which they could have made decisions.'* Based on my above analysis, I accept the Complainants' grievances in this regard as justified. I do not accept that it was reasonable of the Provider (i) not to tell the Complainants in clear and unambiguous terms that the cost of cover had exceeded their premium payments for some time, and (ii) that the fund value was being relied upon to cover the excess costs.

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I consider that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is life assurance cover. The importance to the Complainants of fully appreciating – at the material time – that the Provider was decreasing the fund in order to pay for the policy cover, was that they 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.

In relation to the Provider's Final Response Letter dated 13 April 2017, I note the confusion which ensued on the part of the Complainants arising from the Provider's reference to their policy being *'flexible'* in particular in relation to *'the length of time to which the policy is to be maintained'.* I note that the Complainants' particular grievance regarding the content of this letter, comprises a large proportion of its submissions to this Office.

With this in mind, having reviewed the chain of correspondence which ensued between the parties, I believe that it is disappointing that the Provider failed to clarify what it meant in its letter dated 14 April 2017, in the body of its subsequent Company File. This omission – which in my view, is abject – was noted by the Complainants in subsequent correspondence dated 30 April 2018, as follows: The Provider *'… singularly fail[ed] to address the question of it having informed [the Complainants] this was a flexible policy at the time it was taken out or at all up until April 2017. This is unacceptable.'*

I note that the Provider offered clarification on the matter in correspondence dated 11 May 2018, as follows:

> *'I confirm that this policy is not and never was a term policy. As such, the Provider did not have a term of cover and therefore an option to change the term on the policy never applied. It was a flexible policy with regard to the fact that the Complainants could have chosen alternative levels of premium or life cover and it was capable of lasting for whole of life assuming recommended premiums were paid.*

The Provides goes on to apologise '… *if the phrasing … caused some misunderstanding.'*

I am satisfied that the Complainants' policy *'is not and never was a term policy'* as is submitted by the Provider and that it was capable of lasting for whole of life assuming recommended premiums was paid, as confirmed by the details set out in the First Schedule of the policy document. I am satisfied that there was never an option open to the Complainants to change the term on the policy and therefore any perceived concerns on their part as to 'lost opportunity' in this regard are unfounded. It was a flexible policy with regard only to the fact that they could have selected alternative levels of premium or life cover.

I nonetheless accept that the Provider's reference in its letter dated 13 April 2017 to the word '*flexible'* when it came to the term of the policy, was confusing. It is my view that the lack of clarity in the Provider's communications with the Complainants during the lifetime of the policy was, in my view, unfortunately compounded in more recent times, by the content of its letter dated 13 April 2017. I am of the view that this correspondence may have

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caused the Complainants such concern that they lost confidence in the Provider. In this respect I am especially conscious that the policy was cancelled *'at [the Complainants'] request'* just under a year later, in March 2018.

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, accurate 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. Furthermore a regulated entity must supply information to a consumer on a timely basis.

Having examined the matter, I believe that there was a continuing failure by the Provider to inform the Complainants clearly and transparently at the opportune time, as to how their policy was being administered.

The Complainants have set out that in resolution of their complaint, they are seeking the return of some of the premiums that were paid by them during the lifetime of the policy, namely *'… from year 11 to date that is in excess of the initial monthly premium paid by us from year 1 through to 10 …'* Though the policy is now cancelled (since March 2018), I am aware that the Complainants did have the benefit of life cover for many years prior to policy cancellation. Therefore, in the event that a claim had arisen, the Provider may have paid out on the life cover.

I accept that the issue here is one of a requirement for greater and better communication from the Provider and for this identified significant lapse in same, I consider that the appropriate remedy here is that the Provider make a substantial compensatory payment to the Complainants. Having regard to the particular circumstances of this case, in particular the failings that have been noted above, it is my Decision that the complaint is partially upheld and I intend to direct the Provider to make a compensatory payment of €12,000 (Twelve Thousand Euro only).

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Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Sections 60(2)(b), 60(2)(f) and 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 €12,000 (twelve thousand Euro), 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

10 September 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.