An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0222
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Delayed or inadequate communication
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a Whole of Life Policy taken out in 1996. The complaint relates to the Provider's review of the policy in 2016 and in the previous years. The Complainants were advised in 2016 that they had to substantially increase their premiums to keep their existing cover in place.

The complaint is that the Provider has not correctly administered the policy, particularly in relation to the review of the policy.

The Complainants' Case

The Complainants purchased the Plan in 1996, and state that they were assured by the agent that it was for both of their lives to be paid out when one or other of them died. The Complainants state that they had paid their premium every year without fail and at times having to struggle to pay. The Complainants state they are anxious and worried to have been told that their policy is not as they were promised. The Complainants consider that the increased premium is unfair.

The Complainants state that they would like the policy cover and premium to stay at the level it is at. The Complainants state they cannot pay the €13k+ per year which the Provider wants them to pay for their existing cover.

The Provider's Case

It is the Provider's positon that the Review Process resulted in a recommendation made in February 2016, that at the next scheduled review date of September 2017, either the annual premium needed to be increased from €2,946.68 to €13,378.40 or the life cover reduced from €124,175 on each life to €17,172 and the Serious Illness Cover for the first life reduced from €52,834 to €7,306, in order to maintain the plan up to the next scheduled review in September 2018.

The Complainants also objected to the fact that the Provider did not carry out a scheduled review in 2011 and only offered €250 by way of an apology.

The Provider's response to the complaint is to point to the fact that under Section 7 "Policy Review" of the Terms and Conditions it allows for periodic reviews of the Plan, with the implied possibility that either the premium may need to be increased or the benefits reduced, in order to maintain the plan into the future.

The Provider states that the10th Anniversary Policy Review was carried out in accordance with the Protection Portfolio Plan Terms and Conditions in October 2006. The Provider says that this review recommended that either the annual premium needed to be increased from €2,946.68 per year to €4,642.96 per year or the life cover reduced from €97,296 on each life to €57,318 and the Serious Illness Cover for the first life reduced from €41,399 to €24,388 in order to maintain the plan up to the next scheduled review in September 2011.

The Provider states that alternatively the Complainants were also advised that they could obtain, upon request, a quotation from the Provider for a different combination of premium and cover that might better suit their financial situation at the time.

The Provider submits that the Complainants returned the Policy Review Options Form indicating that they wanted to discuss alternative quotes (Option C).

It is the Provider's positon that despite the fact that Quotes were issued to the Complainants' Broker at the time there was no follow up by the Provider and the plan continued unchanged which meant that the Complainants were being undercharged for their level of benefit from 2006 on.

The Provider states that unfortunately due to an administrative oversight, the subsequent Scheduled Review due in 2011 was not conducted at the time. The Provider says that this oversight only came to light in 2016, at which time the Provider wrote to the Complainants to advise that had the review being carried out at the time, a recommendation would have been made to either increase the premium or reduce the benefits, in order to maintain the Plan until the next scheduled review in September 2016.

The Provider submits that the result of the failure to carry out the 2011 Plan Review meant that the Complainants had been undercharged for their chosen level of cover from 2006 to 2016, the cost of which was borne by the Provider. In its notification letter of 2 February 2016 the Provider apologised for this oversight and offered a Customer Service Award of

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€250 and to extend the scheduled September 2016 review out to September 2017 in order to give the Complainants time to consider their options. The Provider's letter also advised the Complainants of the expected increase in premium or decrease in benefit that would result when the September 2017 Plan Review would be conducted.

The Provider states that these changes were based on the Provider wiping off the accumulated additional charges that had built up since 2006, as a result of the lack of review changes. The Provider states that the total write off of charges amounted to €4,323.31.

The Provider submits that this meant that the September 2017 Plan Review Options were calculated as if the 2011 Scheduled Plan Review had been carried out and assumed that the Complainants had chosen to maintain their level of cover at the time (Option A).

The Provider states that with regard to the proposed changes notified in February 2016 and the subsequent September 2017 Plan Review Options, the degree by which the premium needed to be increased to, or the benefit needed to be reduced by in order to maintain the plan until the next scheduled review in September 2018 were based on the current Risk Cost applicable for the Complainants at the time of the review.

The Provider submits that the Annual Risk Cost at the time of the most recent Plan Review was €7,956.18 compared with the Annual Premium of just €2,917.21. On the basis that the Risk Cost would continue to increase exponentially each month, as the Complainants aged, a substantial increase was deemed necessary in order to maintain the higher level of benefits chosen by the Complainants until the next annual review. The Provider states that alternatively of course the Complainants could consider accepting a comparative reduction in their benefits, if they wished to maintain the same premium.

The Provider states that it should also be noted that a total of €50,306.01 has been paid out in various Hospital Cash Cover claims over the duration of the plan, which also includes a single, lump sum, Serious Illness Cover payment of €31,252.16 on behalf the second life assured in August 2002.

The Provider says that in conclusion, while the Provider understands that no customer welcomes the need for either an increase in their premiums or a decrease in their cover, these options were necessary in order to maintain the Plan going forward and the changes were a true reflection of the cost to the Provider for providing the benefits attaching to the Plan.

Evidence

Plan Terms and Conditions

Section 7

"Policy Review
All of the benefits provided by this Policy and the amount of the premium payable shall be reviewed by the Actuary on the tenth Policy Anniversary and every fifth Policy Anniversary

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thereafter, until the policyholder attains his 65th birthday following which the Review will take place at every Policy Anniversary.

A policy review shall also take place after a claim is made under Section 1A [Life Cover], 1B [Serious Illness Cover], 1F [Accidental Death Benefit], 1I [Long Term Care Benefit], 1J [Terminal Illness Benefit] or 1K [Encashment Value] ….

At the policy review, the Actuary will determine whether the premium being paid is sufficient maintain the benefits provided until the next scheduled Review.

In making this decision, the Actuary will consider, inter alia,

(i) *The value of the Benefit Fund attaching to the Policy*
(ii) *Current rates of mortality and morbidity.*

If, at the Policy Review, the current premium is insufficient to maintain the benefits until the next review or for ten years if longer, the Actuary shall determine and notify the policyholder of

(i) *The amount of premium required to maintain the benefits, and*
(ii) *The reduced benefits which the current premium can support".*

24 October 2006 - Policy Review Options:

> *"Please note that if we do not hear from you by 24 November 2006, [the Provider] are required to process Option A and increase your premium from the above date, as set out in your policy's Terms and Conditions".*

The Complainant sent back the Policy Review Options Form with the following note:

> *"Option C – Quotation for a different level of cover / premium amount" Please phone us to discuss this option"*

Provider internal communication of December 2006:

> *"Hi E..*
> *Following a Policy Review, this client requested that we contact them to discuss other possible options. I was hoping you could contact their broker … to sort this out"*

In the 2013 Annual Benefit Statement it shows that the Premiums received were not enough to cover the Benefit Charges. €2,946.68 premium versus Benefit charges €5,838.11. Likewise the subsequent Annual Statements show that the premiums being paid were no longer enough to support the cost of the Plan Benefits.

> *"Explanatory notes*

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Premiums received – These are the premiums paid by you into your policy over the statement period.

Benefit charges – This this the charge to cover the ongoing costs of the benefits provided by your policy.

Premium reviewable – As unit-linked policies can run for many years, the charges and costs of maintaining them may increase over time. As you get older, for example, the cost of providing your benefits increases. We review your policy to ensure that you are paying the correct amount into your policy to keep the level of cover you have chosen".

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 20th November 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

The Complainants acknowledged on 4th December 2018 their receipt of the Preliminary Decision and that they were accepting the Preliminary Decision.

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

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The issue for investigation and adjudication is whether the Provider correctly administered the policy, in particular in relation to the review of the policy and its communication about those reviews.

Analysis

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

The Provider accepts that it did not carry out the contractually required Reviews over the period 2006 to 2016. The Provider also accepts that it did not follow up with the Complainants as to what option they were choosing following the 2006 Policy Review. By not undertaking the Reviews of the policy over this period, the policyholders were denied an opportunity to decide what action they wished to take regarding the policy. It could, for example, be the case that:

(i) The policyholders may also have wished to exit the policy, after discovering that this is how the policy was to operate in the future. It is one thing to set out in the policy document how something is going to be done, but not knowing the full implications, including the financial implications of a Review process is another matter.

(ii) The policyholders may also have wished to take the fund value that was available at the relevant Review dates. This opportunity has also been lost due to the lack of communication from the Provider, in a timely manner, of the missed Reviews over the period 2006 to 2016.

It is also noted that a contractual review should have taken place in 2002 when a Critical Illness Claim was paid, but there is no evidence of that review having occurred.

The consequence of policyholders not having their plan reviewed when it should be reviewed means the loss to policyholders of an early insight into the operation and effect of such reviews on their policy. In this complaint, I accept that (i) the Provider should have correctly reviewed the policy at the appropriate and contractual review dates and (ii) communicated the failure to carry out the scheduled Reviews earlier than it did. It was not until the 20th anniversary of the policy in 2016 (and in the later complaint communications) that the Complainant became aware that reviews had been missed over the years. It was also not until 2016 that the Complainant was made fully aware (in a practical sense) of what actually happened in the absence of the Reviews and follow up of the policy. What happened in the intervening years was that the Complainants policy fund was exhausted as they were not paying enough to support the cost of cover.

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While the fund can be contractually relied upon by the Provider to fund any shortfall in premium payments, I accept that the Provider should have made this much clearer for the policyholders in its communications.

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.

I believe that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is Life Assurance cover. It was only in the later years that the Complainants were alerted by way Annual Statements that the cost of cover was much more than what they were paying by way of premiums.

The evidenced shows that the Provider (i) missed at least 5 Reviews on the policy (ii) failed to communicate for many years that these Reviews were missed (iii) failed for some time to correctly communicate that the premium being paid was not sufficient on its own to support the cost of the policy benefits (the fund was supplementing the cost of cover for some time, in addition to the Provider making up the shortfall) (v) failed to follow through with establishing what option the Complainants were going to take as regards cover, following the 2006 Review.

That said, I find the Policy terms and conditions that the parties agreed to from the outset, outlined the policy features. Accordingly, the Provider was entitled to Review the policy.

I accept that the documentation sent to the Complainant in respect of their Policy did not set any expectation that the protection benefits and premium would remain at the same level throughout the lifetime of the Policy.

Having reviewed the express wording of the policy terms and conditions, I accept that the Complainant was on notice from the time of commencement of the policy that the policy was to be reviewed on its tenth anniversary and thereafter every 5 years (and in the situation where the policyholder reached aged 65 years, on annual basis) and that the Provider could assess if the level of cover could be maintained at the existing premium until the next scheduled review or whether it was necessary to increase the premium to maintain the level of benefit.

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 Provider from 2006 up to 2016 to correctly inform the Complainants about how the policy had been administered relative to the Reviews provided for in the Policy Document and to follow up over those years with regard to the level of cover the Complainants wished to have in place. Section 51 (5) of the Financial

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Services and Pensions Ombudsman Act 2017, allows for the examination of conduct of a continuing nature.

As regards any allegations in relation to the sale of the policy in 1996, that is whether the policy was mis-sold to the Complainants, this is not being examined due to the passage of time.

However, the key point is that conduct of an ongoing nature allows in certain circumstances a consideration of conduct which might initially have started or been caused by conduct that occurred beyond the 6 year period, but which continues up to a more recent point in time which brings the complaint within my jurisdiction. I accept some of the failings by the Provider outlined above were of a continuing nature.

Section 51 (5) of the Financial Services and Pensions Ombudsman Act 2017 states that:

"(a) conduct that is of a continuing nature is taken to have occurred at the time when it stopped and conduct that consists of a series of acts or omissions is taken to have occurred when the last of those acts or omissions occurred, and

(b) conduct that consists of a single act or omission is taken to have occurred on the date of that act or omission".

While I accept there were lapses by the Provider in regard to the administration of this policy, I do not accept that the lapses warrant a direction for the Provider to maintain the benefits as they were and at their existing lower cost. Overall, I accept that the issues here are ones requiring better administration and greater and better communication from the Provider and for the identified lapses, I accept that a substantial compensatory payment is merited in this complaint. This compensatory payment is to be in addition to the Provider's compensatory measures.

The concessionary measures applied by the Provider for its errors was to amend the unit holding by adding units to the value of €2,484.65 to ensure that missed reviews did not affect the plan. The Provider also agreed to maintain the current payment and current cover until 1 September 2017. The Provider also agreed to not seek to recover any previous shortfall. The Provider states that the total write off of charges amounted to €4,323.31.

Having regard to the particular circumstances of this case, in particular the failings that have been noted above, it is my Legally Binding Decision that the complaint is partially upheld and I direct the Provider to make a compensatory payment of €15,000 (fifteen thousand euro) to the Complainants.

It is noted that the Provider has advised the Complainant of alternative policies that it has available which would provide some certainty as to the cost of the cover being provided, going forward. I would suggest that the Complainants should seek independent advice before deciding on what to do regarding alternative life cover.

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Having regard to all of the above it is my Legally Binding Decision that this complaint is partially upheld.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €15,000, 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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

13th December 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.