An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0227
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a Whole of Life Policy and the Provider's administration of same over the years. The Policy was taken out in 1991. The Provider was to review the policy over the years and communicate whether the premium payments being paid were adequate to provider the benefits under the policy.

The complaint is that the Provider did not correctly administer the policy, particularly in relation to the review of the policy, and in relation to how it addressed the matter of continuing the cover during the course of the complaint.

The Complainants' Case

The Complainants state that a life policy taken out in 1991 was subject to premium reviews every 5 years. That Reviews took place in 2001 and 2006 (in accordance with the Terms & Conditions) and no premium increase occurred.

The Complainants submit that the Provider was in breach of its own Terms and Conditions by not reviewing the policy in 2011. The Complainants state that this was confirmed by the Provider in correspondence to their broker on 05/04/16.

The Complainants say that in February 2016 the Provider wrote to them indicating that the premium on the policy would be increasing from €243.34 to €1,447.61 per month, which

they says represents a premium increase of approx. 500%. The policy would also be reviewed in another 5 years and every 5 years thereafter.
The Complainants state that their complaint is based on the fact that if the Provider had reviewed the policy in line with their Terms and Conditions in 2011, it has indicated that the proposed premium Increase at that time would have been in the region of €1,078. The Complainants state that in this event they would have arranged alternative cover as they would have deemed same to be exorbitant, particularly in view of alternative policies available in the market at the time, even with the Provider.

The Complainants state that they have been severely financially disadvantaged for the future term of their life cover.

The Complainant's positon is that if at this stage they were to complete a proposal form for an alternative policy they would be disadvantaged by:

(a) Being five years older than at the time of the missed review.
(b) Underwriting/Acceptance for a new policy could have changed since the Provider was in breach of its Terms and Conditions in 2011.

The Complainants states that they want the Provider to do the following to put things right:

The Complainants want the Provider to allow them convert their existing level of cover to a Provider Term Life Assurance policy, with a premium based on their ages at the time of the missed review in 2011, with no underwriting. The Complainants also want indexation and a conversion option for the maximum term available. This is the option which they say they would have chosen if the policy had been reviewed in 2011.

The Complainants state that all they are asking is that the Provider allow them to change the cover to a more affordable option which is available with the Provider. The Complainant says that for example 5 year cover on a Term Policy would currently cost approx. €360 p.m. as opposed to the review premium of €1,447 p.m. The Complainant submits that negligence in not reviewing the policy in line with the Terms and Conditions denied them the opportunity to take this course of action in 2011.

The Provider's Case

The Provider says it understands from the Complaint Form submitted by the Complainant that the missed review in 2011 along with the increase requested in the 2016 review is the core issue of the complaint.

The Complainant submits that the increase in payment requested by the Provider is excessive, and that the Provider breached their contract by not reviewing the plan in 2011 in line with the Terms and Conditions of the plan.

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The Provider says it is important to understand the workings of plans such as the Savings and Protection plan held by the Complainant. Each time a payment is received it is used to purchase units in a fund. The cost of providing the benefits and maintaining the plan is then debited from the fund.

Terms and Conditions

> *"15. Mortality Charge*
>
> *(a) The cost of provision of the Cover shall be recovered by a Cover charge made monthly in advance from the Commencement Date.*
>
> *(b) The amount of the Cover charge each month shall be equal to the Cover as set out in sub-Clause (a) above as at the start of each month multiplied by a factor determined from time to time by the Actuary having regard to*
>
> *(i) the age of the Life Assured at the Policy Anniversary which coincides with or precedes the calculation (or, in the first Policy Year, at the Commencement Date)*
>
> *(C) The cover charge is deducted from the Benefit Fund by proportionate cancellation of units in each Unit Fund".*

The Provider submits that the monthly payment made by the Complainants is not designed to solely cover the cost of providing benefits. The payment is used to purchase units in a fund which are then surrendered to cover the cost of providing the benefits, in accordance with the Terms and Conditions of the plan.

The Provider says that the cost of the assurance increases with age, so in the early years the monthly payment exceeds the cost of the benefits and the fund value builds up. In the later years the cost exceeds the payment, and more units are being surrendered from the fund than are being purchased by the monthly payment.

The aim with the monthly payment set at the commencement of the plan is that it is estimated to remain static for as long as possible, while the cost of maintaining the benefits is deducted from the fund. It is estimated at the outset how long the payment can remain at its initial level without an increase being required, while reviews are still carried out in accordance with the Terms and Conditions of the plan.

The Provider submits that the value of the fund is also dependent on market movements. Assumed growth rates are taken into consideration each time a plan is reviewed and if these assumptions are not met, this can have a negative effect on the fund and an increase in payment may be required at an earlier date in order to sustain the plan until its next review date.

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Paragraph 16 of the Complainant's Terms and Conditions provide for their plan to be reviewed every five years, and annually from age 65 onwards.

As the plan started in 1991, the first review due on the plan was in 1996, then 2001, 2006, 2011, 2016, 2021 and annually from age 65.

As outlined above the first review date on the plan was in 1996. However, in 1995 the Complainants voluntarily contacted the Provider to request an alteration to their plan.

The Letter received by the Provider in 22 March 1995 requested:

The sum assured on the First Complainant is to be maintained at its current level of IR£231,525

The sum assured on the Second Complainant is to be reduced from its current level of £173,643 to £65,643.

The current premium of £115.76 has also to be reduced to £68.10 per month.

The Provider states that it confirmed that these changes had been implemented by issuing the Complainants with a Policy Endorsement, dated 1 April 1995.

The Provider submits that the plan would have been reviewed internally at this time to ensure that future units being purchased by the reduced payment, in conjunction with the fund value, was sufficient to maintain the plan and its benefits until the next scheduled review date.

The Provider submits that the Complainants were not disadvantaged by the missed review in 1996 not only due to their voluntary reduction in benefits in 1995, but because their plan was reviewed again in January 2002 (due December 2001) and March 2007 (due December 2006).

The Provider says that in 2002, it reviewed the Complainant's plan and confirmed that it had passed its review at this time, meaning that the units being purchased by their monthly payment, in conjunction with their fund value was sufficient to maintain the plan until its next review. The Provider says that it wrote to the Complainants and confirmed that the plan had been reviewed, had passed its review and estimated that their current payment and fund value would be sufficient to maintain their plan and its benefits for a further 11 years.

The Provider states that in 2007, it reviewed the Complainants' plan again and confirmed that it had again passed its review at this time. The Provider wrote to the Complainants and confirmed that the plan had been reviewed, had passed its review and estimated that their current payment and fund value would be sufficient to maintain their plan and its benefits for a further four years to December 2011.

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The Provider submits that the plan should have been reviewed in 2011, in accordance with the Terms and Conditions of the plan. The Provider states that had it been reviewed at this time, it would have failed its review, meaning that an increase in monthly payment would have been requested at this time, so that more units would be purchased in order to maintain the level of cover that was on the plan, until the next review due in December 2016.

It is the Provider's position that as such, the Complainants were being undercharged for the level of cover that they were benefitting from.

The Provider states that in February 2016 it checked the Plan Review history on the Complainants plan. The Provider says it established that it had not carried out the scheduled review due on the plan in 2011, and that the current payment of €234.34 was less than the amount it would have asked the Complainants to pay for their current benefits if the most recent review had been carried out as scheduled.

The Provider submits that to ensure that the Complainants were not disadvantaged in any way by their plan not being reviewed in 2011 and to put their plan into the same position that it would have been in had it been reviewed in 2011 it wrote to the Complainants and confirmed that:

They were undercharged for the cover that they had benefited from 2011.

The Provider absorbed this undercharge up to this point

The Provider would allow this undercharge to continue up to the date of the next review on 1 February 2017 and that the charging structure on the plan would have to be corrected from this stage. The Provider again would continue to absorb the cost up to February 2017.

The plan would be reviewed in advance of 1 February 2017 on the assumption that a sufficient premium had been paid to that time.

The Provider paid a €250 Customer Services Award.

The Provider states that the size of the undercharge absorbed by it was €11,276.26. The Provider says that the cover that the Complainants benefitted from during the period of 2011 until 2016 cost €11,276.26 more than what they actually paid.

The Provider says that it was its letter dated 2 February 2016 where it provided advance notice of the Plan Review due on 1 February 2017 that gave rise to the complaint

The Provider submits that in the absence of an option being chosen by the Complainant and in order to prevent the plan from terminating, the cover on the plan has been reduced to a level that could be supported by the Complainant's regular payment of €255.51 per month (inclusive of indexation). This is in line with the plan Terms & Conditions. The Provider says that it estimates that this payment will maintain their benefits until the Complainants' next Plan Review is due on 1 December 2021

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The Provider says it is satisfied from its investigations that the Complainants benefitted significantly from their plan not being reviewed in 2011, and that upon realising this error its actions put their plan into the same position it would have been in had a review been conducted in 2011

The Provider submits that upon review of the Complaint Form completed by the Complainants, the Provider notes their statement that having been provided with an estimated increase that would have been requested of them in 2011 they may have opted to cancel their plan and make alternative arrangements.

The Provider also notes that the Complainants wish for the Provider to allow a conversion of their existing plan to a new Term Assurance Plan with a monthly payment based on their ages in 2011, for the maximum term available and without underwriting. The Provider's response is that it has offered generous redress for its s earlier oversight in 2011 and regret that it cannot accede to this request.
The Provider states however, that it would like to put forward an alternative offer of €1,500 to the Complainants. The basis for this is due to the missed review in 2011, which prevented the Complainants from reviewing their financial needs at this time. The Provider says that this award is higher than its normal Customer Service Award, and in addition to the €250 cheque paid in January 2016. The Provider says that should the Complainants choose to accept this offer, it is subject to the plan being cancelled. The Provider says that the Complainants can propose for a new plan through their broker should they wish to do so.

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 27th 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

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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 issues for investigation are (i) whether the Provider correctly administered the policy, particularly in relation to the review of the policy and (ii) in relation to its communications with the Complainant regarding the premium and cover over the years and (iii) in relation to how the Provider dealt with matters during the course of the complaint.

Analysis

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

I accept that the value of the fund could rise or fall and it was not a guaranteed value. I also accept that there was no policy requirement for the Provider to alert a policyholder when the fund fluctuated in value, other than by way of providing this information in the periodic annual statements.

However, I consider that there have been lapses by the Provider in relation to how it has administered the policy over the years, in particular in relation to correct and clear communications with the Complainants about the policy.

I note the following information:

The 2013 Annual Statement showed that the Benefits charges were €6,041.77 in comparison to the Premium received of €2,522.40.

The 2014 Annual Statement showed that the Benefits charges were €7,085.38 in comparison to the Premium received of €2,648.64.

The 2015 Annual Statement showed that the Benefits charges were €2,975.68 in comparison to the Premium received of €2,523.76.

The 2016 Annual Statement showed that the Benefits charges were €8,677.10 in comparison to the Premium received of €2,879.41.

The Provider states that the cost of providing the Complainants' benefits first became larger than the monthly premiums payment being made from December 2005.

At the 2016 Plan Review the Provider wrote to the Complainants advising:

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"We have now conducted a review of your plan to calculate if your combined payments and plan fund are still enough to cover the cost of your level of benefits. In your case, we anticipate that your payments will not be enough to maintain your current level of benefits from 1 February 2017. It is therefore necessary to make some adjustments to your plan".

On 16th March 2007, the Provider advised the Complainants that:

"We are delighted to tell you that, at this Review your premiums are sufficient to sustain your chosen level of cover until the next Policy Review due in December 2011".

The Frequently Asked Questions that accompanied this letter stated:

"When the cost to maintain your policy's level of cover reaches a stage where it is greater than your regular premium, this difference is made up from your fund value".

The Provider states that in 2007, it reviewed the Complainants' plan and confirmed that it had passed its review at this time. The Provider says it wrote to the Complainants and confirmed that the plan had been reviewed, had passed its review and estimated that their current payment ***and fund value*** would be sufficient to maintain their plan and its benefits for a further four years to December 2011.

However, as can be seen above this is not an accurate account of the situation. The evidence shows that the Provider merely advised the Complainants in 2007 that their premiums were sufficient to sustain cover. The Complainants had not been specifically advised at this time or in the intervening years that their premium payments were no longer, on their own, sufficient to pay for the benefits under the policy.

The evidence shows that the Provider failed to undertake a number of scheduled reviews (1996 and 2011) and despite the positon that the premium payments were no longer adequate on their own to pay for the benefits, advised the Complainants that the premiums payments were adequate. The evidence also shows that when the Provider did carry out the Review in 2016 it advised the Complainants in a letter dated 21st December 2016 that: *"we anticipate that your payments will not be enough to maintain your current level of benefits from 1 February 2017"* when clearly the premium payments were not enough to maintain benefits from 2005.

I am not satisfied that the Provider was as clear as it should have been about the adequacy of the premium payments and in relation to its reduction of the fund to supplement the cost of cover.

I am not satisfied that the Provider, in both written and verbal communications from the Provider with the Complainants, advised that it would maintain the level of benefits while the complaint was being investigated, but then reduced the level of cover to match the premium payment being paid.

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Thus it can be seen that there was conflicting communications to the Complainants as to the adequacy of the premium payments being made and as to how the Provider would manage the policy.

I accept that the Provider acted incorrectly and unreasonably in advising the Complainants that matters in relation to their policy would stand during the complaint process, but then backtracking on this by unilaterally reducing the cover to match the premium payments. In this regard the following is noted:

The Provider had advised the Complainants on 7th February 2017 that:

"As there is an active complaint on this plan no alterations will take place until this has been resolved".

However, on the 27th February 2017 the Provider wrote to the Complainants advising that it was reducing the cover to a level that the present premium could sustain.

This *about turn* by the Provider caused the Complainants distress and anguish.

The Provider's response to the *about turn* of not maintaining the higher level of cover during the complaint process was, as per letter of 13th September 2017:

"Unfortunately the information provided in this e-mail was incorrect. It is not possible to defer a Plan Review while there is an ongoing complaint. The plan must be administered in accordance with its Terms and Conditions, and therefore the reviews must be carried out as and when scheduled. However any future ruling from the [the Financial Services and Pensions Ombudsman] would be retrospectively backdated and the plan adjusted accordingly, where necessary".

In its letter of 3rd October 2017 the Provider stated that:

"Unfortunately, during a subsequent telephone call to our Customer Service Department on 7th February 2017, we incorrectly advised the Complainants' broker that the Plan Review would be put on hold while the complaint was ongoing. This was followed up by an email, where we reconfirmed this incorrect information".

I accept that these failings by the Provider would have caused confusion and distress for the Complainants.

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 important also 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, the Provider missed reviews. I consider that there have been lapses by the Provider in relation to how it has communicated actions on the policy over the years, in particular in relation to communicating with the Complainants on how it was managing the policy relative to the increasing cost of cover.

Not fully knowing of the true positon with their policy, 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 the true cost of cover was more than what they were paying by way of premiums. It is one thing to set out in the policy document how something is going to be done, but knowing the full implications of when it happens is another matter.

As stated above the Provider found it necessary to reduce the policy fund to support the benefits from as early as 2005. While the annual statements did highlight that the premiums being paid by the Complainants were less than the cost of the benefit charges, there was also conflicting information being given as outlined above.

I consider that the need for the fullest and most accurate 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.

Having regard to the particular circumstances of this case, in particular the failings that have been noted above, it is my Legally Binding Decision to substantially uphold the complaint.

The Complainants want the Provider to allow them convert their existing level of cover to a Provider Term Life Assurance policy, with a premium based on their ages at the time of the missed review in 2011, with no underwriting. The Complainants also want indexation and a conversion option for the maximum term available. This is the option which they say they would have chosen if the policy had been reviewed in 2011.

In its response to the complaint the Provider did increase its offer of settlement to €1,500 in addition to the €250 already offered. However, not alone do I consider the offer of €1,750 to be wholly inadequate in all the circumstances of this complaint, I also consider that the Provider's terms requiring that the policy would be cancelled if the monetary amounts were accepted, to be most unreasonable and disingenuous as there was no guarantee that any other policy could be provided to the Complainants. This is because the underwriting for any different policy would take into account the Complainants ages and any health issues.

While the Provider's actions outlined above in relation to the administration of the policy, were unreasonable, I accept that the Complainants did have the benefit of having their level of cover at a reduced cost for longer than they should have had, had the Review taken place in 2011. This was at a cost to the Provider, and while fortunately it was not tested, the

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Provider would have paid out on that cover, had a claim arisen. Therefore, I consider that the more appropriate remedy here is that the Provider treat the policy as not having altered as to level of cover and premium being paid prior to the 2017 review. This is to remain so up to date of this Legally Binding Decision. Thereafter, the Provider is to re-offer options going forward, and is also to make a substantial compensatory payment to the Complainants.

The Complainants must then choose whether to keep this policy going or apply for alternative cover with the Provider on the Provider's terms, or seek cover elsewhere. Independent advice would be prudent when making those decisions.

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 do as stated above in relation to keeping the pre 2017 cover in place up to the date of this Legally Binding Decision, re-offer options going forward and pay the Complainants the compensatory payment of €17,000 (seventeen thousand euro). This compensatory payment is to be made instead of the monetary offers already made by the Provider.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld/substantially upheld/partially upheld/rejected, 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 keep the pre 2017 cover in place up to the date of this Legally Binding Decision, re-offer options going forward and pay the Complainants the compensatory payment of €17,000, 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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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20th December 2018

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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.