Decision Ref:	2018-0228
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Failure to provide correct information
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants incepted a whole of life insurance policy with the Company on 1 October 1996.

The Complainants' Case

The Complainants note that the Company did not carry out the review of their policy that was scheduled to take place in October 2016, until February 2017. In this regard, the Complainants set out their complaint, as follows:

"The review was 1/10/2016. This is the date set in stone. There was no review. No notification prior to that date. The policy continued until [the Company] *wrote in February 21st telling us that "we did not carry out the most recent scheduled review"…there was no review carried out on our policy…*[The Company] *appear to be able to carry out reviews anytime and dates appear to mean nothing. Indeed to add insult to injury* [the Company] *changed our policy on 1st April last even though communication was ongoing and said it was "as requested"…in their letter of 10th May 2017 …*

As far as I am concerned when I phoned the chap up about another policy he referred to this policy and said words to the effect 'we were lucky' the review was not carried out. For that I took it to mean it would run until the next review date in 5 years. I had no reason to believe otherwise".

In addition, when the Company did conduct the policy review that had been due to take place in October 2016 in February 2017, it then came to light that whilst the Company did carry out the 2011 policy review as scheduled it had failed to implement this 2011 policy review at that time, due to an administrative error.

In this regard, in correspondence to this Office dated 25 October 2017, the Complainants submit, as follows:

"It appears that while a policy review was carried out in 2011…it was not implemented at the time because of an "administration error".

At the review [the Company] *carried out in February 2017 it is stated they identified an undercharge as a result of* [an] *administrative error, and subsequently* [the Company] *applied a unit adjustment to the amount of €11,805.44. Under the terms and conditions, under benefits charged "the cost of providing the benefits will be recovered monthly **in advance** by cancellation of units from the benefit fund", this clearly did not happen where the cost of providing the benefits were recovered monthly in advance when* [the Company] *subsequently at this review in February 2017 applied a unit adjustment and this is contrary to the terms and conditions of the policy. I want this fund reimbursed including any subsequent losses as a result of this encashment"*.

In addition, the Complainants also seek for the Company to *"let* [their life insurance policy] *run with the previous cover until the review date in 2021 (1 October 2021)"*.

The Complainants' complaint is that the Company wrongly administered their life insurance policy.

The Provider's Case

Company records indicate that the Complainants incepted a unit-linked whole of life insurance policy with the Company on 1 October 1996. The Company notes that the Complainants are unhappy that the review of their policy which was scheduled to be conducted in advance of October 2016 did not take place until February 2017. By way of background and to demonstrate that the Complainants' policy was not negatively affected in any way by the October 2016 review not having been conducted until February 2017, the Company sets out the history of reviews previously conducted on the Complainants' policy.

The terms and conditions of the Complainants' policy clearly provides for the policy to be reviewed after its first ten years, every five years after that and annually from age 65. In this regard, Section 7, 'Policy Review', of the applicable Policy Document provides, among other things, at pg. 18, as follows:

"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 …

At this Policy Review, the Actuary will determine whether the premium being paid is sufficient to maintain the benefits provided until the next scheduled Review".

As the Complainants' policy commenced in October 1996, policy reviews were scheduled to be conducted in 2006, 2011 and 2016.

The Complainants' policy was reviewed in 2006 as scheduled and at this time it was identified that the regular premium in conjunction with any fund value was not sufficient to maintain the policy until the next review in 2011. In order to prevent the policy from terminating a change would need to be made to either the premium or the level of cover. The Company wrote to the Complainants at this time explaining this and setting out options for continued cover and it enclosed a Frequently Asked Questions document on policy reviews. In the absence of an option having being selected by the Complainants, Option A was applied as the default position, as advised in the policy review notification. As a result, the benefits of the Complainants' policy remained unchanged but the premium increased.

The Complainants' policy was reviewed again in 2011 as scheduled and similarly at this time it was identified that the regular premium in conjunction with any fund value was not sufficient to maintain the policy until the next review in 2016. In order to prevent the policy from terminating a change would need to be made to either the premium or the level of cover. The Company wrote to the Complainants at this time explaining same and setting out options for continued cover and it enclosed a Frequently Asked Questions document on policy reviews. In the absence of an option being chosen by the Complainants, the default position as provided for in the policy terms and conditions was for the premium to increase in order to maintain the then existing level of cover. However, the Complainants made a complaint to the Company at this time and whilst their complaint was fully responded to at that time, due to an administrative error the outcome of the 2011 policy review was not implemented.

The Company stresses that the 2011 policy review was correctly carried out, however its agreed outcome was not implemented at that time because of an administrative error. As a result, the Complainants' policy premium and policy benefits both remained unchanged meaning that they were being undercharged from this time for the level of cover that they were benefiting from.

This undercharge was only identified when the next policy review was conducted in February 2017. At the time, in order to put the Complainants' policy into the exact same position that it would have been in had the agreed outcome of the 2011 policy review been implemented, the Company applied a unit adjustment in the amount of €11,805.44. This was the amount that the Complainants had, by the Company failure to implement the agreed outcome of the 2011 policy review at that time, underpaid for the level of cover that they had benefited from since the time of the 2011 policy review. By applying this unit adjustment, the Company corrected its previous error of not applying the agreed outcome

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of the 2011 policy review at that time and put the Complainants' policy into the exact same position that it would have been in had they been paying the correct premium all along.

In this regard, the Company wrote to the Complainants on 21 February 2017 as follows, *"we would like to apologise for this oversight on our part. Although we have been charging too low a premium, as this was an error on our part, we will not seek to recover any past underpayment"*. As a result, the Company paid the difference in cost between what the Complainants were paying to the policy since the 2011 policy review and the actual cost to maintain the cover that they were benefitting from. The Company is thus satisfied that the policy review options that issued to the Complainants in February 2017 were no different to the options that would have been issued to them had the policy been reviewed in advance of October 2016, as scheduled.

The Company acknowledges that whilst the policy review at that time should have been carried out in advance of October 2016, it was carried out just a few months later in February 2017. This policy review, whilst technically late, was not missed. The Company notes that there were no negative consequences for the Complainants by the review having been conducted a few months later than scheduled. In fact, by conducting the policy review in February 2017 the Complainants benefitted further by having the period of undercharge that they were benefitting from since the 2011 policy review extended by another number of months.

Whilst it notes that the Complainants' policy was not negatively affected in any way by the 2016 policy review being conducted a few months later than scheduled, the Company issued the Complainants with a €250 customer service award on 5 May 2017 by way of an apology for its delay in carrying out the 2016 policy review. The Complainants' current monthly premium is €174.77 and this will maintain their policy benefits until the policy becomes due for review again in advance of October 2021.

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

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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 22 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.

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

The complaint at hand is, in essence, that the Company wrongly administered the Complainants' life insurance policy. In this regard, the Complainants incepted a whole of life insurance policy with the Company on 1 October 1996.

The Company did not carry out the review of the Complainants' policy that was scheduled to take place in October 2016 until February 2017, at which time the Company discovered that although it had been carried out correctly and on time, it had failed to implement the 2011 policy review due to an administrative error.

In this regard, I note from the documentation before me that the Company wrote to the Complainants on 21 February 2017, as follows:

"Your plan is a whole of life plan which means that it has no specified end date, and [the Company] *will provide cover for the whole of your life, as long as the required premium is paid.*

The charges applied to your plan, to pay for your benefits, change over time as the lives assured get older and, for example, if benefits or risk charges change. As a result, [the Company] *is required to review your plan on a regular basis. The review is carried out to ensure that the premium being paid, together with any fund value, is sufficient to pay for the current level of cover until the next policy review.*

We recently checked the policy review history on your plan and we have identified that we did not carry out the most recent scheduled review on your plan on 1 October 2016. As your most recent scheduled review was not carried out, we checked your plan. This indicates that your current payment is less than the cost of the benefits and you would have been asked to either increase your premium or decrease your benefits at the last scheduled review.

Firstly, we would like to apologise for this oversight on our part. Although we have been charging too low a premium, as this was an error on our part, we will not seek to recover any past under payment".

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In this regard, I note that the Company states that the 2011 policy review was correctly carried out, however it was not implemented at that time because of an administrative error. As a result, the Complainants' policy premium and policy benefits both remained unchanged resulting in the Complainants being undercharged from this time for the level of cover that they had, as they the level of cover was greater than their monthly premium payment ought to have been provided.

In order to put the Complainants' policy into the exact same position that it would have been in had the 2011 policy review been implemented, the Company applied a unit adjustment for an amount of €11,805.44. This was the amount the Company calculated that the Complainants had underpaid for the level of cover they had since the time of the 2011 policy review.

I accept that by applying this unit adjustment, the Company corrected its error of not putting the Complainants' policy into the exact same position that it would have been in had they been paying the correct premium all along. I further accept that the Complainants were in no way financially disadvantaged as a result of this administrative error. In this regard, the Complainants' policy has no fund value. I note that correspondence to the Complainants dated 14 September 2011 clearly advised that *"The current nominal value is €0.01 (nominal fund value at 07/09/2011)"*.

In summary, when the Company retrospectively applied this 2011 policy review in February 2017, this cost to the policy was €11,805.44. There was no policy fund value to deduct this amount from and so as to prevent this fund value from then having a debit value of €11,805.44, the Company applied a unit adjustment for an amount of €11,805.44 to the policy, effectively bringing the fund value back to its nominal value.

Furthermore, I accept with the Company position that there were no negative consequences for the Complainants by the 2016 policy review being conducted a few months later than scheduled. In fact, by conducting the 2016 policy review in February 2017 the Complainants benefitted further by having the period of undercharge that they were benefitting from since the 2011 policy review was extended by another number of months. In this regard, I accept the Company position that the policy review options that issued to the Complainants in February 2017 are the same options that it would have issued had the plan been reviewed in advance of October 2016.

That said, the Company ought to have implemented the 2011 policy review at that time. Similarly, the Company ought to have carried out the 2016 policy review in advance of October 2016 and not in February 2017.

My concerns in this regard are that:

- The 2011 complaint correspondences appear to have stopped without evidence of the matters being resolved between the parties.

- The Provider did not implement in 2011 the default option, of increasing the premium, as it said it would.

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I consider that the Provider's failure to implement the default option in 2011, of increasing the premium, as it said it would, has contributed to the present complaint. The fact that the Provider allowed the position in relation to the cover and premium payment to continue as it was, could have reasonably caused the Complainants to believe that the matter was resolved to the Complainants' satisfaction. The consequence of same is that the issues about the review process in 2011 remained.

It is noted that the positon with the Provider's maintenance of the policy cover at a reduced cost over the period 2011 to 2017 was not brought to the Complainants' attention until receipt of the Provider's response to the complaint, despite the fact that a review of the policy had taken place and communications issued to the Complainants regarding same prior to the complaint being referred to this Office. I would have expected that the Provider's action of not following through with the 2011 option of increasing the premium, would have been alerted earlier to the Complainants.

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.

Having regard to the particular circumstances of this case, in particular the failings that have been noted above, it is my Preliminary Decision to partially uphold the complaint. The Complainants had sought the existing cover and premium to remain in place until the next review in 2021. While the Provider's actions in relation to the administration of the policy, in particular, its failure to implement the default option in 2011 and carry out the scheduled review for 2016 on time, was 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 default option been put in place. This was at a substantial cost to the Provider, and while fortunately it was not tested, the 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 make a substantial compensatory payment to the Complainants.

Having regard to all of the above I partially uphold this complaint and I direct the Provider to pay the Complainants the compensatory payment of €8,000 (eight thousand euro). This payment is to be made instead of the €250 offer 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 partially upheld, on the grounds prescribed in ***Section 60(2)(b) and (g).***

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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 €8,000 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

18 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.