An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0229
Sector:	Insurance
Product / Service:	Whole-of-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 relates to an Inheritance Protector policy which was taken out in 1991. The complaint is that the Provider did not correctly administer the policy, particularly in relation to the communication on the cost of cover and reduction of the policy fund.

The Complainant's Case

The Complainant is the widow of the First named Assured under the policy. The Complainant is the Second Assured under the policy. The Complainant's late husband arranged this policy in the early 1990s. The Complainant states she well remembers it because it was a very big financial undertaking at the time. The Complainant states that she also remembers the indexation clause and the understanding that the premium and benefits would keep pace with inflation. The Complainant states that inflation was very high in the early 1990s and was a big concern. The Complainant's position is that at no stage was it explained to them that the terms of the policy would be changed.

The Complainant says that they began receiving annual statements from the Provider about 10 years ago. The Complainant refers to the March 2007 annual statement and says it highlights the usual indexation increases. The Complainant states they received a letter from the Provider in October 2007, which mentioned a "Plan review", which advised that *"no action is needed now".* The Complainant states that the plan review was not reviewed with them by Provider or its appointed representatives. The Complainant states that in fact, nobody has ever reviewed the policy with them. The Complainant says that presumably

there was no need for such a review as the indexation was in place and the life cover would pay out on the death of the last survivor. The Complainant states that upon advising the Provider of her husband's death, the policy was not mentioned nor discussed at that time.

The Complainant says that she received another annual statement from the Provider in March 2011. The "Plan Review" stated that *"we will continue to check your payment each year to ensure your payments are sufficient"*. The Complainant states that no review was undertaken and nobody explained what this meant.
The Complainant submits that another annual statement arrived in March 2014. The Complainant says that this time there was no mention of a plan review. The statement for 2016 (dated May) was a one page document that highlighted only the monthly payment and the life cover amount.

The Complainant states that the Plan Review section appeared again in the March 2017 statement — this time stating that: *"the next scheduled review of your plan is due now"*. The Complainant states she received a telephone call from a Mr LK. The Complainant states that she did not know who he was and did not know why he was telephoning but he informed her that she would be receiving an important letter.

The Complainant states that the Provider admitted in its letter dated 10 May 2017, that the original underwriters did not carry out annual reviews. The Complainant says that the Provider also stated in that letter that it provides certain options *"when we see the fund value eroding"*. The Complainant submits that in the last 10 years no such options were advised to her by the Provider or its appointed representatives. In its letter dated May 2016 the Provider suggested that the Complainant keep up-to-date with the policy details through the Provider's Online Service. The Complainant questions was this letter seriously intended for her.

The Complainant says she believes the Provider and its appointed representatives have displayed gross negligence over many years in not adequately explaining the particulars of the product in the first instance and by not keeping her appropriately advised on an interim basis. The Complainant considers that the dangers of the fund value eroding should have been clearly explained to her and as a vulnerable consumer she should have been treated much more compassionately. The Complainant states that she cannot be expected to understand all of the terminology that the Provider uses.

In The Complainant's submission of 6th December 2017 she states :

"At no point in time did [the Provider] highlight the difference between the actual cost of life cover and the actual premium paid for life cover so that a normal consumer could make an informed decision. Only in March 2017 when the policy was fully eroded did [the Provider] highlight the actual cost for the coming year - €12,531.95 per month equating to €150,383.40 annually. This should have been highlighted in every annual review".

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The Provider's Case

The Provider states that the plan was originally taken out through another Insurer who operated in Ireland until its acquisition by the Provider.

The Provider's position is that it continued to administer the plan in line with its original Terms and Conditions.
The purpose of the plan was to provide a life cover benefit which in the event of the death of the second life covered it would be used to cover the tax liability due on the inheritance of the estate.

The Provider states that the mechanism by which the plan worked is as follows. The Provider says that all regular payments collected from the Complainant's bank account were allocated to the plan fund and all plan charges due including the charge to provide the plans valuable life cover benefit were deducted from the plan fund in line with paragraph 27 (ii) of the plan Terms and Conditions.
Any units remaining in the fund after the deduction of the monthly plan charges make up the value of the plan at any given time.

The Provider states that as the accumulated fund value is an integral part of the mechanism for the long term provision of the benefits, the fund value should not be considered as savings or being separate to the regular payment that was being collected and allocated to the plan each month.

The Provider submits that it is the nature of these types of unit linked, life assurance plans to accumulate a value during the early years which would peak in the later years, but then begin to be eroded gradually over time, until eventually the fund would be depleted due to the consistent increase in the monthly cost to maintain the plan and its benefits, as the lives covered aged and the risk of a claim became more likely.

The Provider explains that the cost of providing protection benefits increases as one gets older and when the value of the plan fund, to which new units are being added each month by the recurring direct debit payment, reduces to a level where it is no longer sufficient to meet the plan charges going forward the plan cancels in line with paragraph 20 (ii) of the plan Terms and Conditions.

Section 20 (ii) of the plan Terms and Conditions states:

"If at any time after the second anniversary of the date of the policy the number of units attaching to the policy account is negative the company shall have the right to cancel the policy without value and all liability of the company under the policy shall immediately cease"

The Provider explains that the process for plans of this nature is to conduct a review in advance of the plans cancellation and write to the plan owner with options for continued cover. The Provider states that the options for continued cover are provided over a five year term if the life covered is under the age of 70 and on an annually basis if they are 70 or over at the time of the review.

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The Provider states that it does this because it feels that it is more beneficial for customers to be given the option to maintain their valuable benefits, in this case life cover being used for inheritance tax purposes, as opposed to it being cancelled.

The Provider says that it is very important to note that it is of course the plan owners decision as to how they would like to proceed when the value on their plan erodes to zero, that is select a plan review option for continued cover in line with its process or allow the plan to cancel in line with its original Terms and Conditions.

The Provider submits that it regularly conducts reviews in the background and it wrote to the Complainant in 2007 as part of her Annual Benefit Statement setting out that:

- The value on the plan was €117,572.13.
- The life cover benefit was €1,385.841.
- The plan payment was €942.28 per month
- The plan value in conjunction with the regular plan payment going forward will fund the cost to maintain the plan benefits in its later and more expensive years.
- Assuming a future growth rate of 4.8% the Provider estimated that current payment in conjunction with the plan value would maintain the plan until 2011.

It is the Provider's position that it correctly confirmed to the Complainant that:

"No action is needed now as we will review the premium/benefits nearer the time and advise you about the review options available then".

The Provider states that in other words there was no need for the Complainant to make any changes to the plan payment or level of cover on the plan at the time in 2007 as it was estimated that the current value in conjunction with the payments due to be collected and applied to the plan fund would maintain the cover until 2011. The Provider states that this is the correct context in which this statement was made.

The Provider submits that similarly in the Complainant's 2008 and 2009 Annual Benefit Statements it included details about reviews that had been conducted in the background at these times. The Provider says that the outcome of these reviews again was that the plan would maintain without any change until 2011.

The Provider states that it will be noted from the Complainant's 2008 statement that the plan value at this time had fallen to an amount of €103,841.01 from a previous value of €117,572.13 in 2007. Similarly in the 2009 statement the value had fallen further to €62,019.68.

The Provider explains that the reduction in value from 2007 was as a direct result of the plan costs being greater than regular payment that was being applied as new units to the plan fund each month.

The Provider refers again to paragraph 27(ii) of the plan Terms and Conditions under the heading "Death benefit charges and policy charges" which provides for the cancellation of

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units from the plan fund each month to meet the plan charges. The Provider states that in the 2010 Annual Benefit Statement it advised:

- The value on the plan was €76,930.53.
- This value in conjunction with the regular plan payment will fund the cost to maintain the plan benefits in its later and more expensive years.
- Assuming a future growth rate of 4.8% it would estimate that current payment in conjunction with the plan value would maintain the plan until 2012.
- To avoid the plan ceasing at that time it would at the previous plan anniversary advise what increased payment will need to be made at this time in order to cover the cost of the plan and its benefits at this time.

The Provider states that it is very important to highlight that it offered the Complainant the option to extend her period of cover by increasing the plan payment at this time. In this statement the Provider advised:

> *Plan Review*
>
> *Assuming a future growth rate of 4.80% and our charges for benefits do not change we estimate your payments with the support of the unit account will maintain your benefits until 24 March 2012. To avoid your plan ceasing at that time we will at the previous plan anniversary advise what increased payment you need to make to cover the cost of your benefits at that time.*
>
> *If you prefer, you can extend the period of cover by further increasing your payment now. For example, we estimate that to sustain benefits until 24 March 2018, you would need to increase your current payment to €8,163.34. If you would like to do this please contact us or your financial adviser.*

The Provider submits that the Complainant is saying that she would have considered increasing her payment in 2007 to prevent the value of her plan eroding to zero over the next number of years, but did not take any action at this time as her 2007 statement told her that "no action is needed now". The Provider says that this of course is quoted out of context and the correct context of the full statement made at this time was:

> *"No action is needed now as we will review the premium/benefits nearer the time and advise you about the review options available then".*

The Provider reiterates that this meant that there was no need to make any changes to the plan payment or level of cover at this time in 2007 as it was estimated that the current value in conjunction with the payments due to be collected and applied to the plan fund would maintain until 2011.

The Provider submits that even though the Complainant is saying now that she would have considered increasing her payment in 2007 to extend her period of cover she took no action when this option was given to her in 2010.

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The Provider says that similarly in 2011 and 2012 it wrote to the Complainant as part of her Annual Benefit Statement setting out:

- The value on the plan at these times - (€70,518.79 in 2011 & €52,301.11 in 2012).
- This value in conjunction with the regular plan payment will fund the cost to maintain the plan benefits in its later and more expensive years.
- A review of the plan payment identified that the plan payment in conjunction with the fund value was sufficient to maintain the plan benefits at this time.

The Provider states that the value of the plan between the 2011 and 2012 statement had fallen from €70,518.79 to €52,301.11 again demonstrating the difference between the actual cost to maintain the plan and the regular payment that was being made. This value had fallen further to €31,977.87 by the time of the Complainant's 2013 statement.

The Provider also draws attention to the Complainant's 2014 Annual Benefit Statement in which it set out a breakdown of the payments made to the plan over the previous year in comparison to the plan charges over that year. In this statement the Provider included the following:

"How your plan value has changed since your last statement

Opening cash in value of your plan at 6 March 2013 €31,977.87	
Payments Made	
Total payments made up to 6 March 2013	*€195,285.76*
Payments received since 6 March 2013	*€13,088.31*
Total payments made up to 5 March 2014	*€208,374.07*
Charges applied	
Protection benefit charges	*€43,189.39*
Plan Fees	*€75.96*
Payment Charges Applied	*€217.71*
Government Levies	*€132.21*
The current value represents a reduction in your plan of €28,249.80	

The current value of the plan at 5 March 2014 was €3,725.07".

The Provider says that in her correspondences the Complainant makes references to reviews with her financial advisers not being conducted over the years. The Provider's response is that, a Personal Financial Review with a financial adviser, and a plan review which determines if the fund value in conjunction with future payments due to be applied to the fund are sufficient to pay for the plan costs, are not the same and should not be confused with each other.

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The Provider submits that if the Complainant required any advice (personal financial review) on her plan following her Annual Benefit Statements or at any other time over the years she only needed to contact her nominated independent financial adviser. The Provider states that the current financial adviser showing on its records is again an independent intermediary.

The Providers says that the covering page of the Annual Benefit Statements from 2007 onwards reminded the Complainant to contact her independent financial intermediary if she needed any help reviewing her financial needs.

The Provider reiterates that the objective of the plan from the outset was always to meet an inheritance tax liability on the death of the second life covered. This the Provider says was the sole purpose of the plan.

The Provider submits that for the Complainant to now say that she could have cashed the plan in 2007 and saved on future payments goes against the very reason that the plan was taken out which as mentioned was to pay an inheritance tax liability.

The Provider's position is that to say this serves to only place doubt on whether the tax liability that was there at the outset was present in the plans later years. The Provider says that it understood that there was a need for the full cover provided by the plan however if there was not, the Complainant should have been reviewing her level of cover with her nominated independent financial advisers on a regular basis to ensure that she was adequately covered and making adjustments to the cover provided by the plan as deemed necessary.

The Provider states that it was the Complainant's responsibility to review her level of cover with her nominated independent financial adviser.

The Provider says that the value on the plan eroded to zero by April 2014. The Provider states that at this time it should have conducted a plan review and issued options for continued cover as an alternative to the cancellation provided for by paragraph 20 (ii) of the plan Terms and Conditions.

The Provider submits that as no review or cancellation took place at this time the Complainant was effectively being undercharged for the very substantial level of life cover that she was benefiting from. The Provider states that the monthly payment of €1,101.71 was not sufficient on its own from this time to maintain life cover of €1,604,285.

The Provider states that this undercharge continued on the Complainant's plan up until it was identified in March 2017. The Provider highlights that the real cost to provide the Complainant with €1,604,285 in life cover that she benefited from between April 2014 and March 2017 was €152,830.48 less than what she had actually paid to the Provider over this period. The Provider says that it *paid* this difference in cost.

The Provider's position is that as an alternative to the cancellation provided for by paragraph 20 (ii) of the plan Terms and Conditions it issued options for continued cover in

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March 2017. The Provider states that as it paid the difference in cost between April 2014 and March 2017 (which amounted to €152,830.48) the options issued to the Complainant at this time were issued on the exact same basis as if she had been making the correct payment to her plan all along.

The Provider states that the options issued to the Complainant at this time confirmed that the monthly cost at her age to maintain life cover of €1,604.285 for another year (as she was over the age of 70) would be €11,437.40 per month. Two other options were also provided one of which provided for the cover on the plan to be reduced to a level that could be supported by the plans current regular payment.

The Provider submits that while it fully recognises and appreciates that this was a substantial increase in payment, this payment reflected the cost to provide over €1.6 million in life cover to a 79 year old life covered.
The Provider admits that it did issue some conflicting correspondence around this time including a letter which incorrectly stated that the Complainant had selected Option B. The Provider says that it apologises for this and for any inconvenience that this letter may have caused. The Provider also apologised for the delay experienced in it locating and providing the Complainant with a paper copy of her plan Terms and Conditions.

The Provider states that in the absence of a plan review option being selected by the Complainant, her plan correctly cancelled in line with paragraph 20 (ii) of her plan Terms and Conditions as it had no value attaching and her regular payment of €1,101.71 was insufficient to maintain life cover of €1,160,4285 going forward.

The Provider states that the Revenue Commissioners have strict criteria which must be met in order for a plan to qualify for Section 60 status (Inheritance Tax). An example being that there must never be a break in the plans regular payment. The Provider says that as such the Complainant's plan irrevocably lost its inheritance tax status when the plan cancelled in line with paragraph 20 (ii) of the plan terms and conditions as a result of the Complainant choosing not to continue with her cover by selecting one of the options provided.

The Provider's positon is that notwithstanding that the plan should have been reviewed / cancelled in 2014 as the fund value had eroded to zero it has always correctly administered the plan in line with the original Terms and Conditions. The Provider states that it has never amended the original Terms and Conditions of the plan.

The Provider states that the Complainant benefited significantly by her plan not being reviewed / cancelled at this time by benefiting from life cover of €1,604,285 over the period April 2014 to March 2017 at a monthly payment of €1,101.71 per month. The Provider says that the actual cost to provide this cover over this period was €152,830.48 more than what the Complainant actually paid. The Provider states that it *paid* this difference in cost.

Evidence

In the Provider's response letter dated 4th July 2017 it advised the Complainant that:

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"It is important to remember that in order to qualify for the inheritance tax eligibility, the person covered under the plan must make the payments. Should you miss any payment, and this contact lapses, under an Inheritance Tax Plan (Section 72 Plan), the inheritance tax plan will have lost its eligibility for relief. Therefore, it is imperative that the cost of the cover on this plan is met".

2012 – Plan Review

"A review of your plan payment and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time. This assumes a future fund growth rate of 4.80% and our charges for benefits do not change. We will continue to check your payment each year to ensure your payments are sufficient".

Policy Provisions

"S.60 QUALIFYING POLICY

1. *Written in a form approved by the Revenue Commissioners i.e. Single Life or Joint Life Last Survivor – joint lives must be legal spouses.*
2. *The sum assured / premium ratio must be at least*

8:1 - normal lives

6:1 – rated lives

3. *Premiums must be paid by the life assured – joint lives either spouse can be payer of premiums.*
4. *Premiums must not cease within the first 8 years of the policy, premiums must be fully paid for at least 8 years.*
5. *Premiums must not increase/decrease by 50% during any continuous 8 year period. .."*

Following the receipt of the Provider's response to her complaint dated the 9th April 2018, the Complainant made the following comments:

(1) As [the Provider] state the sole purpose for taking out this policy was to ensure that there would be sufficient funds to meet the death duties on my late husband and my estate on our death. It is quite clear now that this policy was miss-sold to us. Never was it explained that we could be left with nothing having paid more than €250,000 over the years. Never was it explained that [the Provider] could increase its annual premiums by over 1000% and give no certainty that the premiums would not increase the next year by the same amount again.

(2) At no time before the 2014 [Provider] review has the actual annual premium charged been properly disclosed. [The Provider] disclosed the value of the fund but not the actual annual charge. How is a woman of nearly eighty years of age with no financial background expected to decipher this correspondence?

(3) I take issue with [the Provider] inference whether this policy was required by me? [The Provider was] quite happy to take their fees during this period and if they had such concerns over my need for the policy they should have contacted me. If required I can get the Family company auditors .. to contact [the Provider] to clarify this issue.

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(4) *It is quite clear to me from the way this matter has been handled by [the Provider] that the Company's systems are not fit for Purpose and should be independently reviewed. How can a company of [the Provider's] standing by its own admission?*
(a) Mischarge a customer for a period of three years.
(b) Fail to be able to produce a policy document in a timely fashion.

Issue a false document claiming that a customer has agreed to a policy change when no such agreement was in place".

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 Complainant was 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 23rd 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 Complainant acknowledged receipt of the Preliminary Decision by way of letter dated 6th December 2018. In this letter she confirmed acceptance of the Preliminary Decision. This letter was exchanged with the Provider.

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 administered the Complainant's policy, particularly in relation to the review of same and in communicating the Benefit Costs and the situation with the policy fund.

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Analysis

As regards any allegations in relation to the sale of the policy in 1991, that is, that the policy was mis-sold to the Complainant, this is not being examined due to the passage of time. It is also noted that this policy was sold by an Independent Intermediary and an Insurance Company would not generally be responsible for alleged acts or omissions of an Independent Intermediary.

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. 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 Complainant about 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 believe that where the drop in value of the fund was because of the need to supplement the cost of cover greater communication of same would have reasonably been required, and expected by the Complainant.

I accept that there could have been greater and earlier communication to the Complainant of the cost of providing the benefits over and above that which the Complainant was paying by way of premiums. It was only by way of one Annual Statement (2014) that the Provider communicated a Cost of Benefit Charges figure that was greater than the premium payment, indicating that the amount the Complainant was paying was not enough to cover the cost of supplying the benefits under the policy. The previous statements merely showed a decreasing fund value and confirmed that the plan payments were sufficient to cover the cost of benefits.

Thus it can be seen that there was at times conflicting communications to the Complainant as to the adequacy of the premium payments being made.

I accept that this would have caused some unnecessary confusion for the Complainant.

The Complainant's policy does not provide for a Policy Review, but that once the policy account is in negative value the Company shall have the right to cancel the policy. However, on the Provider taking over the administration of the policy, it undertook to carry out such a Review of the policy and to provide options to the policyholder to continue with the cover, instead of cancelling the policy.

A Policy Review gives 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

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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.

The Provider states that the value on the plan eroded to zero by April 2014. The Provider accepts that at this time it should have conducted a plan review and issued options for continued cover as an alternative to the cancellation provided for by paragraph 20 (ii) of the plan Terms and Conditions.

As no review or cancellation took place at this time, the Complainant's policy was allowed to continue up to 2017 with effectively an undercharge for the very substantial level of life cover. The monthly payment of €1,101.71 was not sufficient on its own from this time to maintain life cover of €1,604,285.

The Provider only identified in March 2017 that this was the position. The Provider's position is that the real cost to provide the Complainant with €1,604,285 in life cover from between April 2014 and March 2017 was €152,830.48. This was substantially more than what the Complainant had actually paid to the Provider over this period. The Provider says that it *paid* this difference in cost.

I consider that not fully knowing of the true positon with a 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 that the cost of cover was more than they were paying by way of premiums. Here there was only one statement issued to the Complainant which indicated what the Benefit Cover was costing. However, this was merely set out without any commentary from the Provider as to future costs or of any alternative options that could be availed of by the Complainant.

As stated above the Provider found it necessary to reduce the policy fund to support the benefits from as early as 2007. The annual statements or accompanying communications did not clearly highlight that the fund value was being used, in addition to the regular premium payment, to fund the protection benefits. The Provider did not clearly communicate to the Complainants when this had begun to happen. This was not communicated as clearly as it should throughout the later years of the policy. While it was clear that a fund value was not being built up in the later years, I accept that it was not so clear that the reason was that the premium being paid was not enough to cover the cost of providing the policy benefits.

Clear communication of the true cost of cover in comparison to what was being paid in premiums should have been communicated to the Complainant, together with the knowledge of the fact that a decreasing fund value was decreasing because the fund was supplementing the cost of cover. This would have given the Complainant the choice at an earlier date, as to whether to continue with the policy or withdraw from the policy and take the benefit of any fund value. I accept that the fund value could have been changing for other reasons such as the fluctuating values due to the investment market rises and falls.

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In the above regard, I do not accept that it was reasonable of the Provider to not tell the Complainant earlier that the actual cost of cover had begun to exceed the premium payment, and that the reason the fund was decreasing in value was because of the excess cost of benefits deducted from the fund.

I find that the Policy document outlined the policy features. The Provider was entitled to rely upon the policy fund to supplement the premium payments, in order to pay for the policy benefits. However, I consider that the Provider did not correctly and clearly communicate with the Complainant from 2014 when it had exhausted the fund value to supplement the premiums that were being paid by the Complainant. 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.

The Provider accepts that it erred in not conducting a policy review and in not providing options to the Complainants when in 2014 the premium payment and fund value no longer was enough to provide for substantial life cover.

The Provider also accepts that it issued some conflicting correspondence to the Complainant, including a letter which incorrectly stated that she had selected an option in relation to accepting a lower sum assured going forward. The Complainant also experienced a delay by the Provider in providing a copy of her Terms and Conditions, when requested in 2017.

I am satisfied that the Complainant was somewhat on notice from 2014 of the depleting fund and of the fact that the cost of benefits were substantially more than what was being paid in premiums. However, I accept that she was reasonably entitled to greater and better communications from the Provider on these matters. I also accept that once the Provider had introduced the step of reviewing the policy in order to prevent it from cancelling and providing some level of cover when the premium payment became too expensive, the Provider should have implemented such a review in 2014 when it saw that the premium payments and policy fund were not able to support the cost of cover. I consider that as the Provider had failed to review the policy in 2014 (and offer options), the only position that should prevail now with this policy is that its cancellation should relate back to the date that the premium and fund could no longer support the cost of cover. I consider this is so, as that is what would have naturally have happened in accordance with the policy terms and conditions. Also for the policy to be a qualifying policy, legislation required that the premium must be paid by the life assured, not by the Provider. Here the Provider only noticed the situation of the undercharge for cover in 2017 and undertook to waive any requirement for its re-payment and accepting that cover was fully in place for that period. However, I consider that there was no consent or agreement from the Complainant that the

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Provider should continue the policy after it had reached a situation where it should have cancelled.

Having regard to the particular circumstances of this complaint, in particular the failings that have been noted above, it is my Legally Binding Decision that the complaint is substantially upheld and I direct the Provider to reimburse the Complainant with the premiums she paid from the date that the policy should have cancelled (which was in or about April 2014). Additionally, I direct the Provider to make a compensatory payment to the Complainant of €8,000 (eight thousand euro).

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Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to reimburse the Complainant with the premiums she paid from the date that the policy should have cancelled (which was in or about April 2014), and to make a compensatory payment to the Complainant in the sum of €8,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant 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

18th 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.