Decision Ref:	2018-0231
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Failure to provide correct information Fees & charges applied Results of policy review/failure to notify of policy reviews Maladministration (life)
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint centres around the administration of a Whole of Life Policy which the Complainants took out in 1993. At a Review of the policy in 2017 the Provider advised of the need for a substantial increase in the premium payments.

The complaint is that the Provider did not adequately alert the Complainants to the fact that the premium payments that they were paying were not enough on their own to cover the cost of benefits. The Provider had been supplementing the cost of cover from the policy fund for some time, with the result that there was a substantially reduced surrender value.

The Complainants' Case

The Complainants state that in 1993 they began an Insurance Protection Plan with the Provider with the understanding that it had an Assured Value provided they paid premiums made known to them in writing by the Provider.

The Complainants state that a Review was carried out in 2003 and 2008, which were satisfactory. The Complainants state that the 2014 Statement showed a surrender value of €3,363.83.

The Complainants state that a Review took place in 2013, but that they only received correspondence from the Provider in relation to it on 29th June 2017. The Complainant say that there was no increase in premium mentioned to them in 2013, 2014, 2015 or 2016.

The Complainants submit that all times they believed that if premiums paid by them using a direct debit, were inadequate they would receive written notification from the Provider so that they could reduce cover.

In 2015 the Plan was transferred to the present Provider. The Complainants state that in July 2015 they were advised by the Provider that their next Review would be in 2017. The Complainants state on this occasion they got information in addition to options. The Complainants position is that the premiums were too expensive and they cancelled the Direct Debit on 19th May 2017 and filed a complaint in relation to the surrender value of the policy.

The Complainants submit that they were never given a figure indicating the shortfall in their premiums being paid by Direct Debit payment until June 2017. The Complainants state that the Provider never sent them any letter prior to 2017 allowing them the option of reducing their cover.

The Complainants want the Provider to restore the Surrender Value, which was approximately €3,600. The Complainants consider that the cost of any service should be made known to a client prior to purchase and that the method of payment is a correct.

The Provider's Case

The Provider states that the Complainants' plan was reviewed in line with paragraph 18 of their plan Terms and Conditions in May 2017. The Provider says that at this time the plan value was €406.71 with the 2017 review identifying that an increase in payment was required in order to maintain the same level of cover on the plan until its next review in 2018.

The Provider states that the Complainants are unhappy about their plan review feature and in particular that the plan fund is used to meet their plans regular ongoing costs. The Provider says that the Complainants are of the opinion that their monthly direct debit payment alone was paying for their plan benefits and that the value on the plan was separate and unrelated to this.

As a result of their 2017 review the Complainants cancelled their direct debit payment to the Provider with their bank and their plan subsequently cancelled as a result of non-payment. The Provider submits that because the Complainants are unhappy that the plan fund is used to meet the plans ongoing costs they have requested that the Provider pay them the value that was attaching to their plan when their Annual Benefit Statement issued in 2014 — this value was €3,363.83.

The Provider explains that the Complainants' plan is a reviewable unit linked whole of life protection plan. The Provider states that each time a monthly direct debit payment was

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collected from the Complainants' bank account this payment purchased new units in their plan fund. The Provider says that separate to this unit buying process units in the fund equivalent in value to the monthly costs are cancelled to pay for the plan charges. This includes the charges to provide the plan benefits.

The Provider states that this is the purpose of the plan fund and this is the mechanism by which payments to the plan are made and plan charges collected.

The Provider submits that 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 says that this process of units being cancelled each month from the plan fund to meet the plan charges is as set out by paragraph 17 of the Complainants' plan terms and conditions, a copy of which was provided to them when their plan started.

The Provider submits that this charging mechanism on the plan has always been correctly administered in line with the plan terms and conditions.

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 a plan review is necessary.

The Provider submits that Plan reviews are provided for by paragraph 18 of the plan Terms and Conditions and when a review is conducted it looks at factors such as the value of the fund (if any), the benefits on the plan and current mortality and morbidity rates. From this the Provider establishes the highest level of cover that can be obtained by continuing with the current payment and what payment is required in order to maintain the current benefits on the plan to the next review date.

The Provider states that all money paid into the plan is allocated to the plan fund and all plan charges due are deducted from the plan fund. When the value in the fund is no longer sufficient to meet the plan charges a review is conducted. This is how the plan was always designed to operate.

Paragraph 18 of the plan Terms and Conditions provide for it to be reviewed on its fifth anniversary, every five years after that and annually once the oldest life cover reaches age 65. The Provider states that a copy of their Terms and Conditions were issued to the Complainants when their plan started.

In paragraph 18 it states, as follows:

"The sum assured, serious illness benefit and premium currently in force under this policy shall be reviewed by the actuary on the fifth policy anniversary and on every fifth policy anniversary thereafter unless and until the life assured attains age 65 following which the review shall be made at each policy anniversary. The benefits will also be reviewed after a claim".

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Paragraph 18 goes on to explain what happens each time a review is conducted.

It is the Provider's positon that the plan started in 1993 and was scheduled to be reviewed in 1998, 2003, 2008, 2013 and annually going forward from 2015 (when the First Complainant reached age 65). The Provider states that reviews can happen sooner if any of the assumptions made at the time that a plan is reviewed are not met — for example the estimated investment return is not met or a withdrawal is made from the plan fund.

It is the Provider's positon that the plan would have passed its review in 1998 and similarly it passed its review in 2003. This meant that the Provider estimated that the fund value at these times in addition to the future payments due to be collected and applied to the fund value over the next five years would maintain the costs of the plan until it became due for its next review at which point it would be reviewed again.

The Provider states that it wrote to the Complainants in 2003 to confirm that their plan had passed its review at this time. The Provider states that it reviewed the plan again as scheduled in 2008 and wrote to the Complainants again at this time confirming that their plan had passed its review. Included with this letter was a frequently asked questions document.

The Provider says that similarly the Complainants' plan was reviewed again in 2013 and again at this time their plan passed its review. The Provider states that while the Complainants say that they did not receive this correspondence until it sent them a copy in 2017 the Provider can assure that it was posted in 2013.

The Provider states that the review correspondence was issued to the Complainants' correct correspondence address and that it has no records on file to say that it was returned to the Provider as undelivered by An Post which is normal practice when An Post cannot deliver any of its correspondence.

The Provider submits that it regularly conducts reviews in the background and it included the outcomes of these reviews in the Complainants 2015 and 2016 Annual Benefit Statements.

The Provider submits that at these times it confirmed to the Complainants that:

2015

"A review of your plan payments 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 4.00% and our charges for benefits do not change. Your next plan review will be on 1 July 2017 when we will again check that the payments to your plan are sufficient to cover the cost of your benefits. However if you make an alteration to your plan in the interim we may review earlier than this date".

The Provider's positon is that a separate review was conducted on the Complainant's plan in 2015 and it wrote to the Complainants again at this time to confirm that their plan had passed its review.

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In the Complainants' 2016 Annual Benefit Statement the Provider stated that:

> 2016
>
> *"Assuming a future growth rate of 3.40% and our charges for benefits do not change, we will review your plan at the next scheduled review date 1 July 2017. At that stage we will tell you what payment you need to make to cover the cost of your benefits at that time".*

The Provider states that at this time it also provided the Complainants with the option to extend their period of cover beyond 2017 by increasing their payment at this time.

> *"If you prefer you can extend the period of cover by increasing your payment now. For example we estimate that to sustain benefits until 1 June 2023 you would need to increase your current payment to €456.07. If you would like to do this please contact your financial adviser".*

The Provider states that the Complainants' Plan was reviewed in 2017 as estimated in 2015 and 2016. The Provider's position is that at this time this review identified that the plans fund value in addition to the payment due to be collected and applied to the fund over the next year was insufficient to maintain the Complainants' plan and its current level of cover until the plans next review in 2018. The Provider states that as such a change needed to be made at this time.

The Provider states that the plan was now subject to annual reviews going forward in line with paragraph 18 of the Terms and Conditions as the First Complainant was over the age of 65.

The Provider says it wrote to the Complainants setting out a number of options including one to move to a new guaranteed whole of life plan that was not subject to future reviews. The Provider states that the Complainants did not select an option and instead cancelled their direct debit with their bank which resulted in their plan cancelling as a result of non-payment.

The Provider submits that in addition to the Complainants' plan payment always being correctly applied to their plan fund and plan charges then being deducted from this fund in line with paragraph 17 of their plan Terms and Conditions their plan has also been correctly reviewed in line with paragraph 18.

The Provider states that the first time that the plan fund could no longer meet the plan charges going forward was in 2017 and its review at this time informed the Complainants of this. The Provider states that all previous reviews identified that the plan passed its review meaning that no change was required at these times.

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The Provider states that it is worth mentioning that from 2014 it began to include in the Annual Benefit Statement a breakdown of how much the Complainants paid into their plan over the previous year and a breakdown of the plan charges. For illustration the Provider sets out the following table below with the detail from the Complainants' Annual Benefit Statements from 2014.

The Provider states that it is noted that the charges being drawn from the plan fund were greater than the new regular payments being invested in the fund.

Year	Payments Received	Benefit Charges	Current Value
2014	€1,789.44	€2268.51	€3363.83
2015	€2,022.81	€2643.73	€3,061.32
2016	€1627.56	€2590.24	€1882.43
2017	€1953.07	€3452.10	€406.71

The Provider states that it hopes the above table helps to explain to the Complainants why their plan value reduced to an amount of €406.71 by the time it was reviewed in May 2017.

The Provider says that all payments made to the plan fund including the method how plan charges are deducted have always been correctly administered in line with the plan Terms and Conditions. The Provider submits that in addition the plan has correctly been reviewed in line with the plan Terms and Conditions and as demonstrated 2017 was not the first time that the Complainant went through the review process. The Provider says that as such it is not agreeable to the Complainant's request of being paid the value that was attaching when the Annual Benefit Statement issued in 2014.

Evidence

Complainant's response of 23rd February 2018, to the Providers submission.

It is the Complainants position that they were advised from the outset that they had a reliable and secure policy with a savings element and they accepted that. The Complainants point back to one of the original submissions they received in 1993, in support of their hope for some savings from the policy. This correspondence stated:

> *"Life assurance is designed to cater for long-term savings in the most competitive manner whilst providing you and your family with financial security at a time, such as your untimely death".*

The Complainants states that they ceased the Direct Debit payment to the plan when they noticed changes which severely disadvantaged them in 2017.

The Complainants state that correspondence in May 2017 came in abundance and conveniently for the Provider when their money was spent by it at an opportune time for it as the Second Complainant approached her 65th birthday in June 2017. The Complainants state that one should not need to be an actuary or financial expert to benefit from a policy.

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The Complainants state that they stand by their original complaint, that they should have been informed clearly if and when their premiums paid by Direct Debit became inadequate and then given the choice to consider their option of whether to reduce cover.

The Complainants state that the Provider was totally dismissive of their complaint, repeatedly reminding them that they were getting older. The Complainants state that this was a fairly obvious fact as indeed every living person is getting older by the minute. The Complainants submit that as long standing, compliant customers they had hoped for a kinder tone from the Provider's representatives.

Policy correspondence / documentation

Terms and Conditions

> *"17. Benefits Charges*
> *The amount of the cover charge each month shall be based on the Benefits 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) and*
> *(ii) If the Permanent Disablement option has been selected as shown on the Policy Face an additional factor will be charged related to the cost of this benefit, and*
> *(iii) Such other factors relevant to the mortality risk as were agreed between the Policyholder and the Company at the Commencement Date or subsequently".*

11/08/2008 – the Provider to the Complainants

> *"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 in July 2013"*

26/06/2013 – the Provider to the Complainants – Policy Review. The Complainants' position is that they did not receive this correspondence in 2013. The Provider initially advised the Complainant that it could not locate a copy of this letter, but later advised that it had checked its archives and found same.

> *"This regular review is to ensure that the premiums you pay into your policy are sufficient to keep the level of covey you have chosen. ..*
>
> *[The Provider] has conducted a review of your policy for 2013. At this review we have calculated that your current premium is sufficient to keep your chosen level of cover until your next policy review. This means that no further action is required by you. We will contact you again when your next policy review is due".*

19/07/2013 – the Provider to the Complainants

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"No action is required from you at this time".

02/07/2014 – the Provider to the Complainants – Annual Statement

"Your annual statement is an important document and we recommend that you keep it in a safe and secure place for future reference. No action is required from you at this time".

The Premiums Received were €1,789.44. The Benefit Charges were €2,268.51.

"Explanatory notes
..
Benefit Charges – this is the charge to cover the on-going 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".

13/05/2015 – the Provider to the Complainants

"This regular review is to ensure that the premiums you pay into your policy are sufficient to keep the level of cover you have chosen. … At this review we have calculated that that your current premium, together with any fund value, is sufficient to keep your chosen level of cover until your next policy review".

19/06/2015 – the Provider to the Complainants

"Plan Review
A review of your plan payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time".

July 2015 – Annual Statement

"Plan Review
A review of your payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time".

May 2016 – the Provider to the Complainants - Annual Statement

".. we will review your plan at the next scheduled review date 1 July 2017. At that stage we will tell you what payment you need to make to cover the cost of your benefits at that time".

May 2017 – the Provider to the Complainants – Annual Statement

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> *"Plan Review*
> *The next scheduled review for your pan is due now. This is when we check that the payments are enough to cover the cost of your benefits".*

Payments made €2,022.81

Charges Applied - Protection Benefit Charges €2,643.73

> *"We take protection benefit charges each month for cover provided for that month. We take these charges from your fund based on the unit price at the time"*

04/05/2017 – the Provider to the Complainants

> *"We've carried out your latest review and your current payments and any fund value you've built up are no longer enough to keep your current level of cover".*

01/06/2017 – the Provider to the Complainants

> *"We've carried out your latest review and your current payments and any fund value you've built up are no longer enough to keep your current level of cover".*

03/07/2017 – Provider to the Complainants

> *"As previously advised, your current payment is insufficient to maintain the current level of benefits under the above plan from 1 July 2017 to 1 July 2018".*

Policy Review Frequently Asked Questions

> *"3. What happens if my usual premium is not enough to maintain my cover?*
> *When your usual premium is no longer enough to maintain your current level of cover and you do not have enough in your unit-linked fund to cover this difference, you can choose either to increase your premium amount or to reduce your level of cover".*

The Provider has advised in its submission to this office on 2nd February 2018 that from 1st August 2008 the plan costs being deducted from the fund exceeded the regular payment which was purchasing units into the fund.

The Provider also advised that the first time the plan fund could no longer support the plan going forward was in 2017.

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

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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.

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

Analysis

The issue for investigation and adjudication is whether the Provider correctly and reasonably administered the policy, particularly in relation to the reviews carried out on the policy and with the Provider's communications in relation to the reviews.

I accept that the Policy document outlined the policy features. The Provider was entitled to Review the policy. The Provider was entitled to use the policy fund to supplement the cost of benefits specifically where the premium payments were not meeting that cost. I accept that the documentation sent to the Complainants 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.

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 on the administration of the policy.

Having reviewed the express wording of the policy terms and conditions, I accept that the Complainants were on notice from the time of commencement of the policy that the policy was to be reviewed by the Provider's Actuary every 5 years and yearly from when the Policyholder reached age 65 years. The Actuary was to determine during each review process the value of the Policy Unit Account to 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.

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

I accept that there could have been greater and earlier communication to the Complainants of the cost of providing the benefits over and above that which the Complainants were paying by way of premiums. It was only in 2014 that the Provider communicated a Cost of Benefit Charges figure that was greater than the premium payment, indicating that the amount the Complainants were paying was not enough to cover the cost of supplying the benefits under the policy. The 2014 statement showed that the cost of providing the Protection Benefits for the period came to €2,268.51 However, the amount paid in premiums for that year amounted €1,789.44. Similarly in 2016, and 2017 the Provider communicated that the cost of providing the protection benefits exceeded the amount being paid by the Complainants.

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.

It is noted that at each policy anniversary up to 2017, the Provider was telling the Complainants that it was only in the more expensive years of the plan that it would be relying on the fund value to supplement the cost of cover, but that this was already the situation. The Provider does not specify what it considers are the *"more expensive years of the plan".*

I consider that during the administration of the policy the Provider incorrectly issued conflicting communications to the Complainants as to the adequacy of the premium payments being made.

For example from 2008 the Provider was relying upon the policy fund to supplement the cost of benefits. However, what was being communicated to the Complainants over the years was that:

> *"A review of your payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time".*

These conflicting statements were issued on numerous occasions by the Provider over the years when in fact it had being using the policy fund in addition to the premium payments to provide the benefits.

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

The Complainants have sought by way of a remedy in their overall complaint, a full refund of the surrender value that existed in 2014, that is €3,588.43. I accept that the Complainants have paid a substantial amount in premiums, but it is also noted that the Complainants had the benefit of life cover over that period (which could not be provided without a cost).

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

I find that the Policy document outlined the policy features. The Provider was entitled to Review the policy. However, 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 that the cost of cover was more than 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 Company found it necessary to reduce the policy fund to support the benefits from as early as 2008. I consider that 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. A breakdown of the payments being made, the cost of benefits and the policy value were provided over the later years of the plan, but there was little or no commentary on those figures. To confound this position I consider that there was conflicting information being given as outlined above. It is not reasonable to expect Policyholders to do numeric calculations on the various figures provided in annual statements, while at the same time as providing confliction information on those payments.

Clear communication of the true cost of cover in comparison to what was being paid in premiums should have been communicated to the Complainants. They should also have been informed that the fund value was decreasing because the fund was supplementing the cost of cover. This would have given the Complainants 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 specifically tell the Complainants earlier that the actual cost of cover had begun to exceed the payment, and that the reason the fund was decreasing in value was because of the excess cost of benefits deducted from the fund.

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 Legally Binding Decision that the complaint is upheld and I direct the Provider to make a compensatory payment to the Complainants of €5,000 (five 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 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 Complainant in the sum of €5,000, 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

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.