An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0062
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Maladministration Delayed or inadequate communication Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants entered into a Joint Life First Death Policy, a Unit-Linked Protection Plan, Plan Number [0LxxxxxD] which was sold to them by a third party provider and commenced on 14 February 1992.

The Provider was responsible for the administration of the policy in question.

In November 2015, the Complainants' fund lapsed as a result of the fund value reaching zero.

The Complainants submit that the Provider did not act fairly or reasonably toward them and the Complainants' complaint is that they were not provided with all options available to them, each time the policy was reviewed and, in particular, that they were not informed by the Provider of their right to withdraw the value from their policy.

The Complainants' Case

The Complainants submit that the Provider did not act fairly, in keeping them informed about their policy and they submit that the documentation provided to them by the Provider was misleading and inaccurate.

The Complainants' complaint is that they were not provided with all options available to them, each time that their Policy was reviewed by the Provider.

The Complainants submit that they were not aware of their right to withdraw the value from their plan and that had the Provider informed them of this right then they could have withdrawn the money in the Policy when it still had a value. The Complainants' submit that *"this was a conscious concealment of our rights under the policy*" and that the Provider *"allowed the Policy to decrease every year to their benefit."*

The Complainants submit that the relationship between themselves and the Provider was "*unbalanced*" with the Provider "*having the greater power and knowledge in this situation."* The Complainants submit that they did not realise the severity of the situation, until November 2015, when their policy was "*unilaterally cancelled by [the Provider]*". They submit that "at this stage we had paid approx. €23,947.00 in premiums."

The Complainants' submit that if they had been told by the Provider of their right to withdraw the value of the plan, then they would have done so in order to "*cut their losses"*.

The Complainants submit that it has been acknowledged by the Provider that they could in fact have withdrawn from the policy by way of surrender, but that the Provider did not disclose this information to them in any of its review letters. The Complainants submit in this regard, that:

> *"The governing terms state that following each Plan Review, the Provider would recommend one or more of the following options which should be exercised by the policyholder..."*

The Complainants submit that the use of the words "*would recommend*" by the Provider, implies that the Provider would provide them with guidance in respect of their policy. The Complainants submit that in each review letter, however, the Provider only sought either to obtain an increased premium from them and/or to decrease the benefit available under the policy. The Complainants submit that, as a result, they believed that these were the only options which were available to them at the time.

The Complainants submit that whilst the Provider has sought to "*justify the withholding of the right to surrender in the review letters*, on the basis that the Complainants could have obtained their own financial advice in this regard, the Complainants submit that this was not explained to them, at the time.

The Complainants submit that the Provider owed them "*a duty of care to be up front and frank with us at all times regarding our policy*". The Complainants submit that, "*it is both unreasonable and unfair given the position of all parties in this dispute for [the Provider] to say there is a clause contained in the policy document, and if you don't know it's there, then that's your fault. We placed our trust in [the Provider] and complete disclosure should have been provided in each review letter as to our full options, particularly where 'fundamental changes in investment conditions' were occurring.*"

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The Complainants' submit that as the Provider failed to undertake a review in 2002, they cannot know how much they could potentially have surrendered the policy for, at that time.

The Complainants submit that whilst the Provider has stated that they were not financially disadvantaged by its failure to conduct a review in 2002, it has not provided them with any figures to substantiate this statement. The Complainants submit that they do not accept that there was no material change to their policy between 2002, when the initial review should have taken place, and 29 June 2004, when they received the first review letter.

The Complainants are seeking compensation in the sum of the premia which they paid in to the plan.

The Provider's Case

The Provider has submitted that the policy in question was sold by a third party provider. It submits that when the Complainants' plan started, in 1992, the Complainants were issued with a Policy Document by the third party provider responsible for the sale of the plan, and that this document set out how the plan worked including the fact that it would be reviewed over the life of the plan.

The Provider submits that the plan which the Complainants entered into was a Unit Linked Protection Policy and that such a plan works in a particular way - when payment is received, the Provider uses the monies to purchase units in the selected fund. It then encashes units held within the fund to cover the cost of the benefits and plan fees each month, with the remaining units making up the value of the plan on any given day. It submits that in the beginning, the payment alone is sufficient to cover the cost of the benefits and as there are excess units, after the costs are deducted, the plan begins to build up a fund value. The Provider submits that over time, however, as the life covered gets older, the cost of providing the benefit increases. The cost of life cover depends on the amount of cover required, the age of the customer at that time and the term that the cover is required for, as people get older, the cost of providing life cover gets higher.

The Provider submits that in order to ensure that the payments being made and the value built up within the fund is sufficient to maintain the existing benefits, the Plan is designed to be reviewed at regular intervals throughout the life of the plan, i.e, after the first ten years and every five years thereafter, reducing to once yearly once the eldest life covered reaches age 70.

The Provider submits that the options which would be provided to the Complainants following each review, as well as the Complainants' right to withdraw the value built up in the plan, were clearly set out within the policy document.

The Provider submits that despite its having issued eight plan review letters to the Complainants between 2004 and 2015, its records show that no steps were taken by the Complainants to accept any of the recommendations made by the Provider. It further

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submits that the Complainants did not make any contact with it to question the contents of the letters they had received, or to seek alternative recommendations.

The Provider rejects the Complainants' contention that it was the Provider's poor administration/information which led to the reduction in the value of the policy, over the years (and the subsequent cancellation of the benefits). The Provider submits that the plan value reduced as a result of the increasing costs of the benefits, and the Complainants' decision not to take steps in respect of the policy, when notified of the outcome of each policy review. The Provider submits that it is satisfied that the information which was provided to the Complainants, throughout the term of the plan was sufficient to enable them to seek financial advice on how their plan worked and as such, to decide on what steps, if any, to take regarding the plan and its value.

The Provider submits that it acknowledges that as the policy was sold to the Complainants in 1992 and a review was due to take place after the initial 10 years, *i.e,* in 2002, but that this did not occur until 2004. The Provider submits that the Complainants were not financially disadvantaged in any way by the initial plan review not being conducted as scheduled in 2002. The Provider submits that this is:

> "*clear from the fact that when the Plan was reviewed in 2004, estimates at the showed that the plan could continue at its current levels, for a further 12 years. Bearing in mind the Complainants took no action throughout the life of the plan to ensure it would last longer, it was 2015, some 13 years later, before the plan cancelled due to a zero fund. We are satisfied that the outcome of a plan review in 2002, had it occurred, would not have changed any of that which occurred between 2004 and 2015.*"

The Provider submits that it is satisfied that the information set out in the Plan document, was clear in explaining to the Complainants that the Life Programme was a protection plan (rather than a savings plan), exactly how the plan in question worked and that it was possible to withdraw the value from the plan.

The Provider submits that in using the value of the plan to fund the associated costs, the Provider has administered the plan in accordance with that set out in the governing terms. The Provider submits that the payments made by the Complainants were never intended to take the form of savings but rather, they were to be used to purchase units in a fund, which would in turn meet the costs of the benefits and plan in place.

The Provider submits that the information and options which were set out in each plan review letter which issued to the Complainants were in accordance with the governing terms. The Provider submits that this information was sufficient to enable the Complainants to contact the Provider, should they have any questions regarding their plan or wish to meet with a financial adviser and that further, the letters noted the value of the plan and the options available to them, in order to maintain the existing level of benefit.

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The Complaint for Adjudication

The Complainants' complaint is that they were not provided with all of the options which were available to them, each time the policy was reviewed and, in particular, that they were not informed by the Provider of their right to withdraw the value from their policy.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 05 March 2019 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.

The plan in question, a "Life Programme Plan" was sold to the Complainants by a third party provider on **14 February 1992**. Consequently, this investigation and adjudication does not examine issues relating to the sale or appropriateness of the product.

Insofar as the conduct of the Provider is concerned, the complaint is that the Provider failed to provide the Complainants with sufficient information in relation to their policy, that the documentation provided to them by the Provider was misleading and inaccurate and that they were not provided with all of the options available to them, each time that their Policy was reviewed by the Provider, specifically they state that they were not informed of their right to withdraw the value from their plan.

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In the course of examining this complaint, and in coming to my determination, I have had detailed regard to the documentation furnished as part of this complaint. As the level and the nature of the information which was furnished to the Complainants by the Provider forms a central part of the complaint, I have examined in detail below, the information contained within the review letters and benefit statements which issued to the Complainants over the term of the Plan in question.

First I will examine the Life Programme Policy document itself, which provides the basis for the Policy Reviews and the Surrender Option.

Policy Document

Section 11 of the Life Programme Policy document is entitled "*Policy Review*" and provides as follows:

11 Policy Review

a. *This policy review shall be reviewed by the Company at each Review Date. The first Review Date shall be on the tenth Policy Anniversary and thereafter on every subsequent fifth Policy Anniversary provided that the Company shall carry out a Policy Review on the Policy Anniversary immediately prior to the seventieth birthday of the Assured (as defined in (e) below) and yearly thereafter.*

…

c. *A review shall take into consideration (inter alia):*
   (i) Future Premiums payable;
   (ii) The value of Units allocated to this Policy; and
   (iii) The excess of the Sum Assured over the Policy Value.

d. *The purpose of the review shall be to assess whether Units then remaining allocated to the Protection Account and any Units to be allocated thereto in respect of the Premiums which may fall due to be paid in the future shall be sufficient to support the Policy charges until the next scheduled Policy Review.*

In making such assessment, the company shall be entitled to take into account such factors as it shall (at its absolute discretion) consider relevant.

Following the review the Company may recommend one of the following options should be exercised by the Policyholder:

i. that future Premiums are increased;
and/or
ii. that Policy Benefits are reduced;

provided that, if the Policyholder does not exercise either of these options, and at some subsequent date the Policy Charges exceed the Policy Value then this policy shall

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automatically terminate at the said date and all Policy Benefits provided hereunder shall be cancelled.

Section 13 of the Policy:

13. Cash Option

a Provided that this Policy shall at the time in question, have acquired a Surrender Value, the Policyholder may at any time, by giving notice to the Company, elect to partially encash the value at the Bid Prices of the Units then allocated to the Protection Account provided the amount so encashed and the value of the Units remaining are of such minimum amounts as may be determined by the Company from time to time…

b. If any payment shall be made by the Company under this condition, the Company may at its absolute discretion reduce the sum assured…

c. The Company shall have the right to carry out a Policy Review in accordance with Condition 11 in connection with any election made by the Policyholder pursuant ro paragraph (a) above.

Section 14 of the Policy is entitled "*Surrender Option*" and provides as follows:

14. Surrender Option

Provided that this Policy shall, at the time in question, have a Policy Value, the Policyholder may at any time not being earlier than two years after the Commencement Date and provided that two full years' Premiums have been paid, by giving Notice to the Company, elect to encash this Policy for a Surrender Value. The Surrender Value shall be the Policy Value based on the Bid Prices ruling upon receipt of such Notice or, at the absolute discretion of the Company, as determined on the next Valuation Day.

I will turn now to look at the information which was provided to the Complainants by the Provider in review letters and annual benefit statements.

Plan Reviews

As the plan in question was incepted on **14 February 1992**, the first review was due to have been carried out by the Provider in **2002** on the tenth anniversary of the Policy, per section (a) above. However, it was not until **29 June 2004**, that the initial Plan review took place, two years later than it should have occurred.

2004 – First Review of the Complainants' Life Programme Completed by the Provider

By letter dated **29 June 2004** the Provider issued a letter of review to the Complainants, which stated that:

We have recently carried out a review of your Life Programme. The Life Programme is a life assurance policy, designed to provide life assurance cover throughout your life or for

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as long as you require it. The contributions that you pay towards your Programme are invested on your behalf, and the cost of the life cover is deducted monthly from the investments attaching to your policy.

When you started your Life Programme, we calculated the regular contribution using assumptions about future investment returns that were generally accepted at the time. We have now reviewed your policy in accordance with the policy conditions, to see if your regular contributions are sufficient to support the life cover until your next policy review in February 2007.

It went on to provide the "Results of the Review", as follows:

Based on this review, we expect that the current contribution will support the life cover on your policy until the next review in February 2007.

However, we expect that the life cover will not be supported beyond 12 years from now. This is because it is likely that the investment value of your Programme will have been completely used up in providing your life cover by then – so, unless some action is taken before then, your Life Programme may lapse, i.e., it may terminate without any benefits.

You may therefore wish to increase your regular contribution, in order to maintain the life cover for a longer period. For example, if you wish to maintain the life cover until your 70th birthday, we estimate that the contribution required from now on is €101.98 per month.

…

Confirmation Slip

If you wish to increase your regular contribution, please complete the enclosed Confirmation Slip and return it to [the Provider] in the pre-paid envelope provided. If we do not hear from you, we will assume that you do not want to make any alteration to your policy.

Next Review

We will contact you again close to the next review date in February 2007, to let you know whether your contribution is still adequate at that time for the life cover provided.

If in the meantime if you have any queries, please do not hesitate to contact our Customer Services Helpdesk on LoCall xxxx xxx xxx.

In terms of the information provided as to the value of the Policy at that time, I note that the review letter stated that the monthly contribution at that time was €83.49, the sum assured was €46,981 and the value at the review date (11 June 2004) was **€5,813**.

2007 – Second Plan Review

The Provider conducted its second review of the plan in 2007, and wrote to the Complainants, by letter dated **03 August 2007**. This review letter advised of a plan value, at that time, of **€8,098**.

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On this occasion, the Provider estimated that the plan could continue at its existing levels until the next scheduled review in **2012,** but that it was likely that the value would be completely used up, beyond ten years' time.

The Provider advised the Complainants that if they wished to maintain life cover for a longer period, so that the existing benefits remained in place until the older life covered under the policy reached age 75 (which was due to occur in 2018), they could increase their level of payment to **€95.25** per month (in 2007).

The Complainants' submit that the surrender value of the policy had increased to **€8,089.00**, as per the second review letter received by the Complainants in **August 2007**, but that they had paid approx. **€12,090.00** in premiums at that time.

The Complainants' submit that after the 2007 review, the surrender value continued to diminish as they continued to pay their monthly premiums.

2012 – Third Plan Review

By letter dated **25 January 2012** the Provider issued a plan review letter to the Complainants. On page one of the Plan Review Letter it is stated that the value of the plan at that time, was **€3,826**.

On this occasion, the Complainants were advised that the results of the review showed that it expected that the level of contributions could support the life assurance cover on the policy until February 2013 but also advised, in bold type, that:

> ***It is important to bear in mind that, if you do not increase your contribution, the life assurance benefit under your policy may cease within 3 years from now.***

The Provider also advised the Complainants that should they wish to ensure that the existing benefits remain in place until the oldest life covered reached age 75 (in 2018), they could increase their level of payment to **€179.91**.

2013 – Fourth Plan Review.

By letter dated **14 March 2013** the Provider wrote to the Complainants with details of a review, which had been carried out on **05 March 2013**.

The value of the plan was **€3, 172,** at that time.

On this occasion, the Complainants were advised that the plan could be maintained at its current levels until the next scheduled Plan Review, in 2014 but that it was expected that:

> *"the life assurance cover will not be supported beyond 2 years from the effective date of the review. This is because it is likely that the investment value of your policy will have been completely used up in providing your life assurance cover by then. Therefore, unless*

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some action is taken before then, your policy will lapse and it will terminate without any benefits."

It is important to bear in mind that, if you do not increase your contribution, the life assurance benefit under your Policy may cease within 2 Years from now."

The Plan Review indicated that increasing the level of payment to €198.48, would maintain the exiting level of benefits until 2018 (when the Second Complainant reached age 75).

2014 – Fifth and Sixth Plan Reviews

At the time that the Complainants' plan was reviewed for a fifth time, on **06 January 2014**, the value of the plan was **€2,354.00**. The review indicated that it was expected that the contributions in place at the time would support the life assurance cover on the policy until 2015.

The review letter indicated that increasing the level of payment to **€214.38**, would be sufficient to maintain the existing level of benefits, until 2018.

The Complainants' Plan was next reviewed by the Provider on **01 October 2014**, at which time the value of the policy was **€1,397.44**. The review letter stated that life assurance cover would be supported for 9 months from the date of the review because it was likely that the investment value of the Complainants' policy would have been completely used up in providing life assurance cover by that time. The Provider advised that in order to maintain the existing level of benefits until the eldest life covered reached age 76 (2019), the level of payment required was **€240.63**.

2015 – Seventh Plan Review

The Complainants' Policy was subsequently reviewed on **01 September 2015**, at which time the monthly contribution was **€84.32**, the Life Assurance Cover provided was **€46,981** and the value of the policy was **€0.00.**

The outcome of the Review was communicated to the Complainants, as follows:

"the current contribution does not support the life assurance cover on your policy beyond the effective date of this review. This is because the investment value of your policy has been completely use dup in providing your life assurance cover. Therefore unless some action is taken before then, your policy will lapse with no value and it will terminate without any benefits."

The Provider estimated that the contribution required to support the Complainants' life assurance cover, at the same level, until February 2016 was **€391.21**.

The review letter also indicated that:

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"You may decide not to opt for the above increase. If you continue to pay the present premium of €84.32, this will maintain a reduced benefit of €12,531 up to your next review in February 2016."

It advised that if no action was taken then cover would cease *"6 weeks from 03/09/2015*"

Ultimately, the plan lapsed and the benefits were cancelled by the Provider, in **November 2015.**

Annual Benefit Statements

As well as the above plan review correspondence, "*Premium Portfolio Statements",* issued to Complainants, which set out the following details in relation to the Policy:

2008

Initial Sum Assured	€46, 981.00
Monthly Annual Premium	€83.49
Premiums paid to 28/12/07	€15,946.03
Value as at 28/12/07 Net	€7,726.87

2009

Initial Sum Assured	€46,981.00
Monthly Annual Premium	€ 83.49
Premiums paid to 28/12/07	€16,947.91
Value as at 22/12/08 Net	€ 4,752.60

2010

Initial Sum Assured	€46,981.00
Monthly Annual Premium	€ 83.49
Premiums paid to 28/12/07	€17,949.79
Value as at 22/12/09 Net	€ 4,801.94

2011

Initial Sum Assured	€46,981.00
Monthly Annual Premium	€ 84.32
Premiums paid to 28/12/07	€18,951.67
Value as at 22/12/2010 Net	€ 4,773.07

2012

Initial Sum Assured	€46,981.00

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Monthly Annual Premium	€ 84.32
Premiums paid to 28/12/07	€19,967.66
Value as at 22/12/11 Net	€ 3,675.80

2013

In **January 2013** a Portfolio Statement issued, in the same format as previously and then in **February 2013**, the Complainants received a further "*new format Annual Benefit Statement*", which was explained by the cover letter as including details as required by the Consumer Protection Code 2012.
The Policy value as at 21 December 2012 was stated to be €3,194.15.

2014

In December 2014 the Complainants received a statement which stated, amongst other things, the following information:

Your current cash in value at 02 December 2014
Your current cash in value at 02 December 2014" €1,148.42

Ultimately, as no action was taken by the Complainants, the policy lapsed with zero value, in 2015.

I note that at the within each Annual Benefit Statement it provided contact details for any questions the Complainants may have had about their policy.

The Plan review letters, under the heading "Next Review" advised that the Provider would contact them again, close to the next review date to let them know if the contribution was still adequate at that time for the life cover provided, but that "*If in the meantime you have any queries, please do not hesitate to contact our Customer Services helpdesk on [number]".*

I note that the Complainants' financial advisor had emailed the Provider on **10 October 2011** and requested details of the Policy, as follows:

> *Hi,*
>
> *Please issue an up to date statement confirming all details on both life policies mentioned below:*
>
> *Policy No: [x]*
> [LxxxxxD] (*Policy the subject of this complaint)*
>
> *Also, please issue client retirement options letter for the following policy:*
> *Policy No: [y]*
>
> *Thank you,*
> *[Name]*

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A letter dated **12 October 2011** issued to the Complainants:

Re: *Policy Number(s) [LxxxxxD]*
Policy Owners: *[the Complainants]*

I refer to previous communication in respect of the above. Please find below details as requested based on the unit prices input on 11 October 2011.

Policy Number	*[LxxxxxD]*
Product Type	*Life Programme*
Fund Type	*Balanced Fund -50%*
Dynamic Fund -50%	
Commencement Date	*14 February 1992*
Sum Assured	*€46,981.00*
Current Monthly Premium	*€84.32*
Premiums Paid to Date	*€19,714.70*
Current Value	*€3,712.11*

The value is not guaranteed as prices may fluctuate.

In accordance with the Stamp Duties Consolidation Act 1999, a levy is payable on life assurance premiums (currently 1%). The payment amount received from you (which is shown above) is inclusive of the levy. We will then remit this levy amount to the Revenue Commissioners.

I trust this clarifies your query. However should you require any further information, please do not hesitate to contact me.

Having examined the correspondence which the Provider issued to the Complainants, I consider that the Provider could have been clearer in its communications over the years about the cost of the life cover being provided. In particular, once it was the position that it was not only the contributions (premiums) being paid by the Complainants that were supporting the life cover costs, but rather that the policy fund was also being used to supplement the cost of cover, this should have been communicated clearly to the Complainants. The exact timing of when this had begun to occur is not clear from the documentation submitted.

I also consider that the communications from the Provider on this point are somewhat contradictory and unclear as the actual position. Reference is made in each of the plan reviews to the fact that, on the one hand, "*we expect that the current contribution will support the life assurance cover on your policy until the next review ..*" but also that "*we expect that the life assurance cover will not be supported beyond [period of years] from the effective date of the review. This is because it is likely that the investment value of your policy will have been completely used up in providing your life assurance cover by then.*"

Nowhere, however, is the actual cost of life cover separately identified for the Complainants.

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By letter dated **16 October 2015**, the Complainants received a letter advising that:

"I am writing to you further to previous correspondence regarding the review of your Life Programme. In that correspondence we advised that changes were needed to prevent the plan being cancelled when the unit account went negative. Since the payment under the plan is insufficient to maintain the benefits and the unit account is now negative, I wish to advise that your plan will lapse in accordance with the terms and conditions with effect from 14th November 2015."

I do not find that it is clear, however, at what point the contributions alone ceased to cover the cost of the policy benefits and I consider it reasonable that a Provider sets this out at the earliest opportunity, be that be at policy anniversary date or at review stage.

Overall, I consider that the information furnished to the Complainants by the Provider over the years was not sufficiently clear in this regard.

Purpose of the Plan

The Complainants have submitted that the Provider concealed the fact that they could withdraw the value of the Plan. The Provider has submitted that the options provided to the Complainants were in line with the purpose of a Unit Linked Protection Plan. I accept that such a plan operates on the basis that when payment is received by the Provider, units are purchased by it in a selected fund and units are then surrendered to cover the cost of benefits and fees each month. At the beginning, the payment alone is enough to cover the cost of the benefits and that as there are excess units, the plan begins to build up a fund value. Over time however, the cost of providing benefit/life cover increases as the lives covered get older.

The Provider has submitted that the purpose of a plan review is to review the amount of payment being made and the plan benefits to identify what, if anything, needs to be done in order to sustain life cover until the next review date.

Despite the Provider having submitted that the Plan was not a savings plan and that the information which issued to the Complainants reflected this, I note that the Life Programme Brochure itself provided as follows at the outset of the brochure:

> ***The principal features of your Life Programme***
>
> ***The key benefits***
>
> *Your Life Programme provides you with the benefits that you have agreed with your [Provider] financial planning consultant and which are the most appropriate to your circumstances. This is a combination of:*
>
> 1. *A high level of life assurance cover, and*
> 2. ***A savings element designed to build up a really substantial sum.***
>
> *[my emphasis]*

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Analysis

I find it striking that one of the key benefits was specifically stated by the Provider in its documentation to be, "*A savings element designed to build up a really substantial sum",* and given this, I do consider that the Provider could have provided better communications to the Complainants on this element of the product over the years, specifically it could have drawn greater attention to the position that this *key benefit* was not being achieved and/or was being greatly affected by the rising cost of life cover.

I have taken into account the Complainants' submission that because the Provider did not carry out the scheduled review in 2002, they do not know what value their policy would have had at that time, and how much they could have potentially surrendered the policy for.

I consider that the failure of the Provider to carry out a review in 2002 means that the Complainants did not know what the value of the Policy was at that time. In circumstances, however, where the Complainants did not, at any time during the remaining course of the plan, seek guidance with regard to the Policy, I am of the view that, on balance, even if a plan review had occurred in 2002, it would not in all likelihood have changed the outcome of the events which unfolded.

I have taken on board the Complainants' submission that they expected the Provider to act in their best interest and to advise them accordingly, and I note the Complainants' point that the Provider did not explicitly set out the surrender option to them. However, taking into account the type of policy in question, the role of the Provider as administrator of the Policy, and the information which was furnished as to how to contact the Provider and/or seek financial advice, if they had concerns or queries, was set out within the documentation which was furnished to them.

I do however consider it reasonable that, at a time when the contributions being paid are no longer sufficient on their own to cover the cost of providing the policy benefits, this should be clearly communicated. Further, for any confusion that the lack of clear information may have caused the Complainants as regards the achievement of a stated "key benefit" of the plan, I consider that a compensatory payment is merited. As the link between contributions being paid and the value that accumulates on the plan are so close, I accept that the Complainants may have reasonably expected more informed communications / advice on these matters.

To conclude, it is my Decision that the complaint is partially upheld and I direct a compensatory payment of €5,000 (this payment is instead of the monetary amounts offered by the Provider for its identified failings, i.e., an offer of €250 to the Complainants in respect of its failure to carry out a review in 2002 and €250 in respect of a failure to include the email dated 10 October 2011, as part of a Data Access Request by the Complainants).

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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 partially upheld, on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €5,000.00, 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

29 March 2019

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.