Decision Ref:	2019-0101
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Dissatisfaction with customer service Failure to process instructions in a timely manner Value of policy at surrender less than expected or projected Failure to explain/understand index linking
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

In **January 1988** the Complainant incepted a flexible, unit-linked, whole of life policy with the Provider, when he was 48 years of age. The policy was surrendered with an effective date of the 30 June 2017 and an amount of €1,172.05 was paid out to the Complainant.

The Complainant takes issue with the manner in which the policy was administered, and the customer service received while the policy was in place.

The first complaint is that in June 2017 the Provider delayed in actioning the Complainant's request to terminate his policy.

The second complaint is that the Provider failed to properly administer the Complainant's policy insofar as it incorrectly addressed communications to the Complainant and insofar as indexation notifications/important policy communications went missing.

The third complaint is that following the sale of the policy to the Complainant in 1988, the Provider failed to offer the Complainant any opportunity thereafter, over a period of almost 30 years, to review the ongoing suitability of the product for his changing needs.

The fourth complaint is that the Provider furnished insufficient information to the Complainant in response to queries raised as to transactions relating to the policy, in particular, queries raised regarding the encashment process effected in 2002.

In his Complaint Form to this office, the Complainant outlined that he would like all communications from the Provider looked at. He outlined further that the policy in question was not fit for purpose *"for some time".* The Complainant stated that he is seeking a refund of all premiums paid since he reached the age of 65.

The Complainant's Case

While the Complainant does not dispute that the policy was suited to his needs when it was commenced, he argues that after he reached the age of 65 in April 2004, the policy was no longer appropriate, given his circumstances. When he reached the age of 65, the Complainant no longer had dependent children, a mortgage or a full-time job. He is of the view that the Provider should have reviewed or re-assessed the suitability of the product for his needs after he reached the age of 65. The Complainant contends that the Provider allowed the policy to continue beyond the initial term when it no longer suited his needs or requirements. He states that he was given no financial advice about the continued suitability of the product and believes that the product was no longer *"fit for purpose".*

The Complainant states that policy reviews were carried out every five years and, on several occasions, he opted to continue to pay the same premium for the next five years, thus reducing the sum assured. However, despite his instruction to maintain the same premium level, on some occasions the level of benefits increased due to inflationary increases and consequently the same premium was not maintained.

The Complainant submits that communications he received during the life of the policy have been extremely confusing. He submits furthermore that communications were often delayed and questions he raised were left unanswered. He is of the view that important documents and indexation notifications regarding his policy were not sent to him as they ought to have been, borne out by identified *"gaps"* in communications. The Complainant submits that on one occasion a letter dated the 22 August 2017 containing sensitive information issued to an incorrect address and was opened by a third party.

The Complainant explains that in 2017 he received a number of documents pertaining to his policy, including paperwork surrounding a 2002 encashment. He states that when he raised queries about this 2002 encashment, the Provider failed to sufficiently address his queries and failed to provide him with further information.

The Complainant submits that on the 3 June 2017 the Provider was contacted and advised that he wished to surrender his policy with effect from the 1 July 2017. He states that he was under the impression his request was being actioned until he received communication from the Provider in August 2017 requesting a signed instruction to cancel the policy. He states that he eventually received an encashment cheque in December 2017. Although no additional premiums were paid between July and December 2017, the Complainant

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submits that during this period the Provider wrote to him *"to chase him for payment",* which caused him considerable distress.

The Provider's Case

The Complainant's Policy was a unit linked whole of life policy which was taken out by the Complainant on 1 January 1988. As a whole of life Policy it did not have a fixed term. The Policy was, however, subject to periodic reviews, in accordance with the Policy terms and conditions. The Provider's position is that the periodic reviews were carried out over the years, the outcomes of which were notified to the Complainant at those times. The Provider says that its records also reflect that the Complainant engaged with the Provider following the 2003 and 2013 reviews to make adjustments to the Policy at those times. The Provider states that Review letters issued and were clear on the term that the premiums quoted applied to.

The Provider submits that if the Complainant had not surrendered the Policy in 2017, the Policy could in fact have remained in force for the remainder of the Complainant's lifetime, provided he continued to pay premiums due.

The Provider states that the suitability of the Policy for The Complainant was determined at point of sale in 1988 and if the Complainant's personal or financial circumstances had changed over the years it was at all times open to him to bring those changed circumstances to the Provider's attention. The Provider states that as can be seen from its file of papers, the Provider communicated with the Complainant regularly over the years. Most of the correspondence issued invited the Complainant to contact the Provider or his financial advisor if he wished to discuss the Policy at any time.

It is the Provider's positon that its Records reflect that the Complainant, and in more recent years the Complainant's daughter, did contact the Provider on a number of occasions to make amendments to the Policy. The following are examples that the Provider points to:

- 1989 - The Complainant increased the life cover from IR£12,000 to IR£20,000
- 1994 — The Complainant confirmed he had changed address
- 2002 — The Complainant took a maximum part surrender from the Policy.
- 2003 — The Complainant reduced the level of life cover following a *failed* Policy review
- 2012 — The Complainant contacted the Provider after he received an arrears letter
- 2013 — The Complainant's daughter contacted the Provider on behalf of the Complainant following a *failed* Policy review to confirm the Complainant wished to increase the premium.
- 2013 — The Complainant confirmed he did not wish indexation to apply for 2014.
- 2014 — The Complainant requested that indexation be removed from the Policy.

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The Provider states that it does not accept that it failed to furnish the Complainant with sufficient information in relation to the maximum part surrender taken by the Complainant from the Policy in 2002. The Provider says that records reflect that during the course of the complaints process the Complainant's daughter was provided with a copy of the encashment form completed by the Complainant and a named bank, as assignee, on 9 January 2002 (received by the Provider on 25 January 2002). The Provider submits that a copy of the covering letter, cheque and policy endorsement that issued to the Complainant on 28 January 2002 in respect of the maximum part surrender have also been provided to the Complainant's daughter for her records. The Provider submitted into evidence a copy of these documents and also enclosed a copy of the available system records pertaining to the part surrender and the consent received on 16 January 2002 from, a named bank, as assignee, to proceed with the part surrender.

The Provider states that it can be seen from the records that the cheque (in the sum of €9,315) was made payable to the Complainant and marked account payee only. The Provider submits that the endorsement which was provided to the Complainant confirmed that 'an amount of €9,340.00 inclusive of part-encashment charge of €25.00 has been paid by the Provider on the 25.01.2002 in discharge of part surrender claim under the policy'.

In an email dated 11 July 2017 the Complainant's daughter outlined that the Complainant did not recall taking the maximum part surrender from the Policy in 2002. The Complainant's daughter asked if it was possible to confirm details of the bank account into which the part surrender was lodged. In a follow up email on 22 July 2017 the Complainant's daughter raised additional enquiries in relation to the amount of the part surrender.

The Provider says that it responded to the Complainant's daughter's enquiries by letter dated 8 August 2017. The letter outlined that the Provider was not in a position to comment on transactions the Complainant had with his own bank in or around 2002. The letter outlined that the Provider's records reflected the Complainant had taken the part surrender from the Policy and the Complainant's daughter was referred back to the documents previously provided to her which it states demonstrated this.

The Provider states that having carried out enquiries, it is not possible for it to receive a statement that dates back to 2002 from its bank but it believes sufficient evidence has been provided of the encashment.

The Provider submits that as set out previously, its records confirm that the cheque was requested by the Complainant, that the part surrender was approved by the Bank and that the cheque and endorsement were both issued directly to the Complainant at the address on its records. The Provider says that it has no record of the cheque being

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returned by the Complainant, no record that the cheque was not cashed and no record that the Complainant contacted it at the time if he was unhappy with the amount received or did not wish to proceed with the part surrender. The Provider says that regretfully it is not in a position to confirm what bank account the Complainant lodged the cheque into.

The Provider states that it should be noted that following the introduction of the Consumer Protection Code 2012, Annual Benefit Statements were issued to the Complainant each year from 2013. The Provider says that the 2013 statement was issued to the Complainant on 27 January 2014 and reflected (as did all subsequent statements) that he had taken a total of €9,315 in part encashment from the Policy. The Provider submits that it has no record of the Complainant making any enquiries from it on receipt of the statement in January 2014 (or any subsequent statement) that he was concerned in relation to the amount of the part encashment reflected on the statements.

The Provider says that the Policy provided the Complainant with valuable protection benefits for almost 30 years. Had a valid claim arisen during that time, the Provider would have paid out the sum assured to the Complainant's estate. The Provider states that during that time the Complainant paid a total of €30,121.14 into the Policy and that records reflect, however, that he took a part surrender of €9,315.00 from the Policy in 2002. The Provider states that the Complainant also received a surrender cheque in the sum of €1,172.05 following his decision to cancel the Policy in 2017.

The life cover benefit under the Policy was €31,854.77 when the Complainant decided to cancel the Policy in 2017. The Provider says it is important to note however that the life cover was €40,806 in 2003 and the Complainant reduced the level of cover to €29,095 following the periodic review which was carried out in August of that year. The Provider says that the life cover was reduced again following the 2008 review to €26,207 as the Complainant did not engage with the Provider following that review.

In relation to the annual indexation of the premium and benefits under the Policy, the Provider says that the Complainant was notified each year of this and it was open to him to reject indexation in a given year, or have it removed from the Policy at any time. The Policy conditions provide that indexation will apply each year unless a policyholder selects otherwise. The Provider states as can be seen from its file of papers, the Complainant suspended indexation in 2013 and removed indexation in 2014. The Provider states that it can be seen from the Annual Benefit Statements issued to the Complainant at those times that the Provider did not apply indexation in those years.

The Provider states that it sincerely regrets that the Complainant's Policy was not surrendered as quickly as it ought to have been but it hopes that the Complainant will find that he received the value of his Policy on 30 June 2017 which was the date he requested the Policy be cancelled with effect from. The Provider submits that in the

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circumstances and taking into account that the Provider's letter of 22 August 2017 was addressed to the Complainant at the address it held on its records, the Provider is willing to pay the Complainant the sum of €1,000 for any inconvenience caused. The Provider states that this offer will remain open to the Complainant until this office has adjudicated on the complaint.

Further submissions from the parties

The Complainant's submission of 23rd November 2018

> *"1-2 In the first 2 date references I think [the Provider] meant 2017 not 2014? I think the point we want to make here is that [the Provider] made it onerous to cancel the policy (requesting a second letter of authority, not responding to emails and requesting signed cancellation / proof of identity and even misaddressing the letter). The arrears letter caused [the Complainant] a lot of distress. One thousand euros is a fair offer but please bear in mind that [the Provider] did not exercise the same obsession with receiving signed paperwork when they let the policy run for almost 10 years with little / no communication. Nor is there evidence of the reviews being anywhere near as comprehensive / administratively thorough or requiring the engagement or agreement of the policy holder.*
>
> *3. [A] cousin, who lives in Ireland, helped [the Complainant] with the identity documents and wrote the note sent with proof of identity (throughout the document [the Complainant] has only signed a few documents - the rest is not his writing). [The Complainant] can confirm the letter was open. The letter made it clear [the Complainant] was cancelling a [Provider's] life policy, which was [the Complainant's] personal business.*
>
> *4. Do [the Provider] have indexation letters pre 2012? The fact that indexation letters were not returned does not prove they were actually sent and received, giving [the Complainant] the option to suspend / remove indexation as his circumstances changed post 2002. For almost 10 years [the Complainant] received little / no communication from [the Provider] and this indicates "reviews" were not adequate (and if occurring at all his involvement was not sought by [the Provider]). In point 8 [the Provider] say that [the Complainant] did not engage following the review. I suspect this means he did not receive the letter and [the Provider] did not follow up - he only seems to have signed the December 2013 one. [The Complainant] ended up quite concerned about the money that he was paying over and that is when [the Complainant's daughter] became involved. However it was not until we sought to wind up the policy that [the Complainant's daughter] fully realised what had gone before. I do not accept that [the Complainant] received adequate communications around reviews and indexations. Indeed most annual statements do not highlight the previous encashment so I do not agree with [the*

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Provider] on this point - I can only see reference to 9,315 part encashment on the excel type 2014 document though this is different to the rest.

5. There is reference to retirement in previous paperwork - see [...] plan policy in section 1, issue date 22.1.1988, which under "event 3" states cover "on or after the commencement date and before age 65 years." This indicates that to continue to take money from [the Complainant] after he was 65 years old (April 2004) should have required new paperwork and explicit consent.

6. What is a failed policy review (2013)? [the Provider] state no indexation was issued this year but apparently this was meant to be a 25 year review date? As [the Complainant] had turned age 65 before this date the original policy should not have continued. Worse still, in 2013 when [the Complainant] was 74, the premium increased by over 50% from 297.58 to 483.06. At the very least this is the portion that [the Complainant] should be refunded.

7. [The Provider] consistently ignore that they (apparently) did a FULL cash surrender rather than a PART cash surrender (in their letter they have now called it a "maximum part surrender" but I cannot find this terminology used anywhere else). They fail to acknowledge that the surrender form is inconsistent with the amount apparently surrendered. They ignore that a policy review should follow a PART (not full) cash surrender yet they apparently did a full and then continued the policy (see "Important Notes" on the bottom of the form). Also, the surrender request form has not even been written by [the Complainant] though the box at the top of the form clearly states the form should be completed by the legal owner of the policy. I have raised previously the fact that the signature is not like [the Complainant's] and you can see this by comparing it to his signature on other documents before and after 2002. Where is the paperwork if he set up a new policy after FULL encashment had occurred? Is this why the direct debit stopped and payments began to be collected in cash after January 2002? [The Bank] have confirmed that this is what happened but again [the Provider] have failed to mention it. [The Bank] have confirmed they have no record of 9,315 being credited to [the Complainant's] account in 2002/03 and can provide statements (for a euro a page). [The Provider] have failed to provide evidence that [the Complainant] received the proceeds of the encashment and, as mentioned in point 4, all the annual statements did NOT state that he had taken 9,315 euros.

… having seen the paperwork and the [the Provider's] response, it is easy to see how and why [the Complainant] became increasingly confused by them and the policy - it is very unclear, sporadic and contradictory. In light of the lack of communication between 2002/3 and 2012/13 I do not see how [the Complainant] could have been expected to query the encashment or any other aspect of the policy. Indeed in the letter of 26 August 2003 it refers to [the Complainant] agreeing to maintain his policy but where is the evidence that this is what [the Complainant] agreed? It has not been supplied. The whole policy appears to have been badly handled from beginning to end".

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The Provider's response of 11th December 2018

"1-3. We trust the information provided in our letter of 13 November adequately addresses these matters. We note [the Complainant] believes our offer of €1,000 to be fair in the circumstances. We confirm that this offer will remain open until your office has adjudicated on the complaint.

4. Records reflect that indexation letters did issue to [the Complainant] each year. For the purposes of the adjudication of the complaint we have provided copy letters issued to [the Complainant] in the six years prior to the surrender of the Policy.

It is the Company's normal practice to issue correspondence to policyholders by ordinary post. We hope it can be seen from our letter of 13 November last that [the Complainant] did receive correspondence from the Company over the years as he engaged with the Company on a number of occasions following receipt of correspondence. While [the Complainant's daughter] has indicated that [the Complainant] only signed and returned the reply card following the 2013 review, we hope it can be seen from our file of papers that [the Complainant] did also sign and return a reply card in December 2002 in order to reduce the benefits under the Policy from 1 January 2003.

5. As set out previously, the Policy was a reviewable protection policy which a customer can keep in place for the whole of their life if they so wish. The Policy did not come to an end when [the Complainant] reached the age of 65. If [the Complainant] had not surrendered the Policy it could have remained in force for the remainder of his lifetime, provided premiums due were paid.

The benefits listed under 'event 3' in the Policy schedule relate to accidental death and total and permanent disability benefits. Those were additional benefits a policyholder could select when taking out a … Policy with the Company. Cover for those benefits ceases when a policyholder reaches the age of 65. We hope it can be seen from the application form completed by [the Complainant] on 5 January 1988 (enclosed in our file of papers) that he did not select those benefits when he took out the Policy. This is confirmed by the Policy schedule which reflects the amount of cover for those benefits to be 'nil'.

6. As set out above, [the Complainant's] Policy did not cease when [the Complainant] reached the age of 65. For internal purposes where the premium being paid at the time of a review is assessed to be no longer sufficient to maintain the same level of cover until the next review date, the review is referred to as a failed review. In that event options are provided to a policyholder (such as those provided to [the Complainant] by letters dated 12 November 2007 and 14 December 2012) to help ensure the Policy can remain in force until the next review date.

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Indexation letters are not issued to policyholders in review years. This is because the information contained in an indexation letter is incorporated into the review letter. By way of example, the review letter issued to [the Complainant] on 14 December 2012 confirmed on page 3 that 'the premium and benefits shown above assume that you accept indexation of 5.00% at 1 January 2013. If you do not wish to accept this please inform us. You should notify us immediately if any of the above details are incorrect'.

In relation to the increase in [the Complainant's] quarterly premium following the 2013 Policy review, we hope it can be seen from our file of papers that an alternative option was provided to [the Complainant] if he did not wish to increase his quarterly premium at that time. [The Complainant] chose, however, to increase the quarterly premium and we note that [the Complainant's daughter] assisted him in that regard.

7. We have set out our position in relation to the part surrender taken by [the Complainant] in 2002 in our letter of 13 November last. We also included in our file of papers a copy of the available information relating to the part surrender. While both IR£5,000 and €9,340 are referenced on the surrender request form, our systems indicate and the cheque that issued to [the Complainant] confirms that an amount of €9,315 (representing €9,340 less a €25 administration fee) was surrendered from the Policy at that time. We hope it can also be seen from the documents furnished that a review was conducted some months after the part surrender took place and [the Complainant] engaged with the Company following that review.

We note [the Complainant's] comments in relation to the signature on the surrender request form. The form contains a section entitled 'who should complete this form' beneath which it is confirmed that 'if the Policy is currently assigned, the form should be completed by the assignee'. As set out previously, [the Complainant's] Policy was assigned to [a named Bank] at the time of the part surrender. The surrender request form was therefore signed by [the named Bank]. While not required to do so, [the Complainant] did also sign the form and we hope it is evident that [the Complainant's] signature on the surrender request form matches the signature on the application form which he completed on 5 January 1988".

The Complainant's submission of 20th December 2018

"I don't think [the Provider] have answered some of my questions, preferring to skirt the issue, for example, as they do when they say both surrender amounts were selected on the form but they omit to then say why they chose the higher. I actually only saw the lower. I also don't believe [the Complainant] had a mortgage in 2002 but as I recall [the Provider] lost some paperwork on him.

When asked about [the Complainant] renewing the policy [the Provider] also hide behind the fact they sent [the Complainant] paperwork over the period but do not

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mention their own initial paperwork referred to retirement and they do not explain the lack of contact 2003 - 2012, instead referring to indexation letters over the last 6 years (which is 2012 and beyond). I am conscious I am dealing with a solicitor so this does have the potential to go round in circles wherever possible to avoid any acceptance of responsibility! They say [the Complainant] engaged with them but for many years [the Complainant] simply kept paying money he was being asked for, which is his way, and they do not say why the direct debit changed to cash collection and again there is no paperwork to explain it. [The Provider] have not answered many questions raised.

I won't go though each point (because we have nothing new to say) but we remain dissatisfied with the responses. However, we will not make any further submissions and are happy for it to progress to the adjudication stage in the hope they will also notice the same".

The Complaints for Adjudication

The first complaint is that in June 2017 the Provider delayed in actioning the Complainant's request to terminate his policy.

The second complaint is that the Provider failed to properly administer the Complainant's policy insofar as it incorrectly addressed communications to the Complainant and insofar as indexation notifications/important policy communications went missing.

The third complaint is that following the sale of the policy to the Complainant in 1988, the Provider failed to offer the Complainant any opportunity thereafter, over a period of almost 30 years, to review the ongoing suitability of the product for his changing needs.

The fourth complaint is that the Provider furnished insufficient information to the Complainant in response to queries raised as to transactions relating to the policy, in particular, queries raised regarding the encashment process effected in 2002.

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

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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 1st April 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.

A submission dated **15th April 2019** from the Complainant was received by the Financial Services and Pensions Ombudsman after the issue of the Preliminary Decision to the parties. The Complainant's post Preliminary Decision submission sought to highlight that the premiums set out in the submissions were being paid every three months. The Complainant considered that it was necessary to highlight same for consideration when setting the compensation. This submission was exchanged between the parties and an opportunity was made available for any additional observations arising from the said additional submission. There was no further submission from the Provider. The content of the Complainant's submission however has not persuaded me to alter my previous preliminary determination. The premium payments that went towards the life cover that the Complainant had available to him for some time were noted in the investigation and adjudication of the complaint. The final determination of this office is set out below.

Analysis

The first complaint is that in June 2017 the Provider delayed in actioning the Complainant's request to terminate his policy.

The Provider says that the Complainant's daughter contacted a Financial Advisor and tied agent of the Provider by email on 4 May 2017 to raise enquiries in relation to the Policy. The Provider says that the Financial Advisor acknowledged receipt of the email on 8 May 2017. The Financial Advisor confirmed to the Complainant's daughter by a further email on 20 May 2017 that he was still waiting on one final piece of information before he could respond to the enquiries made. He then provided his response on 31 May 2017.

The Complainant's daughter subsequently emailed the Financial Advisor on 3 June 2017 to confirm that the Complainant wished to let the Policy lapse with effect from 30 June 2017. The Complainant's daughter later followed up with the Financial Advisor on 12 June 2017 as she had not received a response. In her follow up email, the Complainant's daughter requested that a formal complaint be logged in relation to the suitability of the Policy for the Complainant. The Financial Advisor forwarded the email to the Provider that day and the Provider's Complaint Management Team acknowledged receipt of the complaint on 14 June 2017. On the same day, Ms B (who works on the Complaint Management Team) emailed the Complainant's daughter to advise that unless the Complainant provided a letter of authority, it would not be possible to liaise directly with her in respect of the

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complaint. Further emails were exchanged between the Complainant's daughter and Ms B in this regard and a signed letter of authority was received from the Complainant on 27 June 2017.

The Provider states that Ms B issued formal response to the matters raised by the Complainant's daughter on 7 July 2017. The Provider states that unfortunately, while the matters raised by The Complainant's daughter in her email of 12 June 2017 were addressed in Ms B's letter, it appears the earlier email of 3 June 2017 to the Financial Advisor had been overlooked. As such, the Policy was not cancelled on 30 June 2017 as the Complainant's daughter had requested.

The Provider submits that following receipt of Ms B's letter of 7 July 2017, the Complainant's daughter raised additional enquires on 11 July 2017. She also requested a confirmation that the Policy had been cancelled. Ms B responded that day to confirm she was investigating the matters raised and a formal response was later issued to the Complainant's daughter on 8 August 2017. The Provider says that Ms B confirmed that a written instruction was required from the Complainant before the Policy could be cancelled. The Complainant's signed cancellation instruction was subsequently received by the Provider on 15 August 2017 and on 22 August 2017 the Provider issued a letter to the Complainant to confirm the proof of identity documents required to process the cancellation. The Provider states that regretfully, the letter contained a typographical error and was addressed to the Complainant at '4 C…' rather than '4 C.. View'. The Provider states that this caused a slight delay in the Complainant receiving the letter and the proof of identity documents were not received back until 5 September 2015.
The Provider's positon is that by the time the proof of identity documents were received, the complaint had been filed in the Financial Services and Pensions Ombudsman (FSPO). The Provider states that a hold was then placed on the cancellation of the Policy to facilitate discussions with the FSPO's Dispute Resolution Team.

The Policy was later cancelled on 28 November 2017 but with an effective date of 30 June 2017, the date on which the Complainant's daughter had originally confirmed the Policy was to be cancelled from. The Provider issued a cheque in the sum of €1,172.05 (representing the value of the Policy on 30 June 2017) to the Complainant by letter dated 28 November 2017. The Provider says that as the Complainant had not paid any premiums after 30 June 2017, no premium refund was due.

The Provider states that it notes the Complainant's daughter has made reference to a letter dated 21 August 2017 in her complaint. The Provider says that this was an arrears letter which was automatically generated as at that time the Policy had not been cancelled.

The Provider states that it sincerely regrets that the Complainant's Policy was not surrendered in a timely manner. The Provider says that in the circumstances and taking into account that the Provider's letter of 22 August 2017 was addressed to the Complainant at '4 C..' rather than '4 C…View', the Provider offered the Complainant €1,000 for any inconvenience caused. The Provider states that this offer will remain open to the Complainant until this office has adjudicated on the complaint.

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From the above I accept that the Provider could have communicated in a more clear and earlier manner with the Complainant and his daughter, than it did. In particular I consider that from 3rd June 2017 when the Complainant's daughter communicated to the Provider by e-mail that it was decided by the Complainant to let the policy lapse on 30 June 2017 that (i) the Provider could have set out clearly what was required for the Complainant's daughter to act on the Complainant's behalf (ii) that the Complainant would have to provide a written request to surrender the policy (iii) that certain proofs were required for to surrender of the policy and (iv) the Provider could have correctly addressed the letter to the Complainant.

The Provider offered the Complainant €1,000 for any inconvenience caused and I am satisfied that this payment adequately addresses the Provider's failings in the above regard.

The second complaint is that the Provider failed to properly administer the Complainant's policy insofar as it incorrectly addressed communications to the Complainant and insofar as indexation notifications/important policy communications went missing.

The Provider notes that despite the typographical error the Complainant received the letter as the proof of identity documents that were requested in the letter were subsequently provided by the Complainant. The Complainant's daughter has indicated that the letter was open when the Complainant received it. The Provider states that the note which The Complainant submitted with his proof of identity documents made no reference to this. The Complainant confirmed as follows:

> *'please find attached documents as requested and also a copy of the original letter from your Company to me. Please note the address section referred to on your letter as the address was incomplete and caused a delay in correspondence reaching me. Thank you'.*

The Provider submits that the letter contained the Complainant's name and policy number and that no additional information of a sensitive nature was included in the letter.

The Provider states that its Records reflect that indexation letters were issued to The Complainant each year. The Provider says that its file of papers contain a copy of the indexation letters issued to the Complainant in the six years prior to the cancellation of the Policy. The Provider states that no indexation issued for 2013, as that was a review year. The Provider says that as can be seen, the indexation letters were issued to the Complainant at his correct address. The Provider states that it has no record of any of these letters being returned. The Provider says that taking the 2013 and 2014 letters as examples, it can be seen that the Complainant received those letters as he subsequently engaged with the Provider to first suspend and later remove indexation from the Policy.

The evidence does not support any wrongdoing on the Provider's behalf in the sending of communications by post, other than the incorrect addressing of a correspondence

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mentioned in the first complaint above. The question of whether there was correct administration in relation to the Indexation of the policy will be further addressed under the third complaint set out below.

The third complaint is that following the sale of the policy to the Complainant in 1988, the Provider failed to offer the Complainant any opportunity thereafter, over a period of almost 30 years, to review the ongoing suitability of the product for his changing needs.

The evidence shows that the Policy was taken out in 1988. The Policy Provisions set out what is expected in regard to Policy Reviews and Indexation, as follows:

> *"Indexation*
> *Provided premiums due have been paid or deemed paid, the Total Regular Premium shall be increased on each Policy Anniversary having regard to the increase, if any, in the Consumer Price Index .. unless the Company shall receive written Notice within one month from the date of increase that indexation has been declined. ..*
>
> *Failure to pay any Total Regular Premium increased in accordance with this Condition within one month of the date of increase shall be deemed to be notification that indexation is declined. If indexation is declined or deemed to be declined on more than two successive occasions, the right to future indexation shall lapse but may be reinstated subject to Proof of good health of the Life / Lives Assured".*
>
> *"10. Policy Review*
> *"Policy Review Date" means the tenth Policy Anniversary, each succeeding fifth Policy Anniversary up to the attainment of age 70 years by any Life Assured, each Policy Anniversary thereafter, the date of each Part Encashment, the date of suspension or increase/decrease of Total Regular Premium and the date of exercise of the options provided by Conditions 5.1, 23 and 24"*

As the Policy was taken out in 1988, the First Policy Review should have happened on 1998. In a correspondence from the Provider (dated 7th July 2017) it says that the 1998 review was carried out and that the premium the Complainant was paying was sufficient to maintain the level of benefits.

However, the Provider has not submitted any evidence of the First Review being carried out in 1998, or the correspondence that was issued to the Complainant at that time.

The next policy review was to happen in 2003. As regards the second Policy Review of 2003 the Provider advised that: *"The results of the review indicate that if you wish to maintain your present level of life cover you must increase your premium. The options open to you at this stage are listed on the next page".*

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The Complainant communicated to the Provider that he wanted to: *"Reduce the benefits from 1 January 2003".*

On 30th January 2003, the Provider sent the Complainant confirmation and policy endorsement of reduced benefits.

On 12th November 2007, the Provider communicated a 5 year Review indicating as follows:

> *"The results of the review indicate that if you wish to maintain your present level of life cover you must increase your premium. The options open to you at this stage are listed on the next page".*

The Provider sent the Complainant a reply card for selection of what review option he wished to select.

On 19th June 2008, the Provider advised the Complainant that: *"I refer to the recent Policy Review and note that we have not received your reply card".*

The Provider informed that it reduced the benefits with effect from 1 January 2008. (This was a default option set out in the Provider's Review communications, that is, if no option is chosen that option B would apply).

The Complainant turned age 70 years in 2009 and in accordance with the Policy Provisions, a yearly review was to take place thereafter. However, there is no evidence of these annual reviews being carried out from 2009 or in the subsequent years. The Provider does not address this matter in its submissions.

In the absence of any evidence of these annual review I consider that there was a failing by the Provider in the administration of the policy in relation to these scheduled yearly reviews.

The Review of the policy should provide an early opportunity for the Provider to realistically assess how the policyholder's needs are being met. Furthermore, it should give the policyholder an up to date picture of the level of cover chosen and provide an indication as to how long the policy fund is likely to sustain that cover. This is particularly important as it allows the Provider discuss with the policyholder what, if any, action needs to be taken.

I accept that the Provider's failure in relation to the carrying out of a yearly review meant that the Complainant was not fully advised on a yearly basis of how his policy could be managed differently based an up-to-date review. The Complainant was also denied the choice as to whether to continue with the policy based on any review information or withdrawn at that stage and take the benefit of a higher surrender value. I consider that had the yearly reviews happened, the information supplied then may have also altered

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how the Complainant would have viewed the indexation position on his policy, at an earlier time.

I accept that the Provider was not obliged to continually assess suitability of the policy to the extent that it did at the outset, that is to see if the policy met the Complainant's needs. However, I do consider that the reviews of the policy as required in the Terms and Conditions would have enabled the Complainant to focus on cost of cover, ability to pay the premium and the necessity for the chosen level of cover. Therefore, I accept that these scheduled annual reviews should have taken place and in regard to this element of the complaint I partially uphold the complaint and consider that a compensatory payment is merited.

The fourth complaint is that the Provider furnished insufficient information to the Complainant in response to queries raised as to transactions relating to the policy, in particular, queries raised regarding the encashment process effected in 2002.

I accept that the Provider furnished sufficient information in response to the queries on the 2002 encashment and I do not intend to uphold this aspect of the complaint. The Provider's systems indicate and the cheque that issued to the Complainant shows it was for an amount of €9,315 (representing €9,340 less a €25 administration fee). The documents furnished show that a review was conducted some months after the part surrender took place and the Complainant engaged with the Provider following that review.

The Encashment form contains a section entitled 'who should complete this form' beneath which it is confirmed that 'if the Policy is currently assigned, the form should be completed by the assignee'. The Complainant's Policy was assigned to a named Bank at the time of the part surrender. The encashment request form was therefore signed by the named Bank. The Provider's positon is that while not required to do so, the Complainant did also sign the form. The Provider also communicated over the intervening years on its annual statements that the encashment was made.

To conclude, it is my Legally Binding Decision that in relation to complaint matters 1 & 3 the complaint is substantially upheld and I consider that a compensatory payment is merited in respect of same. Therefore, I direct that the Provider pay the Complainant the compensatory payment of €4,000 in respect of the 3rd aspect of the complaint.

I accept that the €1,000 already offered by the Provider in respect of the 1st aspect of the complaint is a fair compensatory amount and the Provider has stated that this offer would remain open to the Complainant until this office had adjudicated on the complaint. The total compensatory amount payable to the Complainant is therefore €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 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 make a compensatory payment to the Complainant in the sum of €5,000, 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.

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GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

25th April 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

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.