An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0106
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Value of policy at surrender less than expected or projected
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is the Estate of the deceased, who sadly passed away early in 2016. The deceased was the policyholder and life assured of four life assurance policies with the Provider.

The Complainant's Case

The Complainant sets out the complaint, as follows:

> *"*[The policyholder] *passed away on [date] 2016. I have written to* [the Provider] *regarding numerous policies regarding* [the deceased]*. I am disputing 2 specific policies – *****335 & *****583. From looking at the documents (dated March 2009) it would appear that the sums assured were €1,278.03 (*****583) & €1,941.17 (*****335). When I received payment I only received €822.80 & €582.30 respectfully. I wish to refer specifically to letters dated March 2009 from* [the Provider] *which state "*[the area manager] *has assured me that collection has now taken place and the policies have now readmitted to full benefit". I therefore ask the Financial Ombudsman to investigate this matter as I have only received a total cheque payment for €1,570.08 for all policies i.e. *****262 (€86.92), *****246 (€78.06), *****335 (€582.30) & *****583 (€822.80)".*

In this regard, the Complainant refers to correspondence the policyholder had received from the Provider dated 19 February 2009 which advised that the sum assured in respect of policy *****335 was €1,941.17 and correspondence dated 6 March 2009 which advised that the sum assured in respect of policy *****583 was €1,278.03.

However, following the policyholder's death in 2016, the Provider only paid out the amounts of €582.30 in respect of policy *****335 and €822.80 in respect of policy *****583.

As a result, the Complainant is seeking *"an additional payment I believe I am due from policies *****335 & *****583…I believe I am due at least €1,941.17 & €1,278.03 for each policy and not the €582.30 & €822.80 I only received"*.

The Provider's Case

Provider records indicate that the Provider was notified by telephone in January 2016 that the policyholder had died four days earlier. It received the completed bereavement forms, will and death certificate on 14 February 2016. The policyholder had held four life assurance policies with the Provider, namely policy numbers *****262, *****246, *****7335 and *****583. The Provider processed the four death claims and paid the Complainant by way of cheque dated 16 February 2016 the total claim settlement amount of €1,570.08, as follows:

Policy	*****262**	*****246**	*****335**	*****583**
Sum Assured	€68.57	€61.33	€525.67	€742.80
Scheme 1 Bonus	€9.90	€9.14	€0.00	€0.00
Discretionary Bonus	€8.24	€7.40	€55.20	€77.99
Interest	€0.21	€0.19	€1.43	€2.01
TOTAL CLAIM	**€86.92**	**€78.06**	**€582.30**	**€822.20**

In this regard, policy *****262 was a whole of life non-profit policy that the policyholder had incepted on 16 May 1952 that guaranteed life cover in the event of her death in the amount of €68.57 in return for a four weekly premium of €0.13. In addition, policy *****246 was a whole of life non-profit policy that the policyholder had incepted on 29 April 1955 that guaranteed life cover in the event of her death in the amount of €61.33 in return for a four weekly premium of €0.13. The policyholder was required to pay the premiums for these two policies until she reached age 70. She reached the age of 70 in 1997. After this time, the policies became 'Fully Free Paid', meaning that she did not need to pay any further premiums and the policies would remain active until a claim was made.

Policy *****335 was a whole of life non-profit policy that the policyholder had incepted on 19 October 1979 that guaranteed life cover in the event of her death in the amount of €525.67 in return for a four weekly premium of €2.54.

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The policyholder was required to pay the premiums for a period of 30 years, after which time the policy became 'Fully Free Paid', meaning that she did not need to pay any further premiums and the policy would remain active until a claim was made. This policy became fully free paid in October 2009.

Policy *****583 was a whole of life non-profit policy that the policyholder had incepted on 4 May 1990 that guaranteed life cover in the event of her death in the amount of €742.80 in return for a four weekly premium of €6.35. The policyholder was required to pay the premiums until she reached age 85. This occurred in 2011. After this the policy became 'Fully Free Paid', meaning that she did not need to pay any further premiums and the policy would remain active until a claim was made.

These four policies were whole of life non-profit policies. The Provider guaranteed to pay the sums assured when a claim was made, but these sums assured were set at the commencement of each policy. The Provider calculated each of the sums assured in line with industry standards, taking into account factors like the age, gender and health of the policyholder. The Provider notes that whilst the cost of living has risen dramatically since the policyholder incepted her policies, the sums assured have not altered with inflation and have remained the same. In this regard, the Provider notes that a life assurance policy is a legal contract and it provided the policyholder with the policy schedules when each policy commenced. These documents confirmed that the policies were whole of life policies and that the Provider only guaranteed to pay the sums assured when the life assured died. The Provider states that it is satisfied that it has honoured these guarantees by way of cheque dated 16 February 2016 in the amount of €1,570.08.

The Provider notes that the Complainant's complaint relates specifically to policy numbers *****335 and *****583. Provider records indicate that the policyholder did not pay the premiums due for these two policies for a period in 2007 which resulted in the policies being lapsed with a value on 9 January 2008. Following contact with the policyholder, these policies were readmitted on 22 January 2008 but were then lapsed with value again in February 2009. The policyholder complained to the Provider in March 2009 and the two policies were subsequently readmitted to full benefit, that is, the original sum assured on each.

The correspondence that the Complainant refers to, that is, the correspondence dated 19 February 2009 advising that the sum assured in respect of policy *****335 was €1,941.17 and the correspondence dated 6 March 2009 advising that the sum assured in respect of policy *****583 was €1,278.03, refers to the secured sum assured offered on a lapsed basis which took into consideration discretionary bonuses that had been applied by the Provider at that point. Following the resolution of a complaint from the policyholder in March 2009, these two policies were reinstated to their original basis and reverted to the secured sum assured at the outset, so they were no longer in a *lapsed with value position*. The Provider notes that this was done at the request of the policyholder in making her complaint at that time.

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Policy numbers *****7335 and *****583 were whole of life non-profit policies and the only element guaranteed to be paid at the claim stage was the sum assured, which was fixed from the outset. Previously however, the Provider had been able to add discretionary bonus payments to its non-profit policies when the economic conditions were favourable. These discretionary bonus payments are never guaranteed, and can be taken away.

Discretionary bonus payments had been applied to policy numbers *****335 and *****583 when they had lapsed with value in February 2009, hence the correspondence dated 19 February 2009 advising that the sum assured in respect of policy *****335 was €1,941.17 and the correspondence dated 6 March 2009 advising that the sum assured in respect of policy *****583 was €1,278.03. Economic conditions became such that the Provider later made a business decision to remove discretionary bonus payments to its non-profit policies in 2011 and it wrote to all policyholders to advise that it was withdrawing paying these discretionary bonuses. In certain circumstances, the Provider is now paying a discretionary bonus when it receives a claim, however it is applying much lower bonuses than the Provider could offer before 2011.

In conclusion, the Provider states that it is satisfied that the claim amounts it paid to the Complainant on 16 February 2016 – that is, €86.92 for policy *****262, €78.06 for policy *****246, €582.30 for policy *****335 and €822.20 for policy *****583 - were correct and calculated in accordance with the terms and conditions of each of the policyholder's policies.

Decision

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

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

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

A Preliminary Decision was issued to the parties 28 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

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period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

The complaint relates to the communication and amount paid in respect of two of the four life assurance policies that the deceased policyholder held with the Provider.

The Complainant relies on correspondence the policyholder received from the Provider setting out the value of the policies in 2009 in support of her complaint.

The Complainant is seeking *"an additional payment I believe I am due from policies *****335 & *****583…I believe I am due at least €1,941.17 & €1,278.03 for each policy and not the €582.30 & €822.80 I only received"*.

I note that policy *****335 was a whole of life non-profit policy that the policyholder had incepted on 19 October 1979 that guaranteed life cover in the event of her death in the amount of €525.67 in return for a four weekly premium of €2.54. The policyholder was required to pay the premiums for a period of 30 years, after which time the policy became 'Fully Free Paid', meaning that she did not need to pay any further premiums and the policy would remain active until a claim was made. This policy became fully free paid in October 2009.

Policy *****583 was also a whole of life non-profit policy that the policyholder had incepted on 4 May 1990 that guaranteed life cover in the event of her death in the amount of €742.80 in return for a four weekly premium of €6.35. The policyholder was required to pay the premiums until she reached age 85, that is, 12 December 2011, after which time the policy became 'Fully Free Paid', meaning that she did not need to pay any further premiums and the policy would remain active until a claim was made.

I note from the documentary evidence before me that as it had not received/collected premium payments from the Complainant in respect of policy *****335 at that time, the Provider wrote to the Complainant on 19 February 2009, as follows:

> *"We write to inform you that the policy below has lapsed and therefore it is now possible that you may be inadequately insured. Subject to the* [Provider's] *rules, reinstatement of the policy will be considered, providing all outstanding arrears are paid within thirteen months of the clear date, stated below.*
>
> ***Policy Number*** ********335***
>
> ***Life/Lives Assured*** [the policyholder] ***Proposer*** [the policyholder]

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Table	***Date of Entry***	***Age***	***Premium***	***Reduced Sum Assured***	***Assignment or Nomination number***	***Clear Date***
74	*19/10/1979*	*52*	*€2.54*	*€1,941.17*		*09/10/2008*

This notification is to confirm that the above policy (which has become lapsed due to the non-payment of premiums) has been converted into a Reduced Amount Free Policy. This is in accordance with the rules contained in the Schedule of the policy. This notification should be placed with the policy document concerned as both documents will be required by the [Provider] *when a claim arises.*

The Reduced Sum Assured (which is paid on the death of the life assured or at maturity) is subject to reduction in accordance with any special conditions contained within the Schedule".

Similarly, as it had not received premium payments from the Complainant in respect of policy *****583 at that time, the Provider wrote to the Complainant on 6 March 2009, as follows:

"We write to inform you that the policy below has lapsed and therefore it is now possible that you may be inadequately insured. Subject to the [Provider's] *rules, reinstatement of the policy will be considered, providing all outstanding arrears are paid within thirteen months of the clear date, stated below.*

Policy Number ******583*

Life/Lives Assured [the policyholder] ***Proposer*** [the policyholder]

Table	***Date of Entry***	***Age***	***Premium***	***Reduced Sum Assured***	***Assignment or Nomination number***	***Clear Date***
74	*04/05/1990*	*63*	*€6.35*	*€1,278.03*		*16/10/2008*

This notification is to confirm that the above policy (which has become lapsed due to the non-payment of premiums) has been converted into a Reduced Amount Free Policy. This is in accordance with the rules contained in the Schedule of the policy. This notification should be placed with the policy document concerned as both documents will be required by the [Provider] *when a claim arises.*

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> *The Reduced Sum Assured (which is paid on the death of the life assured or at maturity) is subject to reduction in accordance with any special conditions contained within the Schedule"*.

I note from the documentary evidence before me that the Complainant then made a complaint to the Provider seeking to have these two policies reinstated. In this regard, I note that in its correspondence to the Complainant dated 4 March 2009 the Provider states, as follows:

> *"**Complaint in relation to Policy Numbers: *****335 : *****583***
>
> *I am writing in connection with your complaint against* [the Provider] *concerning the above policy …*
>
> *I understand your concern to be that you had contacted us on three occasions to request collection, but this did not happen.*
>
> *Consequently, you were issued with an arrears notice and the policies eventually lapsed.*
>
> *I can confirm that I contacted…the area manager, on your behalf and asked him to ensure collection took place without delay.*
>
> [The area manager] *assures me that collection has now taken place and the policies have now been readmitted to full benefit"*.

As a result, policy numbers *****335 and *****583 were readmitted to full benefit.

I note that policy *****335 guaranteed life cover in the event of the policyholder's death in the amount of €525.67 whilst policy *****583 guaranteed life cover in the event of her death in the amount of €742.80. Both of these sums were fixed from the outset of each policy and neither policy guaranteed any further or additional payment in the event of a claim. The Complainant correctly notes that in its correspondence dated 19 February 2009 the Provider advised that the reduced sum assured for policy *****335 was €1,941.17 and in its correspondence dated 6 March 2009 that the reduced sum assured for policy *****583 was €1,278.03. I note that these amounts took into consideration discretionary bonuses that had been applied by the Provider at that time.

In this regard, I note that the Provider had been able to add discretionary bonus payments to its non-profit policies when economic conditions were favourable. These discretionary bonus payments are not guaranteed, and could be taken away at some future date. Economic conditions became such that the Provider later made a business decision to remove discretionary bonus payments to its non-profit policies in 2011.

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The Provider states that it wrote to all policyholders at that time to advise that it was withdrawing paying these discretionary bonuses. A template of the letter that the Provider states it sent was included in evidence and states as follows:

> ***"This letter contains important information about the way your policies are managed.***
>
> ***Whilst no action is required, you should read the contents of this letter carefully and retain it along with your policy documentation for future reference.***
>
> *I am writing in connection with your* [Provider] *policy/ies, which you may recall were those whose premiums were originally paid regularly to your* [Provider] *agent. Generally, if your policy/ies were started prior to January 1994 the policy/ies are classed as 'non-profit'. This means that the amount payable on death or maturity is the sum assured stated on the policy document, and there is no entitlement for the policies to receive bonuses.*
>
> *As has been the case in the past for policies similar to yours, a discretionary bonus may be payable in addition to the guaranteed benefit.*
>
> *The purpose of this letter is to explain in what circumstances a discretionary bonus would be added to the guaranteed benefit on a death or maturity claim under your policy/ies.*
>
> *Under the rules set by our regulators, each year the* [Provider] *must consider whether its fund holds more assets than are required for the careful management of its business. If there are excess assets then these may be earmarked by the* [Company] *to be added as future bonuses on eligible policies (although if the financial position of the* [Provider] *subsequently deteriorates, such amounts previously earmarked may be removed). Your policy (or each of your policies as described above) will be eligible for a discretionary bonus if at its maturity date or at the time of a death claim there are excess assets earmarked to it. This is the only circumstance where a discretionary bonus would be added to your policy/ies.*
>
> *The decision to pay such a bonus and the amount of any such bonus, is made by the* [Provider] *based upon its financial circumstances from time to time. We intend to indicate when excess assets are earmarked to eligible policies in our annual report on compliance with our Principle and Practices of Financial Management which we publish on our web site.*
>
> *The* [Provider] *has determined that, at the current time, it does not have assets in excess of those required for the careful management of its business, so no discretionary bonuses are currently being added when maturity or death claims arise for policies such as yours.*

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We believe that this is likely to continue to be the case for, at least, the next few years".

The discretionary bonuses that the Provider had applied to policy *****335 on 19 February 2009 and policy *****583 on 6 March 2009 when it had lapsed with value both policies were subsequently removed by the Provider in 2011.

The policyholder was only ever guaranteed life cover in the amount of €525.67 in respect of policy *****335 and €742.80 in respect of policy *****583 and that additional payments, if any, were at the discretion of the Provider.

I would point out that I have been provided only with a template of the above letter, not a copy of the particular letter which the Provider asserts it sent to the policyholder.

Even if I assume that the policyholder received this correspondence, I am concerned about its presentation and the level of detail it contains compared to the letters the policyholder received when the policy in question lapsed in 2009.

The letters the Complainant received in 2009 identified the reduced sums assured as €1,941.17 and €1,278.03 in tabular format as set out above.

I acknowledge that these communications stated that "*the reduced sum assured (which is paid on the death of the life assured or at maturity) is subject to reduction in accordance with any special conditions contained within the schedule".*

I note that the template letter (quoted above) that the Provider asserts it sent in 2011 states "*the purpose of this letter is to explain in what circumstances a discretionary bonus would be added to the guaranteed benefit on a death or maturity claim under your policy/ies".* It goes on to state "*… no discretionary bonuses are currently being added when maturity or death claims arise for policies such as yours".*

I believe the communications which the policyholder received were confusing. Firstly, she was informed of a very definitive "*reduced sum assured*". This communication did not identify that the sum assured included a discretionary bonus that could later be removed.

I acknowledge it did say that it was "*subject to reduction in accordance with any special conditions contained within the schedule*".

Further, the template letter used in 2011 states that no discretionary bonuses are currently being added. Given that the policyholder had already been notified of a bonus that had been added, I believe it would have been reasonable to expect the Provider to inform her that these would no longer be available on the death of the life assured or on maturity as had been notified to her in 2009.

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The Complainant was expecting a larger payment because the value of the policies that was indicated in communication sent by the Provider to the policyholder in 2009 was significantly more than the amount paid by the Provider following the claim.

In its defence the Provider stated that the values quoted in its 2009 communication include discretionary bonuses that would be added in the event of a claim and that it had informed the policyholder in 2011 that a decision had been made the effect of which was that discretionary bonuses would not be added to future claims.

However, the communication that was sent by the Provider in 2009 to the policyholder indicated a Reduced Sum Assured that is the aggregate of a guaranteed amount and a discretionary bonus. The communication from the Provider is poor because it doesn't give details about how much of the Reduced Sum Assured is guaranteed and how much of it is the discretionary bonus. It would also have been good practice for the communication to indicate that the portion of the Sum Assured that is a discretionary bonus is not guaranteed and may not be available when the policy benefit is claimed in the future.

The policies that are the subject of the 2009 communication from the Provider had lapsed because the policyholder had ceased paying premiums. The Reduced Sum Assured takes into account that premiums are no longer being paid so the guaranteed amount of the Reduced Sum Assured on the 2009 communication is less than the guaranteed amount of the original policy.

Unfortunately the communication does not specify how much of the Reduced Sum Assured is guaranteed and how much is a discretionary bonus. When the policyholder reinstated the policies following receipt of the Provider's 2009 communication, the guaranteed amount reverted to the guarantee reflected on the original policy documents.

The communication that was issued by the Provider in 2011 is generic in nature and while it states that discretionary bonuses are not being added to policies on maturity it would have been much more helpful if the communication had been specific to the policyholder and had indicated the value of each policy after the decision to discontinue discretionary bonuses had been made.

The decision by the Provider to discontinue discretionary bonuses may be understandable given the economic conditions that prevailed at the time. However, the poor communication from the Provider in 2009 and the generic nature of the 2011 communication left the Complainant (and possibly the policyholder) with an expectation that the value of the policies on maturity would be higher than it actually was.

I believe that the manner in which the Provider communicated with the Complainant led to a situation where the policyholder and the executors of her estate had an expectation that the sum assured as identified in the communication of 2009 would be paid on the death of the policyholder. For this reason and to do justice between the parties, I partly uphold this complaint and direct the Provider to pay a sum of €1,000 in respect of the poor

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communication that I believe has greatly contributed to the confusion surrounding the amount of money due under the two policies and the inconvenience caused.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2) (b), (c) and (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 €1,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider.

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

25 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,

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(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.