Decision Ref:	2019-0116
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Value of policy at surrender less than expected or projected
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a unit-linked Whole of Life policy taken out in **1996**.

The complaint is that the Provider wrongly reduced the policy's critical illness benefit from €78,533 in 2011 to €48,292 in 2017, and that it wrongly increased the policy premiums from €99.09 in 2016 to €104+ in 2017 and did not notify the Complainant about the increase in advance.

The Complainant wants the Provider to pay him the difference between the policy's critical illness benefits in 2011 and 2017 (the difference between €78,533 and €48,292, namely €30,241).

The Complainant's Case

The Complainant submits that he made a claim for critical illness benefit on his Whole of Life policy in 2017 and found that the benefit fell *"far short of [the] amount [he] was given to understand would be paid"*. The Complainant further submits that the 2011 benefit on the policy was €78,533 but that he was offered only €48,292 when he made his claim in 2017. The Complainant states that he wishes *"to seek payment of [the] difference, especially in*

view of [the] fact [that] the premium was risen to €104+ and has only recently been noticed by [the Complainant] on [his] bank statement – no notification was received by [him]".

The Provider's Case

In its Final Response Letter, the Provider submitted that *"[The Complainant] informed us that [he] wished to decrease [his] benefits and maintain [his current] premium. [The Provider] wrote out to [the Complainant] on **13 April 2016** confirming [it] had done this, and informing [the Complainant] of [his] new level of benefits"*.

In a further submission, the Provider stated that*: "[the Provider] wrote to [the Complainant] on **8 March 2017** to confirm that his premium and benefit levels were going to increase by 5% from **1 April 2017**. The letter confirmed that the premium would increase to €104.05 per month (inc 1% Government levy) and that the critical illness benefit would increase to €48,492.65. The letter invited [the Complainant] to contact [the Provider] if he did not wish to proceed with the increases"*.

The Complaint for Adjudication

The complaint is that the Provider wrongly reduced the policy's critical illness benefit from €78,533 in 2011 to €48,292 in 2017, and that it increased the policy premiums without notifying the Complainant about the increase in advance. The issue for investigation and adjudication is whether the Provider correctly calculated the benefit due to the Complainant under the policy when he made a claim for critical illness benefit in 2017, and whether it notified him in advance about policy premium increases.

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

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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 19 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.

Evidence

Policy Document

Condition 10 of the policy document, entitled **'Policy Review'** states that the policy is subject to reviews, and that the *"current levels of Benefit under the policy"* will be examined at each review. The Provider notes the policy provides that if it considers that:

> *"…… the Benefits cannot be maintained at the levels applicable immediately prior to the Policy Review Date until the next Policy Review Date, the [Provider] will notify the Policyholder of:*
>
> *a) the new levels of Benefit which will apply from the Policy Review Date until the next Policy Review Date; and*
>
> b) *the increased level of Premiums necessary to restore the former level of Benefits and to maintain them at this level until the next Policy review Date"*.

Condition 9 of the policy document is entitled **'Indexation'**. It states that:

> *"…..the Premium shall be increased on each Policy Anniversary by the greatest of:*
>
> *a) 5% of the amount thereof on the preceding day and;*
>
> *b) The percentage increase, if any, in the Consumer Price Index for the twelve months last published before the relevant Policy Anniversary or other such index or scale or such other twelve month period as [the Provider shall decide] and;*
>
> *c) The minimum increase from time to time acceptable to [the Provider] unless [the Provider] shall receive written Notice within one month from the date of increase that indexation has been declined"*.

Condition 9 notes that the policy benefit will increase in the same proportion as the increase in the premium.

Policy Review Letter issued to the Complainant dated 21 February 2006

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"The results of the review indicate that if you wish to maintain your present level of benefits you must increase your premium….. The premium and benefits shown above assume that you accept indexation of 5.00% at 1 April 2006. If you do not wish to accept this please inform us".

Letter issued to the Complainant dated 29 May 2006

"I refer to the recent Policy Review and note that we have not received your reply card….. It is hereby declared that following the Policy Review: the Additional Critical Illness is reduced to €61,533".

Policy Review Letter issued to the Complainant dated 14 February 2011

"The results of the review indicate that if you wish to maintain your present level of benefits you must increase your premium…. The premium and benefits shown above assume that you accept indexation of 5.00% at 1 April 2011. If you do not wish to accept this please inform us".

Reply Card included with the above letter

"Please revise this policy in line with the results of the policy review as follows (tick box):"

(A) Increase your premium to €140.65 per month with effect from 1 April 2011. This will allow your benefits to continue at their current level for a further 5 years. □

Or

(B) Leave your premium at €81.52 per month and reduce your benefits from 1 April 2011 to: □

	Complainant €
Additional Critical Illness Benefit	49,146

The Provider's letter to the Complainant dated 14 February 2011 included a reply card, as illustrated above, which gave the Complainant two options going forward:

- Option (A) would allow the Complainant to maintain his current level of benefits for a further five years in return for an increased monthly premium
- Option (B) would allow the Complainant to maintain his current monthly premium in return for a reduction in his benefits

I note that the reply card forwarded to the Provider from the Complainant indicated his choice to maintain the policy premiums at €81.52 per month and to reduce his benefits to €49,146.

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Policy Review Letter issued to the Complainant dated 29 February 2016

"The results indicate that if you wish to maintain your present level of benefits you must increase your premium…. The premium and benefits shown above assume that you accept indexation of 5.00% at 1 April 2016. If you do not wish to accept this please inform us".

Reply Card included with the above letter

"Please revise this policy in line with the results of the policy review as follows (tick box):"

(A) Increase your premium to €134.75 per month with effect from 1 April 2016. This will allow your benefits to continue at their current level for a further 5 years. ☐

Or

(B) Leave your premium at €99.09 per month and reduce your benefits from 1 April 2016 to: ☐

	Complainant €
Additional Critical Illness Benefit	45,993

Or

(C) Change the level of benefits to those below and increase your premium to €114.99 per month with effect from 1 April 2016. This will allow this reduced level of benefits to continue for a further 5 years: ☐

	Complainant €
Additional Critical Illness Benefit	52,865

The Provider's letter to the Complainant dated 29 February 2016 included a reply card as outlined above which gave the Complainant three options going forward:

- Option (A) would allow the Complainant to maintain his current level of benefits for a further five years in return for an increased monthly premium
- Option (B) would allow the Complainant to maintain his current monthly premium in return for a reduction in his benefits
- Option (C) would allow the Complainant to maintain a reduced level of benefits for a further five years in return for a moderate increase in his monthly premium.

I note that the reply card forwarded to the Provider from the Complainant indicated his choice to maintain the policy premiums at €99.09 per month and to reduce his benefits to €45,993.

Annual Statement 2013

"Additional Critical Illness Benefit €51,603.30"

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Annual Statement 2014

"Additional Critical Illness Benefit €54,183.47"

Annual Statement 2015

"Additional critical illness benefit €56,892.64"

Annual Statement 2016

"Additional critical illness benefit €45,993"

Annual Statement 2017

"Additional critical illness benefit €48,292"

Telephone call recordings

Audio evidence was submitted by the Provider as part of its formal response to this Office.

Call dated 07/03/2017

The intermediary states that he has spoken to the Complainant and that the Complainant wants his premiums to remain at the current level.

Calls dated 17/05/2017, 09/06/2017 and 10/07/2017

These calls are between the Provider and the aforementioned intermediary and relate to the Complainant's claim for benefit under the policy.

Call dated 29/11/2017

This call is between the Complainant and the Provider. The Provider confirms that the Complainant's claim has been admitted, and the Complainant confirms that he is *"not happy"* with the amount payable under the claim. The Provider states that the Complainant elected in 2016 to keep his existing premiums and reduce his cover under the policy, but the Complainant states that this is *"completely out of order"*, that he does not understand, and that *"an agent must have made some mistake"*. The Complainant states that he is going to *"leave it with"* the Provider who should revert to him when the matter is *"sorted out"*. The Provider undertakes to raise a complaint, and the Complainant then states that his premiums have increased every year and are now €104 per month.

Complainant's submission dated 25/09/2018

"One thing I am concerned about and would like you to look into is why [the Provider is] taking €109+ from my Account for the last fourteen months".

Provider's submission dated 12/10/2018

"The monthly premium (and benefit level) increased on 1 April 2018 due to indexation of 5% being applied to the policy from that date, in accordance with the

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policy conditions…….. An indexation letter is issued to the policyholder prior to the increase in premium and benefit level being applied and the policyholder is invited at that time to contact us should they wish for the indexation not to apply".

Analysis

The policy which is the subject of this complaint was incepted in March 1996 and is a unit-linked, Whole of Life policy. The policy has the benefit of being 'whole of life' as long as the premiums continue to be paid and they can support the policy benefits. The main benefit of a unit-linked protection contract is that it affords the policyholder the opportunity to pay a premium in the early years that more than covers the cost of the premium for the life cover benefit, with the balance of the premium remaining invested in the designated investment fund. The purpose of this is twofold:

1. It allows the policyholder to build up a fund that is accessible at all times or;
2. It can help to supplement the premium paid in future years, allowing the policy benefits to be maintained.

On this basis, the policy provides for ongoing periodic 'Policy Reviews' (Condition 10 of the policy conditions) in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date.

It is appropriate to note that the cost of providing the policy benefits increases as the life assured gets older. Usually, the accumulated fund diminishes the impact of the increasing premium required at each review date. However, if the premium level and the fund value cannot maintain the policy benefits until the next review date, some action needs to be taken (either the premiums are increased or the sum assured is reduced). If the fund value has been completely exhausted, the level of the premium increase required may be significant.

The Complainant's policy is also subject to indexation, which means that both the premium level and the benefit level increase yearly. This is set out in Condition 9 of the policy conditions, but as outlined above the policy holder can decline that increase to both premium and benefit(s).

I would point out that even though a unit-linked Whole of Life policy allows the policyholder to build up a fund value over and above what is needed to pay for the life insurance premium, this usually only happens if the fund performs well. It can be the case that the policy would have little or no cash value. Such policies are not intended to be savings plans.

The first scheduled review of the Complainant's policy took place in **2006** and results indicated that an increase in premiums would be required if the level of cover was to be maintained. Alternatively, the Complainant could reduce his level of cover meaning that

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the premiums would remain the same. The Provider wrote to the Complainant, outlining his options, in February 2006, and included a *"reply card and prepaid envelope"*. The Complainant was "*invited to select the best option that best suited his needs at that time"*. The Provider wrote again to the Complainant in May 2006, noting that it had not received a reply card from him and enclosing an endorsement for the Complainant's policy setting out the revised policy details. The endorsement stated that *"the Additional Critical Illness [was] reduced to €61,533"* (from €64,916) and that the premium would be *"€63.24"* per month.

The second scheduled review of the Complainant's policy took place in **2011** and, again, results indicated that an increase in premiums would be required if the level of cover was to be maintained. The signed reply card forwarded to the Provider from the Complainant at that time confirms his decision to maintain his premium at the then current level (€81.52 per month) and reduce the amount of Critical Illness Benefit from €78,533 to €49,146.

The third scheduled review of the Complainant's policy took place in **2016**. Again, results indicated that an increase in premiums would be required if the level of cover was to be maintained. The signed reply card forwarded to the Provider from the Complainant (via the Complainant's broker) confirms his decision to maintain his premium at €99.09 per month and to reduce his benefits to €45,993. A copy was also forwarded to the Complainant's broker (the independent intermediary).

It would appear that the Complainant did not convey any preference to the Provider with regard to the level of cover at the time of the 2006 policy review, and so the Provider decreased the Critical Illness Benefit cover in order to maintain the premium at the (then) current level. When the next scheduled policy review took place in 2011, the Complainant elected to maintain his premium and reduce his cover. He communicated this to the Provider by returning a signed reply card, dated 15/03/2011, via his broker. At the 2016 policy review, the Complainant again elected to maintain his premium and reduce his cover (rather than maintaining the higher level of cover, which would have required an increased level of premium). Again, he communicated this to the Provider by returning a signed reply card, dated 07/02/2016, via his broker.

A policy review affords the Provider an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, a policy review should give the Provider the information to furnish the policyholder with an up to date picture of the level of cover chosen and provide an indication as to how long the premium and policy fund is likely to sustain that cover. Such reviews are important, as they allow the Provider to liaise with the policyholder with regard to what, if any, action needs to be taken. This is important for the policyholder. I am satisfied that the Provider clearly outlined the Complainant's

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options to him in the course of carrying out the scheduled policy reviews in 2006, 2011 and 2016 and note that the Complainant could have sought advices from his broker when contemplating the choices set out for him by the Provider. If the Complainant received advices in this respect from his broker and is not happy with such advice, then any such issue is a matter for the broker rather than for this Provider.

I note that annual statements issued to the Complainant in 2013, 2014, 2015, 2016 and 2017. The Critical Illness Benefit level of cover was noted on each statement, and thus the Complainant had the opportunity to become aware of the level of benefit payable should he have had reason to make a claim during those years. In addition to this, after the Provider reviewed the policy in 2016, the Complainant's broker emailed the reply card, signed by the Complainant, to the Provider in March 2016. The completed reply card notes that the Complainant had selected option B to apply, which states:

> *"Leave your premium at €99.09 per month and reduce your benefits from 1 April 2016 to: Additional Critical Illness Benefit €45,993".*

The Complainant's broker, in his telephone call to the Provider in March 2017, confirmed that the Complainant wanted his premiums to remain at the current level.

The Provider submits that:

> *"Indexation resulted in the benefit and premium amount increasing on 1 April 2017. The increased amounts were critical illness cover of €48, 292.65 for a monthly premium of €104.05".*

The Provider confirms that it wrote to the Complainant in March 2017, confirming the benefit and premium increase from 1 April 2017.

Given the evidence above, I cannot agree with the Complainant's contention that the eventual amount offered by the Provider in settlement of his claim fell *"far short of [the] amount [he] was given to understand would be paid"* as he elected to reduce his cover after the 2016 policy review and he confirmed this to the Provider by having his broker return the signed reply card stipulating this. The reduced *"Additional Critical Illness Benefit"* amount was also noted on the annual statement issued to the Complainant in 2016.

In his submission to this Office in September 2018, the Complainant states:

> *"One thing I am concerned about and would like you to look into is why [the Provider is] taking €109+ from my Account for the last fourteen months".*

The Complainant's policy is subject to indexation, meaning that both premiums and benefits increase yearly, unless the policyholder declines that change and opts instead to keep the figures unchanged. This is set out in Condition 9 of the policy conditions which

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state that the benefits and premiums will increase on the policy anniversary date (provided premiums due have been paid or deemed paid) by the greatest of:

a. *"5% of the amount thereof on the preceding day and;*
b. *The percentage increase, if any, in the Consumer Price Index for the twelve months last published before the relevant Policy Anniversary or such other index or scale or such other twelve month period as the Actuary at his sole discretion shall decide and;*
c. *The minimum increase from time to time acceptable to the Company*

Unless the Company shall receive written Notice within one month from the date of the increase that indexation has been declined".

I note that each annual statement which issued to the Complainant from the Provider from 2013 to 2017 states that the policy is subject to indexation. Therefore I am satisfied that the yearly premium and benefit increases due to indexation were clearly set out for the Complainant by the Provider in both the policy document and in the annual statements.

Finally, I note that the Provider has admitted the Complainant's claim for Critical Illness Benefit for payment in the amount of €48,292.65 and that it awaits the Complainant's bank account details in order to proceed with the payment of the claim amount.

For the reasons set out above, there is no evidence before me to show that the Provider wrongfully reduced the critical illness benefit payable under the Complainant's claim, or wrongly increased the policy premiums payable for his policy. I am satisfied that the Complainant's level of cover and monthly premium changed as a result of the Complainant's decision to reduce the level of cover following the 2011 and 2016 policy reviews, and also due to indexation. I am further satisfied that the changes in both cover and premium were communicated to the Complainant in correspondence from the Provider, comprising:

1) Annual Benefit Statements;
2) Confirmation letters from the policy reviews in 2006, 2011 and 2016 showing the reduced level of cover and premium payable; and
3) Indexation Letters.

In light of this, I do not believe it would be appropriate to uphold this complaint.

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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 rejected.

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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

10 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

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.