An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0258
Sector:	Insurance
Product / Service:	Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Dissatisfaction with customer service Failure to provide correct information
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants' policy is a unit linked open ended protection policy. The Policy was taken out in August 1998. The Policy was reviewed in 2016 and the Provider increased the premiums from €37.20 a month to €358.64 a month for the same level of life cover of €70,000.

The Provider took over the policy from the original underwriter of the policy.

The complaint is that the Provider has not correctly or reasonably administered the policy.

The Complainants' Case

The conduct complained of relates to the Provider's implementation of its Policy Review Process, which ultimately resulted in a recommendation made in June 2016 that either the premium needed to be substantially increased or the cover to be greatly reduced.

The Complainants also state that it was their understanding that following a meeting with the Provider's agent / advisor, in 2010, they agreed to enact a 'new policy' for a

reduced amount of cover of €70,000, for a reduced monthly premium of €37.20 and that they believed this was a fixed premium for life and would not change..

The Complainants state that at no time were they warned that their future premium would need to be increased by a level of 864% just to maintain the same cover.

The Complainants want the Provider to maintain the €70,000 cover at a cost of €37.20. The Complainants consider that this is what was agreed by them with the Provider in 2010.

The Provider's Case

The Provider's response to the Complainants' complaint is to point to the fact that the Terms and Conditions of the Complainants' Protection Options Plan allows for periodic reviews of the policy, with the implied possibility that either the premium may need to be increased or the benefits reduced, in order to maintain the policy in the future.

The Provider states that reviews were carried out at regular intervals, as well as on each occasion that alterations to the level of cover were made to the policy, such as in 2002 and 2010. The Provider submits that at each occasion up to June 2016, the result of these reviews was that the Complainants' premium was deemed to be sufficient, in conjunction with the policy's accumulated fund value at the time, to sustain the chosen level of cover until the next scheduled review.

The Provider says it is unfortunate that by June 2016 the cost of providing the Complainants' chosen amount of cover had reached a level which neither the current premium nor the accumulated fund value could support the costs until the next scheduled review in August 2017. The Provider states that it is a matter of fact that the Complainants' accumulated fund value had fallen from €2,990.05 in 2014 when this Protection Options Plan had passed a previous review, to just €511.46 in June 2016, when the Provider was obliged to issue the recommended options to the Complainants, which are the subject of this dispute. The Provider submits that the monthly cost for providing life cover of €70,000 on both lives assured had reached €174.86 by that time and would continue to rise as the lives assured got older. The Provider states that on this basis there was a monthly deficit of €137.66 between the monthly premium and the cost of providing the cover and this deficit was being made up from the policy's accumulated fund value, which would soon be depleted unless an increase in the premium was agreed or the level of cover reduced.

The Provider says that contrary to the Complainants' belief, it was never possible either in 1998 or more recently for the Provider to predict the quantum of increase needed when their policy would fail to pass a given review.

The Provider refers to the Complainants' assertion that they believed they had switched from a reviewable life policy to a fixed premium policy in 2010, when they reduced their cover from €132,533 on both lives with a premium of €157.06 per month, down to €70,000 life cover with a reduced monthly premium of €37.20. In this regard the Provider says it cannot accept this assertion on the basis that the Complainants received

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a written Endorsement to their existing Protection Options Plan on 27 September 2010, which does not give any assurance or indication that the reviewable nature of the cover had changed or that the premium would remain fixed for the duration of the policy.

It is the Provider's positon that the same Terms and Conditions continued to apply to this contract and in particular the Policy Review process, as the Complainants had not switched from this existing policy to a new contract in 2010, but had simply made an alteration to their existing cover.

The Provider states that its representative categorically rejects the Complainants' assertions that he gave them any assurances that the revised premium would remain fixed for the whole of their lives, he states that as he knew quite well that the Complainants' current policy remained intact and would continue to be subject to future reviews, the outcome of which he could not predict or quantify.

The Provider states that on that basis, while the Provider understands that no customer welcomes the need for either an increase in their premiums or a decrease in their cover, these options are necessary in order to maintain the policy going forward and the changes are a reflection of the true cost to the Company for providing the benefits attaching to the policy.

Evidence

The Complainant's submission of 26th February 2018

> *"I would like to refer to [the Provider's representative's] 2 messages to [another Provider employee] dated 17/6/2016 & 15/7/2016.*
>
> *When I received notification from [the Provider] dated 3/6/2016 of the proposed increase on my monthly payment from 37.20 to 358.64 I immediately contacted [the representative] and told him about the increase and my shock and disbelief. He said he would call out to my house and sort it out.*
>
> *When we met, [the representative] he was very friendly and I would like to quote his words on the increase: "This is ridiculous, in all my years in insurance I have never heard of such an increase. Leave it with me and I will get back to you as soon as possible". All of our conversation was totally friendly and I felt he was very sympathetic to my predicament.*
>
> *With regards to his reference to the reviews, I disagree completely with his explanation. The only advice I ever got from [the representative] with regards to my reviews was, "Don't worry about the review letters, the company is obligated by law to send you an annual review. You don't have to concern yourself with them."*
>
> *At no time did he or the company ever advise me of the increase that could occur.*

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With regard to the message from [the representative] to [another Provider employee] dated 15/7/2016, when he discussed our second meeting, this was arranged so that [the representative] would update me on the price increase on my policy. When he called to my house to explain this he said and I quote, "There is nothing I can do about it, I have no control over those matters, I am just the salesman."

I was very disappointed with this response, because every letter I received for the previous 17 years had advised me that if I ever had any queries I should contact my "Financial Adviser" ... When I reminded him of this, his attitude changed completely, and unlike his previous visit, he became totally unsympathetic to my plight.

I would like to point out that I disagree with his version of what actually occurred when he came to my house in 2010. I have dealt with this in previous correspondence.

I would like to ask [the representative] if he had sold a similar policy to anyone else because if he did he should have been able to give me proper financial advice about what would occur at reviews, instead of telling me to disregard these letters.

I would also like to know if [the Provider] has stopped selling this type of policy, and why it did so."

The Provider's submission of 7th August 2018

"1. (a) Tenth Anniversary Policy Review

The current Provider can find no record of a first review having being conducted by the previous Provider, ..on the scheduled 10th anniversary in 2008.

Unfortunately there are insufficient records to establish why this review was not conducted.

However as there were adhoc premium / cover quotes requested on behalf of the Complainants in mid-2007 .. which indicated that the current premium at the time was sufficient to sustain the chosen level of cover for a term of 16 years from inception (up to 2014). This would indicate that a similar outcome would have resulted from any formal review carried out on the tenth anniversary in 2008.

A subsequent Policy Review conducted in 2010 indicated that the current premiums at the time were sufficient to sustain the chosen level of cover until the next scheduled review in 2011.

1. b Post 65 Annual Policy Reviews

While the Provider accepts that the Terms and Conditions allow for annual reviews to be conducted once the oldest of the lives assured passes their 65th birthday, the

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Complainants did effect changes to their Protections Options Plan … shortly after the first Policy Review that was notified on 23 July 2010.

In September 2010 the Complainants applied for and accepted a reduction of the cover on their Protections Plan.. from €132,533 to €70,000 with an associated reduction in premium from €158.63 to €37.20, which meant that the revised payment would be sufficient to sustain the revised benefits for a term of 15 years from the original date of inception of their .. Policy. This meant that no further reviews would be required until 2013 (1998 + 15 years). On this basis no annual reviews were conducted in 2011 2012 or 2013.

The Provider states that Correspondence issued to the Complainants at this time in respect of the revised terms.

2. Revised 2010 Alterations & Policy Review Term

As has been stated under point 1 (b) above, the fact that the Complainants effected an alteration to their existing Protections ..Plan … in 2010, thus resulting reduced premium was calculated to sustain the revised level of cover for a minimum three year term up to 2013, which was the minimum term used by [the Provider] for projecting future quotes at the time. This meant that there was no requirement to conduct any reviews before 2014 as the revised premium had been calculated to sustain the cover up to 2013 or 15 years from the original date of inception of their .. Policy in 1998.

3. Policy Fund and Increasing Cost of Cover

You have asked that the Provider demonstrate, with supporting vouching, the specific moment when the cost of the cover on this plan began to be supported by the associated policy fund. The Provider's response to this request for clarification is to point out that the Policy Fund was always designed from inception to support the ongoing long term cost of the cover attaching to this policy.

The quantum of premium from inception was set at a level which was higher than that required to simply cover the cost of the cover at the time. This meant that each month a surplus would have begun to accumulate once the monthly risk cost was deducted from the fund value.

It can be seen from the copy Annual Statements enclosed (2013 / 2014 / 2015 / 2016) that between August 2012 and July 2013 the total premiums received for this period was €446.40 compared to the total benefit charges of €392.55 (not including €35.69 in Policy Fees or €4.44 in Government Levy).

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For the period between August 2013 and July 2014 the total premiums received for this period was €446.40 compared to the total benefit charges of €1,208.46 (not including €35.69 in Policy Fees or €4.44 in Government Levy). It was during this period that the cost of providing the amount of chosen cover exceeded the amount of premiums paid and this was notified in the Complainants' Annual Benefit Statements.

4. Policy Status From June 2016 to Date (August 2018)

It can be confirmed that the Complainants' Protection …Plan …remained in force with a reduced level of cover from €70,000 to €13,337 on each life assured for a premium of €37.20 per month, as per the Default Option B following the 2016 Policy Review.

However following the most recent Policy Review in July 2018, the Complainants responded to the options provided by advising that they rejected all of the options put to them and they wish to cancel their plan forthwith.

As a result the plan is now Out of Force and all benefits have been withdrawn with effect from 30 July 2018".

The Complainants' submission of 17 August 2018

The Complainants refer to correspondence dated [10 September 2010] from the Provider which referred to the reduction of cover to €70,000. The Complainant states that the Provider is using this as evidence that they agreed to the policy change. The Complainants dispute the position and state that in 2010 they invited the Advisor to their house as they wanted to change their policy. The Complainants state that they told the Advisor that they wanted life cover of €50,000. The Complainants say that the Advisor spent some time on his laptop and then quoted €37.20 per month. The Complainants submit that they were quite happy with this and agreed to go ahead with it, thinking that they were starting a new policy with the Provider. The Complainants state that there was no mention of the existing policy during this meeting. The Complainants' recall is that when the Intermediary was about to leave he said *"Oh by the way I need to get both of your signatures to say that you agree with these terms".* The Complainants state that when they asked him what he wanted them to sign he said *"just scribble a note saying that you agree and both sign it*". The Complainants submit that the Intermediary then handed them a letter dated 10th September 2010 and is alleged to have stated *"You can write it on this".*

The Complainants say that in conclusion, they agreed to €37.20 for €50,000 cover. The Complainants' position is that they were led to believe that they were entering into a new policy for life cover.

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24 August 2018 Submission from the Provider

The Provider's response is that the documentation submitted demonstrates that the reduced cover of €70,000 for a premium of €37.20 was an alteration to their existing policy and not an application for a new Term Policy.

The Provider says that the letter dated 10 September 2010 was a quotation obtained by the Intermediary on their behalf based on a reduction in their current cover and premium on their current policy at the time. The Provider's positon is that had the Complainants wished to exit their current policy and apply for a new Term Policy they would have been required to complete a brand new proposal / application form, detailing their current medical history which would have been submitted for underwriting by the Provider. The Provider states that this is not what occurred, but that what did happen was that the Complainants asked for a quote to reduce the cover on their existing Policy. The Provider says that when this was presented to the Complainants they indicated their agreement to proceed by signing the quotation letter, thus signifying they agreed to the conditions set out in the letter they signed.

The Provider states that they requested alteration was followed up by an Endorsement Letter dated 27 September 2010 which indicated that the reduced cover and premium was linked to their existing Policy.

The Provider says that if there had been any misunderstanding as to their intentions regarding the reduction in their cover and premium, the Complainants had every opportunity upon receipt of the Endorsement to correct any error.

Time line of events

7 October 2002 – Provider to the Complainants – Endorsement

> *"With effect from 07/10/2002 the above policy has been altered in the following respect:-*
>
> - *Life Cover has been increased to €132 533 on both lives assured.*
> - *Your premium, payable monthly, has increased to €157.06".*

18 April 2007 – The Provider advises the Intermediary of the effect of a partial surrender on the policy.

23 July 2010 – Policy Review correspondence

"We are pleased to tell you that, at this Review, your premiums are sufficient to sustain your chosen level of cover until the next Policy Review in August 2011".

This letter also included a separate Frequently Asked Questions sheet, where it was advised that:

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"What happens in a Policy Review?
When the cost to maintain your policy's level of cover reaches a stage where it is greater than your regular premium, this difference is made up from your fund value. During the Policy Review, [the Provider] will calculate whether the premium being paid is enough to maintain your cover until the next Policy Review. [The Provider] will examine the value of the fund attached to the policy and the Life Assured's age, smoker status and health".

23 July 2010 – Policy Projection

"The current premium is projected to maintain the benefits shown above for 15 years, 3 months from the policy commencement date assuming an investment return Growth A per annum".

6 September 2010 - Provider's file note

"Client called and requested revised benefits quote for reducing cover to 70k on each life. Adv if they wish to take up quote we need jointly signed written instruction sent in. Recommended they take financial advice from agent … before altering policy".

9 September 2010 – Projection Statement

"This is a whole of life protection policy. It is not designed to have a strong savings element and has no set maturity date. Your policy is subject to regular reviews at which time the premium payable may increase. Of course [the Provider] will notify in advance of the review, and of the options available to you at that time. For full details on the Policy Reviews, please consult your policy conditions".

10 September 2010 - Letter from the Provider to the Complainants

"The current monthly premium of €158.63 is projected to sustain the current benefits on this policy for a term of 15 years from inception, assuming 4.8% net growth.

Assuming the Life Cover is reduced to €70,000.00 (on both lives assured), a revised monthly premium of €37.20 is required to sustain the policy for its current term of 15 years from inception, assuming 4.8% net growth".

[The Provider now states that "the term of 15 years" meant until 2013]

The Complainant's handwritten note on this letter states:

"Please go ahead with this quote as and from next payment on 2nd October"

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27 September 2010 – Endorsement to Policy

The Endorsement contains the Complainants' then policy number, and states:

> *"Thank you for your recent request to reduce the Life Cover on this policy.*
>
> *With effect from the 01 October 2010 this policy has been altered as follows:-*
>
> - *Life Cover has been reduced to €70,000.00 on both lives.*
> - *With effect from the 01.10.2010 the premium payable monthly has been reduced to €37.20.*
>
> *…*
> *This Endorsement forms an integral part of the policy and should be kept with the original document. If this alteration is not in accordance with your wishes, please contact us immediately".*

29 September 2010 – Provider's file note

> *"[The First Complainant] rang wanted to confirm if we had amended his policy as per his instructions – confirmed to him a letter had gone in the post on the 27th and that I would put a copy in the post. Endorsement to policy".*

18 February 2011 – Provider's update on policy

> *"Life Cover €70,000*
> *Current Monthly Premium €37.20*
> *Note: All your policy benefits are subject to policy conditions detailed in your Policy Document".*

13 February 2012 – Provider's update on policy

> *"Life Cover €70,000*
> *Current Monthly Premium €37.20*
> *Note: All your policy benefits are subject to policy conditions detailed in your Policy Document".*

18 February 2012 – Provider's file note

> *"Client [the Complainant] called, he has no details of this [policy]. Task set up. I advised this is a WOL [Whole of Life] protection pol, adv of benefits on pol and the prem amount, SV [Surrender Value] is 3122.11 yesterdays value that can rise & fall daily. I advised when next review is due. It is poss to take p/s but this can prompt a*

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review and prem may increase. I told him I cannot predict what prem would be at next review".

5 November 2012 – Provider to the Complainants

"Please find attached details of the benefits your policy provides
"Policy Type: Protection ..
Status: In Force
Commencement Date: 01.08.1998
Term: Whole of Life"

31 December 2012 – Annual Statement

"The Central Bank has recently introduced changes to the way customers receive information about life assurance policies. Under new guidelines issued by the Central Bank you are now entitled to receive a valuation for your policy every year".

"Annual Statement
Premium Reviewable: Yes

..Please refer to your Original Policy Document for the details of how these benefits are payable in the event of a claim.

Your policy benefits are subject to terms and conditions. Please consult your Policy Conditions and Original Policy Document for further details".

1 August 2013 – Annual Statement

"*Under the Life Assurance (Provision of Information) Regulations 2001, and the Consumer Protection Code 2012, [the Provider] is required to provide you with a statement of your policy each year".*

"Annual Statement
Premium reviewable: Yes
..
Policy summary from 01/08/2012 to 31/07/2013
Premiums received €446.40
Government Levy (€4.44)
Benefit charges (€392.55)
Policy fee (€35.69)
Premium enhancement €8.84"

"Explanatory notes
Premiums received – These are the premiums paid by you into your policy over the statement period.
..

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Benefit charges – This is the charge to cover the ongoing costs of the benefits provided by your policy.

..

Premium reviewable – As unit-linked policies can run for many years, the charges and costs of maintaining them may increase over time. As you get older, for example, the cost of providing your benefits increases. We review your policy to ensure that you are paying the correct amount into your policy to keep the level of cover you have chosen".

18 July 2014 – Review of policy

"This regular review is to ensure that the premiums you pay into your policy are sufficient to keep the level of cover you have chosen.

..

[The Provider] has conducted a review of your policy for 2014. At this review we have calculated that your current premium is sufficient to keep your chosen level of cover until your next policy review. This means that no further action is required by you. We will contact you again when your next policy review is due".

Frequently Asked Questions document enclosed with the above letter:

"4. What happens if I do not reply by the deadline provided?
If you do not contact us by the deadline shown on your policy review letter we will process the default option detailed in your Policy Conditions. Depending on the type of policy you hold, the default option will be one of the following:

- *To increase your regular premium amount from the date specified*
- *To reduce your level of cover to match your current premium from the date specified*
- *To continue to pay your existing premium with the difference being made up form the value of the unit-linked fund attached to your policy. However, this will only continue for as long as there is a sufficient fund value attached to your policy. Eventually your fund will run out, your policy will lapse, and your cover and benefits cease.*

…

6.How often does a policy review take place?

A policy review happens after a set period of time from the start date of your policy. Your first policy review will usually take place after five or 10 years and then every five years after that. After the age of 65 your policy will be reviewed every year. For some policy types annual policy reviews will start at either 60 or 79 years of age".

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5 August 2014 – Annual Statement

"Annual Statement
Premium reviewable: Yes
..
Opening surrender value as at 31/07/2013 €3,499.56
Policy summary from 01/08/2013 to 31/07/2014
Premiums received €446.40
Government Levy (€4.44)
Benefit charges (€1,208.46)
Policy fee (€35.68)
Premium enhancement €8.84

Closing surrender value as at 31/07/2014: €2,990.05"

June 2015

"Your statement
..

Plan Review
A review of your plan payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time. This assumes a future fund growth rate of 4.00% and our charges for benefits do not change. Your next pan review will be on 1 August 2016 when we will again check that the payments to your plan are sufficient to cover the cost of your benefits".

"Opening cash in value of your plan at 31 July 2014 €2,990.04
..
Payments received since 31 July 2014: €405.11
..
Charges applied €1,537.33
Plan fees €45.11
Payment charges applied €12.52
..
The current value represents a reduction in your plan of €791.72 since your last statement"

June 2016 – Provider to the Complainant

"Your Statement
..
Plan Review
The next scheduled review for your plan is due now. This is when we check that the payments are enough to cover the cost of your benefits. We will write to you separately with full details of this review and your options".

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"Opening cash in value of your plan at 4 June 2015 €2,198.32
..
Protection benefit charges €2,038.37
..
The current value represents a reduction in your plan of €1,686.86 since your last statement".

3 June 2016 – Plan Review

"We have recently conducted a review of your plan in accordance with the terms of your contract, to calculate if your combined payments and plan fund are still enough to cover the cost of your level of benefits. In your case, we anticipate that your payments will not be enough to maintain your current level of benefits from 1 August 2016. It is therefore necessary to make some adjustments to your plan".

"Please chose on of these options … If we do not hear from you, in order to prevent your plan from terminating your premium will be amended as set out in Option A overleaf with effect from 1 August 2016".

"Option A
If you would like to maintain your current level of cover you will need to increase your monthly payment to €359.64 from 1 August 2016. The change will start from 1 August 2016 and will stay in place until your next review date on 1 August 2017"

17 June 2016 – Intermediary to the Provider advising of the Complainants dissatisfaction with Review of the policy, in particular that it was their understanding that the premium of €37.20pm would sustain the cover of €70,000 on both lives for life.

1 July 2016 – Review of Protection Benefits

"You may recall we wrote to on 3 June advising you that we had carried out your pan's scheduled review and that your current payment will not be enough to maintain your current level of cover. We also outlined the options available to you.

In your plan review, we calculate if your combined payments and plan fund are still enough to cover the cost of your level of cover. In your case, from 1 August 2016 we anticipate that your payments will not be enough to maintain your benefits".

2 August 2016 – The Provider to the Complainant

"We wrote to you originally on the 3 June 2016 enclosing a review of your plan and most recently on the 1 July 2016. As of today's date we do not appear to have received a reply.

As previously advised, your current payment is insufficient to maintain the current payments is insufficient to maintain the current level of benefits under the above plan from 1 August 2016 to 1 August 2017. To prevent your plan from terminating,

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with effect from 1 August 2016 your revised premium will increase from €37.20 to €358.64. Your level of benefits will remain the same and are set out below".

23 August 2016 – Provider to the Complainant

"Thank you for your recent request to increase your regular payment to this plan. We have increased the monthly payment to €358.64 from 1 August 2016"

29 August 2016 – The Complainant to the Provider seeking an agreement that he maintains the monthly premium of €37.20 until the complaint is resolved.

30 August 2016 – The Complainants to the Intermediary setting out their complaint.

7 September 2016 – The Provider to the Complainant

"I wish to confirm that the premium and benefits will alter with effect from 1 August 2016 as follows:
Premium €37.20 per month
Revised Life Cover Life 1 €13,337
Revised Life Cover Life 2 €13,337"

Policy Provisions

"Paragraph 6 - Charges

A. Benefit Charges

The cost of providing the benefits will be recovered monthly in advance by cancellation of Units from the Benefit Fund.

The amount of the monthly charge will be based on the amount of Benefits held at the start of the month multiplied by a factor determined by the Actuary. In determining the factor, the Actuary will refer to

(i) The age, smoker status and sex of the Life Assured at the Policy Anniversary which precedes or coincides with the calculation date.

(ii) Such other factors relevant to the mortality risk as were agreed between the Policyholder and the company at the Commence Date or subsequently.

Paragraph 7 – Policy Review

All of the benefits provided by this policy and the amount of premium payable shall be reviewed by the Actuary on each scheduled policy review.

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Where the extended Guarantee Option has been chosen at the Commencement Date (as indicated on the Policy Face), the first scheduled Policy Review will take place at the twentieth Policy Anniversary; …; otherwise the first scheduled review will take place on the tenth Policy Anniversary.

Thereafter, scheduled Policy Reviews will take place on every fifth Policy Anniversary, until the policyholder attains his 65th birthday, following which the Policy Reviews will take place at every Policy Anniversary.

A policy review shall also take place after a claim is made under Section 1.A, 1.B, 1.F, 1.J, or 1.K.

A policy review may also take place if the policyholder adjusts the premiums or benefits under this policy during the term of the policy".

Quotation issued in 1998

"At any Policy Review, [the Provider] calculate whether the premium being paid is sufficient to maintain the benefits until the next review. In making this decision [the Provider] will consider the value of your fund and the current cost of your benefits.

If, at the Policy Review, the premium is estimated to be insufficient to maintain your protection benefits until the next review, [the Provider] will notify you of this immediately. In order that you may then decide which option best suits your circumstances [the Provider] will tell you;

(i) The amount of premium required to maintain the benefits, and

(ii) The reduced benefits which the current premium can support".

The Complaint for Adjudication

The complaint is that the Provider has not correctly or reasonably administered the policy.

Decision

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

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

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

A Preliminary Decision was issued to the parties on 26th July 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, within the period permitted, the final determination of this office is set out below.

Analysis

The issue for investigation and adjudication is whether the Provider correctly and reasonably administered the policy, in particular in relation to the carrying out of Policy Reviews and in its communication of the actions on the policy.

The policy that the Complainants took out in 1998 is a unit linked life assurance contract, which has the benefit of being a whole of life policy as long as the premiums continue to be paid and they can support the policy benefits.

The main reasoning behind a unit linked protection policy is that it affords the policyholder the chance to pay a premium in the early years that more than covers the cost of the life cover benefit with the balance of the premium remaining invested in the designated investment fund. The purpose of this is twofold, as it allows the policyholders to build up a fund, that is accessible at all times or it can help to supplement the premium paid in future years allowing the policy benefits to be maintained. On this basis the policy is subject to ongoing reviews in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date.

The cost of providing the policy benefits increases as the life assured gets older. In effect, the accumulated fund diminishes the impact of the increasing cost of the policy benefits thereby minimising the increase in premium required at each review date. However, if the premium level and the fund value cannot maintain the policy until the next review date some action needs to be taken (either increase the premium or reduce the sum assured). If the fund value has been completely exhausted the level of the premium increase required may be significant.

The Complainants' policy was to be first reviewed in 2008 (on its 10th Anniversary) in accordance with the policy conditions. The Provider has been unable to show that the

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previous underwriter of the policy carried out a review at that time. The Provider advised that there was insufficient records to establish why this review was not conducted. The policy was scheduled for review again in 2011, and annually thereafter, as the First Complainant had turned age 65yrs in 2010.

It is the Provider's position that in September 2010 the Complainants applied for and accepted a reduction of the cover on their Protections Plan from €132,533 to €70,000 with an associated reduction in premium from €158.63 to €37.20, which meant that the revised payment would be sufficient to sustain the revised benefits for a term of 15 years from the original date of inception of their Policy. The Provider states: ***"this meant that no further reviews would be required until 2013 (1998 + 15 years)"***. The Provider says that on this basis no annual reviews were conducted in 2011 2012 or 2013.

However, I am not satisfied that this is correct, the new arrangement was still subject to the terms and conditions of the policy and the Provider was merely reducing the benefits, the projected term for the provision of the benefits at the stated cost remained the same. I also note that the Provider did not make it clear in communications with the Complainants that the scheduled reviews in 2011, 2012, and 2013 would not be happening. I consider that the Provider could also have been clearer as regards what it meant by the new arrangement being for 15 years from inception.

In its explanation of the new policy term to this office it stated that it meant that: ***"the revised payment would be sufficient to sustain the revised benefits for a term of 15 years from the original date of inception of their … Policy"***. The Provider further states: **"this meant that no further reviews would be required until 2013 (1998 + 15 years)"**.

The Provider further advised that: ***"the revised level of cover for a minimum of three year term up to 2013, .. was the minimum term used by [underwriter] for projecting future quotes at the time"***.

However, all of this was not advised to the Complainants in 2010. What was advise is the following:

> *"Assuming the Life Cover is reduced to €70,000.00 (on both lives assured), a revised monthly premium of €37.20 is required to sustain the policy for its current term of 15 years from inception, assuming 4.8% net growth".*

It is evident from the above that the following information was not made clear by the Provider to the Complainants:

(i) That the 15 year term was to run from 1998 and not from the inception date of the alteration in 2010.
(ii) That the Provider would not be carrying out the annual reviews that were meant to happen in accordance with the Policy.
(iii) That the yearly reviews would not be happening until after 2013.

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(iv) That the Provider was only able to project future quotes for a minimum of three years.

I find no evidence in the documentation from the Provider (or from the previous Underwriter of the policy) of any communication to the Complainants over the years, advising that it had missed an earlier review. The first time that the Complainants became aware of this was in the Provider's response to this complaint, to this office in November 2017.

While I accept that a Provider does not have to notify a policyholder in advance of increasing the annual charges made for mortality rates, I do consider it reasonable that a Provider communicates at the earliest opportunity, be that be at policy anniversary date or at review stage, that the premium being paid is no longer sufficient on its own to cover the cost of providing the policy benefits.

Not knowing the full position of what the Provider was doing, that is, using the fund in addition to the premium payments, a policyholder is denied an early opportunity to decide what action he/she wishes to take regarding the policy. It could, for example, be the case that the policyholder would have wished to exit the policy, after discovering that this is how the policy actually operated in practice (it is one thing to set out in the policy documentation how something is going to be done, but knowing the full implications of the fund deduction process when it happens is another matter). In this complaint, I consider that the Provider could have been clearer in its communication of the position, particularly in the 2014 communications and in the following year's communications, where it is clear that the fund had been supporting the cost of cover, despite a communication from the Provider that the premium payments alone were sufficient to sustain the cover for a further period.

The importance of having had the policy Reviewed on time and with having some communication of the action of decreasing the fund to pay for the policy cover, was that the Complainants would have had the choice at an earlier date, as to whether to continue with the policy or withdraw from the policy and take the benefit of a higher surrender value. The ability to make alternative arrangements for cover when at a younger age was also lost to the Complainants.

In the above regard, I do not accept that it was reasonable of the Provider (i) not to carry out the yearly reviews in 2011, 2012 and 2013 (ii) not to communicate over the years that a review had been missed at its scheduled date in 2008 (iii) to communicate in 2014/2015 that the premium payments were sufficient when the opposite was the position (iv) not to be as clear as it should have been about the duration of the term applying to the altered cover and premium in 2010 and (v) not to have been clearer on the position that it was unable to project future quotes for more than three years.

I consider that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is Life Assurance cover.

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The Complainants' positon is that they thought that the altered cover being provided in 2010 was for life. However, I accept that from the information the Complainants received from the Provider over the years, that information did not reflect that position. The Policy was a reviewable policy with no guarantee as to the premium payment that would be charged for by the Provider for the level of cover that was chosen by the Complainants. However, I do accept that some confusion could reasonable have arisen as to how long the Provider was projecting the altered cover of €70,000 to last for, at a premium of €37.20. I accept that the Complainants could have reasonably expected and understood from the communications from the Provider, that the policy cover would sustain for longer than the 3 years that the Provider says it could only quote that cover for. Therefore, I substantially uphold this complaint and I direct the following: (a) that the Provider maintain the policy benefits of €70,000 at a premium of €37.20 until 2025 (that is 15 years from when the policy was altered in 2010) and (b) pay the Complainants a compensatory payment of €5,000 (five thousand euro).

If it is the positon that the policy has been cancelled by the Complainants, the Provider is to offer the Complainants the option of reinstating the policy on the above basis, waiving any outstanding premiums. Premium payments are then to recommence at the premium of €37.20 for the period outlined above, that is, until 2025.

I would alert the Complainants that in the year 2025 the Provider can Review the policy and given that the premium payments were to substantially increase when last reviewed, they can expect that they will have to pay a much greater amount if they wish to maintain the same cover of €70,000 after that date. Independent advice as to what to do then would be prudent, it may be the positon that alternative arrangements could be made with the Provider or with another Insurer in relation to the cover that is needed, after that date.

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: (a) maintain the policy benefits of €70,000 at a premium of €37.20 until 2025 (that is 15 years from when the policy was altered in 2010) and (b) pay the Complainants a compensatory payment of €5,000 (five thousand euro). The compensatory payment is to be made to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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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

20 August 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.**