An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0317
Sector:	Investment
Product / Service:	Pension
Conduct(s) complained of:	Misrepresentation (at point of sale or after)
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns an Executive Pension Policy taken out by the Complainant's employer in 1990. The dispute relates to the charges that were taken over the years from the payments in respect of life cover and permanent health cover. The charges increased from year to year and reached a stage where the charges exceeded the payment that was being made. The excess charges were taken from the plan fund. Resulting in less monies being invested in the pension fund.

In circumstances where the Complainant is an actual or potential beneficiary of the Plan being contractually entitled to benefit from a long-term financial service, he falls within the definition of "complainant" as set out in the **Financial Services and Pensions Ombudsman Act 2017 (as amended**).

Any conduct relating to the sale of the Plan and/or advice given to the Complainant at the time the Plan was incepted is conduct of the Intermediary which sold the Plan to the Complainant and consequently a complaint about this conduct is not a matter for the Provider. In addition as this conduct occurred **in or around 1990** it appears to fall outside the jurisdiction of this Office **pursuant to s51 of the Financial Service and Pensions Ombudsman Act 2017.**

The conduct of the Provider about which the Complainant is complaining which took place **during or after 2002** falls within the jurisdiction Financial Service and Pensions Ombudsman as set out in **s51 of the Financial Service and Pensions Ombudsman Act 2017(as amended)**. The basis on which the Complainant's Complaint about conduct which

occurred **during or since 2002** is being investigated by this Office is because it is conduct that is of a continuing nature which is taken

> "*to have occurred at the time when it stopped and conduct that consists of a series of acts or omissions is taken to have occurred when the last of those acts or omissions occurred*"

The complaint is that the Provider maladministered the Complainant's Executive Pension Plan:

- wrongfully allocated the monthly contributions to the Plan to maintain Permanent Health Insurance cover and Death Benefit without authorisation and without reasonably informing the Complainant of same;
- wrongfully used some of the Complainant's accumulated pension fund to pay for Permanent Health Insurance cover and Death Benefit;
- misrepresented or did not reasonably communicate how it had allocated the premium paid each year in its Annual Benefit Statement.

The Complainant seeks restitution to his pension fund as he was of the belief he was paying most of the payment to the pension.

The Complainant's Case

The Complainant states that when he took out an executive pension with the Provider in 1990 through his employer, it had three components to it — pension, life cover and disability cover

The Complainant states that at no time since 1990 did the Provider advise him or indicate to him that it could / would or did re-distribute the allocation of the premium payments paid since 1990 between the pension, life cover and disability cover element of the plan. The Complainant states that the plan was essentially sold to him as a bundle. The Complainant submits that he does not believe that the Provider had the right to do this without obtaining his permission or informed consent.

The Complainant says that the Provider has reallocated the distribution of the premia paid and diverted funding of the pension element to maintain life cover and disability cover, without advising him or seeking his permission or consultation. The Complainant says he does not believe that it had the right to do this without obtaining his permission or informed consent.

The Complainant states that the Provider has used the actual pension fund itself to pay premia for life cover and disability cover, again without notification, consultation or permission. The Complainant says he does not believe that the Provider had the right to do this without obtaining his permission or informed consent.

The Complainant says that that what the Provider had actually been doing in relation to the allocation of the premia paid by his employer only came to light when he started to

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investigate the matter in 2012. The Complainant says that until that point he was relying on and was entitled to rely on the representations made by the Provider in its annual letter to him, which essentially was that if he increased his premium year on year it would boost his eventual retirement fund and ensure that the benefits provided were not diminished by the effects of inflation. The Complainant states that in light of what the Provider now says in response to letters written to it on his behalf, he says that its annual letters were false and misleading and misrepresented the true position of what the Provider was doing with payments received from his employer.

The Complainant states that the Provider owed him a duty to set out clearly and unambiguously in its annual statement exactly how it had dealt with / used and allocated the premium paid in each year. It is the Complainant's position that the Provider failed to do that and in so failing covered up what it was actually doing with his premium. The Complainant says that the Provider failed in its duty of care to him, to keep him informed of what it was doing so that he could make informed decision if he had the real information as to apportionment of the premium.

The Complainant refers to letters from the Provider dated 28.01.2008 & 05.02.2009. The Complainant says that these letters would lead any reasonable individual to think that the contribution paid in each of those years of €5,000.00, had been allocated in full to the pension, whereas it now appears from the summary of allocations subsequently received that in those years nothing at all was applied to the pension fund and in fact the Provider had started to eat into the pension fund to fund the life cover and permanent health insurance, without his knowledge. The Complainant considers that the letters the Provider sent were abject misrepresentations of what it had done, which only came to light in November 2012 when his accountant received the summary of allocation of premium from 01.11.1990 to 31.10.2012.

The Complainant says that at no time did the Provider state that there was a sustainability date on the products provided. The Complainant says that the Provider owed him a duty of care to set out the applicability of a sustainability date to the death benefit and Permanent Health Insurance (PHI) on its initial offering to him. The Complainant says that because of that failure on the part of the Provider, he was unaware that what it bundled together and sold him in the beginning was unsustainable in the long term, because the Provider did not inform him. The Complainant submits that he should not suffer the loss of the pension fund value due to the Provider's actions in the way it mis-sold and continued to mis-represent its position.

The Complainant says that at no time did the Provider state that not only were the premia being paid, allowing for annual increase, not only insufficient to maintain the cover bought originally, but that they were also diverting the premia paid from the original percentage allocation spread and then ultimately eating into his pension fund. The Complainant says that the Provider has no right to do this without his knowledge and consent.

The Complainant's position is that he has been treated in a disgraceful manner by the Provider, that it was not honest or up front in what it sold him in 1990 or in its dealings with him since, that its annual statements were misleading, that its contention that the

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Broker to the scheme was somehow responsible is simply an attempt to evade responsibility for the losses that it has caused to him by continuing to misrepresent its product with its annual statements. The Complainant considers that these annual statements were written in such a way and couched in language that gave him to understand that not only was everything going fine with the three elements of the plan but that by increasing the premium every year, he was maintaining the real value of the plans. The Complainant says that the Provider has behaved in an unacceptable manner.

The Complainant says that the Provider owed him a duty of care to review the policy with him on a regular basis and that it failed to do so. The Complainant says that no review was offered by the provider since 2003 when the Broker resigned as brokers to the scheme and the plan was transferred to the Provider's agent.

The Complainant considers that there has been no transparency by the Provider in its dealings with him The Complainant considers that it is a breach of the Provider's fiduciary duty to him and its obligation to treat him with good faith that it failed to disclose, until he specifically requested it, the percentage breakdown allocation of the premia paid to it.

The Complainant says that had the Provider honoured its duty of care to him and been transparent in its dealings with him he could have made informed decisions in relation to the product that it sold to him. The Complainant states that instead he finds himself at the age of 65 years with a pension of significantly less value than what he had been led by the Provider to expect. The Complainant says that he is aware that values of funds can fluctuate, but what he is complaining about is an entirely different matter altogether, which is as is set out above.

The Complainant is seeking the following as a resolution:

1. *A refund of all premiums diverted from his pension and used to fund his PHI and Death Benefit.*
2. *The application of the refunded premiums to his pension fund, subject to adjustment for calculation of what the value of these premiums would be in today's terms if they had been applied to his pension fund when they should have been and, secondly subject to capital injection of what value these premiums would have increased his pension fund by if they had been paid into it when they should have been paid into it.*
3. *[Reinstatement of his Death Benefit cover to a level considered necessary].*
4. *Compensation for the negligence and breach of duty, including statutory duty …"*

The Provider's Case

The Provider states that the Complainant's employer, in conjunction with the employer's then adviser, put in place an Executive Pension Plan with the Provider for

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the Complainant on 1 November 1990. The Provider says that the Complainant's Employer appointed itself as Plan trustee. The Plan was a Revenue approved occupational pension scheme, registered with the Pensions Authority and administered in accordance with Revenue rules and pension legislation. The Plan was set up to provide retirement, life cover and disability benefits (Permanent Health Insurance benefits) for the Complainant and the Employer was eligible to claim corporation tax relief at the prevailing corporation tax rate on the contributions it paid into the Plan on the Complainant's behalf.

The Complainant's complaint relates to the cost of life cover and disability benefits under the Plan. The Complainant is unhappy that the cost of those benefits increased over the years and in particular that a point was reached where, for a time, the monthly cost of those benefits exceeded the monthly contributions being paid into the Plan by the Employer.

The Provider submits that the Plan was administered over the years in accordance with the terms and conditions provided to the Employer, as Plan trustee, in December 1990. The Provider states that if the Complainant or the Employer are unhappy with the nature of the Plan which was taken out in 1990 through an independent intermediary, it recommends that these concerns should be raised directly with the Intermediary. The Provider says that it was open to the Complainant, or the Employer, to contact the Provider at any time over the years in relation to the Plan. The Provider says it issued Annual Benefit Statements and indexation letters over the years to the Employer, as Plan trustee, to be forwarded to the Complainant. The Provider states that these reflected the increasing sums assured under the Plan at those times. The Provider states that the Plan provided the Complainant with substantial levels of, both life cover and disability benefits over the years. By 2012 the life cover benefit exceeded €400,000. The Provider's positon is that increasing cost of life cover and disability benefits was set out in the policy conditions. The Provider states that the Complainant has confirmed in his written submissions that he was aware there were costs associated with the life cover and disability benefits.

The Provider states that by way of summary, the Provider's records reflect that the proposal form for the Plan was completed by the Employer on 5 September 1990, in conjunction with the Intermediary. The proposal form was signed by the Complainant both in his capacity as a director of the Employer and as Plan member. In addition to confirming the initial level of contributions intended to be paid into the Plan each year, the Employer applied to take out life cover and disability benefits under the Plan in respect of the Complainant and it selected to index those benefits.

The Provider says that the records reflect that the policy documents were issued to the Intermediary by letter dated 17 December 1990 for onward transmission to the Employer. The letter enclosed an Executive Pension Investment Plan schedule and conditions and an Executive Permanent Health Insurance Policy schedule and conditions. These documents together set out the terms and conditions of the Complainant's pension, life and disability cover. The Provider states that initial life

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cover benefit was confirmed to be IR£84,500. The initial disability benefit was confirmed to be IR£7,119 per annum with an initial deferred period of 13 weeks.

The Provider's position in relation to the allocation of premiums, Condition 10 of the Executive Pension Investment Plan conditions provides that the Provider will deduct units from the value of the fund to cover the cost of any life cover (mortality) benefits being provided under the Plan, and any disability (morbidity) benefits being provided under a related disability policy. Condition 10 provides:

> *"On a Valuation Date between each two successive Monthly Policy Dates the Actuary at his sole discretion shall calculate a current mortality charge in respect of any Sum Assured and if there is a policy related to this policy then in force a current morbidity charge in respect of such policy. As soon as may be the Provider shall deallocate from the number of Accumulation Units allocated to the Policy a number of Accumulated Units equal in value at Bid Price on the Relevant Valuation Date to any current mortality/morbidity charge, such monthly charge as the Actuary at his sole discretion shall decide from time to time and the appropriate amount, if any, of statutory charges on the Provider in respect of this Policy and any policy related to this Policy..."*

Condition 11 of the Executive Pension Investment Plan conditions states that the Provider may review the sum assured under the Plan at any time having regard to both the mortality charge provided for in Condition 10 and the value of the pension fund. It states that if the value of the pension fund is at any time less than the mortality charge, the Provider may cancel the sum assured or increase the regular life premium. The Provider states that it did not exercise its right to do so as the value of the pension fund at all times exceeded the cost of the mortality charges. The Provider submits that as can be seen from conditions 11, it was not its intention to assess the mortality charges against contributions being paid but rather the value of the pension fund at any time.

The Provider states that the records reflect that alterations were made to the Plan in 1992, through the Intermediary. The deferred period in respect of the disability benefits was increased from 13 to 26 weeks and the life cover was increased by IR£31,150 to IR£119,875.

The Employer then contacted the Provider in October 1995 to obtain information on the Plan. The Provider says it was asked to furnish details of the life cover and disability benefits associated with the Plan. The Provider says it was also asked to confirm what monthly contribution would be required for the Complainant to obtain maximum retirement benefits when he reached his normal retirement age of 65 (in 2015). The Provider states that it supplied the requested information to the Intermediary by letter dated 2 November 1995. The Provider states it informed that the total contributions paid into the Plan at that date came to IR£9,100.58 and that the value of the Plan was IR£7,598.83 as at 24 October 1995. The letter stated that for

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the Complainant to obtain maximum retirement benefits the monthly contributions being paid into the Plan at that time of IR£163.68 would need to increase to IR£929.86. If no change in monthly contributions was made, the estimated maturity value of the Plan at normal retirement age was IR£49,001.

The Provider states that the Intermediary then wrote to the Provider on 25 April 1997 to request information in relation to the Plan. They requested a comparison of the cost of life cover and disability benefits at inception in 1990 and in April 1997. They also requested confirmation of the total contributions paid into the Plan to April 1997 and details of the deductions taken from the Plan over the years in respect of the life cover and disability benefits. The Provider states that it wrote to the Intermediary on 8 May 1997 to provide the details requested. The Provider submits that the following information was set out in the Provider's letter, which it has placed into a table for comparative purposes:

	1990 IR£	1997 IR£
Monthly Premium	134.65	180.45
Life Cover Premium	25.74	56.66
Disability Premium	41.41	37.04
Life Cover Amount	84,500.00	152,994.27
Disability Amount	7,119.00	9,540.15

The letter stated that the total premiums paid to 8 May 1997 came to IR£12,255.75 and these were broken down as follows:

Pension premiums: IR£9,029.78

Disability premiums: IR£I ,478.02

Life cover premiums: IR£1,747.95

The Provider states that it set out the value of the Plan to be IR£12,670.84 as at 1 May 1997. The letter also estimated the maturity value of the Plan at normal retirement age of 65 to be IR£61,741.00.

The Provider states it has no record of receiving further communication from the Complainant, the Employer or the Intermediary until May 2003. The Employer wrote to the Provider on 28 April 2003 to confirm that the Intermediary (which had by that time changed its name) was no longer to act as broker for the Plan and that going forward the employer wished to deal directly with the Provider. This letter was signed by the Complainant and another person for and on behalf of the Employer. The Provider says that the Complainant has stated that this letter had the effect of appointing the Provider as financial advisor for the Plan. The Provider does accept that this letter amounts to the formal appointment of the Provider as a replacement

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adviser The Provider's position is that it is always open to policyholders to deal directly with the Provider but that does not mean it is in an advisory capacity.

The Provider says it received no further correspondence from the Complainant or the Employer until January 2008, although the Employer did continue to pay the regular contributions into the Plan during that time. The Provider says that then in January 2008 the Provider received a single contribution of €5,000 from the Employer which was to be applied to the Plan on the Complainant's behalf. A further single contribution of €5,000 was received from the Employer in January 2009 which was also to be applied to the Plan on the Complainant's behalf. The Provider states that it did not provide any advice or assistance to the Complainant or the Employer in relation to the two single premiums paid into the Plan, nor was any such advice or assistance sought from the Provider in that regard.

The Provider says that the Records reflect that by letter dated 8 May 2012 the Employer authorised, a firm of chartered accountants, to obtain information in relation to the Plan. The accountants then made contact with the Provider and a Plan information statement was provided to him on 15 May 2012. The statement set out that the total contributions paid into the Plan since inception came to €86,750.22 and that the surrender value of the Plan was €46,654.36 at 11 May 2012. The statement advised that the monthly employer contributions were at that time €477.66, which included the cost of all protection benefits, charges and expenses. A Statement of Reasonable Projection was enclosed with the Plan information statement for ease of reference. The Complainant's accountant telephoned the Provider on 18 May 2012 to obtain additional details in relation to the Plan, including details of the cost of protection benefits. The Provider states that it wrote to the accountant on 22 May 2012 to provide the following breakdown of the €86,750.22 in Employer contributions paid into the Plan:

Life cover premiums: €36,327.05

Disability premiums: €18,988.04

Pension premiums: €31,435.13

The Provider states that the Complainant met with the accountant and a broker consultant employed by the Provider to facilitate interactions between an advisor and the Provider to discuss the Plan on 25 July 2012. The Employer was then provided with an up to date Plan information statement on 3 August 2012 which included an annual breakdown of contributions paid into the Plan over the years.

The Provider says that the accountant then contacted the Provider by email on 14 August 2012 to obtain a quotation showing the effect a reduction in life cover from its then level of €405,011.96 to €100,000.00 would have on the Plan. The quotation was supplied by the Provider on 22 August 2012. The accountant then gave a written instruction (which was signed by the Complainant on 23 September 2012) to reduce the life cover under the Plan to €100,000 with immediate effect. The alteration was made and the Provider wrote to the accountant and the Employer on 12 October 2012 to confirm this. The Provider then wrote to the accountant on 17 October 2012

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to provide a breakdown of the cost of risk benefits on an annual basis since the Plan commenced in 1990. Further information was requested by the accountant by letter dated 29 October 2012 and the Provider furnished the information requested by letter dated 8 November 2012.

The Provider states that, by letter dated 3 December 2012, the Employer appointed Mr F, a tied agent of the Provider, to become the financial advisor on the Plan. The Complainant met with Mr F in January 2013 and on 22 January 2013 the Employer wrote to request the removal of disability benefits from the Plan while leaving the life cover at €100,000. An endorsement was then issued to the Employer by letter dated 13 March 2013.

The Provider states that the Complainant raised a formal complaint with the Provider by letter dated 2 April 2013. The Provider says it responded to the matters raised and the Complainant subsequently referred the matter to his solicitor in August 2014. The Provider states that it responded to the various enquiries raised by the solicitor in the months that followed and the Complainant then referred the matter to this office in July 2015.

The Provider submits that as set out above, Annual Benefit Statements were prepared by the Provider over the years on behalf of the Employer, as Plan trustee. The statements were issued to the Employer each year for onward transmission to the Complainant. The Provider says that the information that is required to be included in an Annual Benefit Statement is set out in the Occupational Pension Schemes (Disclosure of Information) Regulations 1998 (as amended). While these regulations require details of the life cover benefit to be included in an Annual Benefit Statement, they do not require the cost of those benefits to be disclosed. The Provider says that each Annual Benefit Statement provided the trustees and the Complainant with information in relation to the levels of life cover (referred to as death in service benefit) and disability benefit the Complainant was covered for at those times.

The Provider submits that it is important to note that since 2009 a Statement of Reasonable Projection ("SORP") has been required to be issued each year in conjunction with the Annual Benefit Statements. The Provider enclosed in its file of evidence to this office a copy of each Annual Benefit Statement and Statement of Reasonable Projection issued since 2009. The Provider states that each Statement of Reasonable Projection takes into account the current value of the Plan, and projects this value forward to the retirement date selected by the Plan member (in the Complainant's case 27 April 2015). The Provider explains that the projected value of the Plan at the member's selected retirement age is expressed to be based under a number of assumptions. These include that monthly contributions will continue to be paid and that a particular investment growth rate will be achieved. A warning is also contained on each Statement of Reasonable Projection in a box and in bold text. The warning confirms as follows:

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"Warning: These figures are estimates only. They are not a reliable guide to the future performance of this investment. The value of your investment may go down as well as up. This value is not guaranteed and the amount available at normal retirement age could be higher or lower than the value stated".

The Provider set out in the following table of a comparison of the contributions paid, fund value and projected value at retirement in relation to the Complainant's Plan from 2009. The Provider states that the details have been taken from the Annual Benefit Statements and Statements of Reasonable Projection. The Provider submits that it can be seen, the projected value of the Plan at retirement increased significantly following the adjustments made by the Employer to the life cover and disability benefits from 2012 on.

Date of ABS & SORP	Total Contributions Paid	Value of Plan	Projected Value at Retirement
20/11/2009	€73, 182.09	€46,025.60	€47,781.38
18/11/2010	€78,402.75	€49,341.32	€50,500.05
13/03/2012	€85,795.06	€49,639.66	€49,678.67
07/12/2012	€89,616.34	€51 ,034.67	€66,591.52
04/12/2013	€95,348.26	€63,512.40	€73,998.17
19/11/2014	€101 ,080.18	€73,565.78	€77,036.06
20/11/2015	€106,533.46	€77,939.90	€80,894.86

The Provider states that the Plan was sold to the Complainant's Employer by the Employer's independent adviser, in 1990 and if the Complainant or the Employer are unhappy with the nature of the product it respectfully submits that they should raise their concerns directly with the Broker. The Provider states that it was open to the Complainant or the Employer to contact the Provider at any time in relation to the Plan, and the Provider notes that contact was made over the years to obtain specific information in relation to the cost of benefits at points in time and to arrange payment of single premiums into the Plan. It was not until December 2012 that a Provider advisor was appointed by the Employer.

It is the Provider's position that the Plan has been administered over the years in accordance with the terms and conditions which were furnished to the Independent Intermediary in December 1990 for onward transmission to the Employer, as Plan trustee. The Provider says it was open to the Complainant or the Employer to take out a separate protection policy in 1990 but the Employer decided instead to include those protection benefits in the Plan. The Provider submits that terms and conditions state that the Provider will deallocate units of the pension fund to cover the costs of providing the life and disability cover. The Provider says that the Complainant has accepted there was a cost associated with the protection benefits and by structuring the protection benefits in this way, the Employer was eligible to claim corporation tax relief at the prevailing corporation tax rate on the premiums it paid.

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The Provider submits that the Complainant had high levels of valuable life and disability cover over the years and had a valid claim arisen under the Plan, it would have paid the sum assured to the Complainant or his estate, depending on the circumstances. The Provider says that it cannot accede to the Complainant's request to refund the premiums paid for the valuable protection benefits the Employer selected to provide for the Complainant under the Plan in 1990, the cost of which the Employer was aware would be taken from the pension fund.

The Provider submitted a copy of the Annual Benefit Statements that were issued by the Provider to the Employer, as Plan trustee, since 2009. The Provider says that the Employer in turn transmitted the statements to the Complainant, as Plan member. The Provider says that the information that is required to be included in an Annual Benefit Statement is set out in the Occupational Pension Schemes (Disclosure of Information) Regulations 1998 (as amended). The Provider states that while these regulations require details of the life cover benefit to be included in an Annual Benefit Statement, they do not require the cost of those benefits to be disclosed. The Provider says that each Annual Benefit Statement provided the trustees and the Complainant with information in relation to the levels of life cover and disability benefit the Complainant was covered for at those times. The Complainant surrendered the Plan in May 2016.

The Provider states that the Plan was an occupational pension arrangement and as such the provisions of the Consumer Protection Code do not apply..

The Provider submits that the Plan has been administered over the years in accordance with the terms and conditions which were provided to the Employer, as Plan trustee, at the outset. The Provider says it was open to the Complainant or the Employer to take out a separate protection policy in 1990 but the Employer decided instead to include those protection benefits in the Plan. The terms and conditions state that the Provider will deallocate units of the pension fund to cover the costs of providing the life and disability cover. The Provider says that the Complainant has accepted there was a cost associated with the protection benefits.

The Provider states that the Independent Adviser continued to act on behalf of the Employer until May 2003. It was not until December 2012 that a new financial adviser was appointed by the Employer and the Provider says it does not accept a letter notifying of the cessation of another independent adviser and an intention to deal with the Provider directly amounts to an appointment of the Provider as a replacement adviser. The Provider says that the formal appointment of a Provider adviser in 2012 clearly indicates such an intention at that time.

The Provider states that as set out in the Plan terms and conditions, the Provider reserved rights to take action in the event the value of the pension fund at any point in time was less than the cost of benefits under the Plan. The Provider says it gave no indication, however, that it would assess mortality charges in light of contributions being paid. The Provider states that, the cost of benefits did not exceed the value of the fund at any time.

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Additional submissions from the Complainant and the Provider

The Complainant's submission of 24th September 2018

"The fact remains that the provider failed to provide the complainant or his employer with the detailed breakdown as to how the provider was apportioning the premia paid in respect of the plan between its different constituent parts.

It owed a fiduciary duty to do this and did not do so, until requested.

The provider did not make the complainant aware of the implication of the interaction between the fund and the cover or when the cost of providing the benefit under the policy first exceeded the premium payments being made. It was not apparent from the annual statements and/or policy review correspondence sent by the provider to the complainant. The provider had a duty to tell the complainant that the cost of cover had exceeded the premium payment and that the pension fund value was in fact being relied upon to cover the excess cost. The correspondence was misleading. As a result of poor transparency on the behalf of the provider, the complainant did not have the full information concerning the policy, which if he had, he could have made informed decisions.

The provider had a duty to advice the complainant as to how the premia were being apportioned. Instead, it sent him out letters indicating that if he increased premium it would ***'boost your eventual retirement fund'****.*

It would seem to the complainant, had he not requested specifically the detail of the allocation of the premium, that the provider would only have advised it once the provider would have exhausted the pension fund".

The Complainant's submission of 30th October 2018

"[The Provider] is aware that it had / has under the Consumer Protection Code 2006, an obligation:

"to ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information". [chapter 2, No 12 of CPC 2006]

[The Provider] is seeking to hide behind its assertion that the Occupational Pension Schemes (Disclosure of Information) Regulations 1998, whilst requiring it to include the level of life cover in the annual benefit statement, do not require it to include the cost of the said same cover. [Where a pension scheme is constituted in trust the trustees are considered to be consumers for the purposes of the Code -- CPC Clarifications July 2007]

[The Complainant] categorically rejects this. The cost of the cover is a key item, which [the Provider] was obliged to bring to the attention of [the Complainant] in a clear unambiguous manner. It failed to do so.

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As the FSOB is no doubt aware, under the Consumer Protection Code 2012,

> *3.19 A regulated entity is prohibited from bundling except where it can be shown that there is a cost saving for the consumer.*
>
> *3.20 Prior to offering, recommending, arranging or providing a bundled product, a regulated entity must provide the consumer with the following information on paper or on another durable medium: a) the overall cost to the consumer of the bundle; b) the cost to the consumer of each product separately; c) how to switch products within the bundle; d) the cost to the consumer of switching products within the bundle; e) how to exit the bundle; and f) the cost to the consumer of exiting the bundle.*

[The Provider] can argue that it was not obliged to disclose the cost to [the Complainant] of each product separately as the product was sold prior to the introduction of the Code. However, it is clear that [the Complainant] was still a consumer within the meaning of that term since the introduction of the Code and that [the Provider] had an obligation to him to amend the way it which it communicated with him so as to ensure that it was providing him with the cost of each constituent element of the bundle. This, it singularly failed to do and did the converse in obscuring the cost and the funding of the cost from [the Complainant].

Over the last three years, we have set out our client's position and the failings of [the Provider] in relation to our client".

The Provider's submission of 8th November 2019

"As set out previously, the Plan in which [the Complainant] was a member was an occupational pension scheme established under trust, approved by Revenue and registered with the Pension Authority. The Plan was sold to [the Complainant's] employer by [the adviser], an independent broker.

The Central Bank have confirmed in various clarification documents that the provisions of the Consumer Protection Code do not apply to revenue approved occupational pension schemes which are constituted under trust. While [the Complainant's] solicitor has correctly pointed out that the trustees of an occupational pension scheme are considered consumers for the purposes of the code, the clarification documents issued by the Central Bank in July 2007 and December 2012 confirm that the '...Code does not apply to Revenue approved occupational pension schemes that are the responsibility of the Pensions Board '

As such, disputes arising in relation to the operation and administration of the Plan are not subject to the provisions of the Consumer Protection Code, but are instead dealt with by way of the internal dispute resolution procedures provided for under the Pensions Act. While the sale of the Plan is not governed by the provisions of the Pensions Act, it is important to reiterate that the Plan was sold to [the Complainant's] employer by an independent broker and the sale took place in 1990 which was many years prior to the introduction of the code. We are not privy to how the Plan was sold.

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We have enclosed a copy of the relevant section of both the 2007 and 2012 clarification documents issued by the Central Bank for your ease of reference. In relation to pension schemes, the clarification documents confirm the scope of the Consumer Protection Code to be as follows: 'The Code applies to the provision of pension products, including PRSAs... The Code does not apply to revenue approved occupational pension schemes that are the responsibility of the Pensions Board - Where a pension scheme is constituted in trust the trustees are considered to be consumers for the purposes of the Code'.

As previously set out, the information included in an Annual Benefit Statement is as set out in the Occupational Pension Schemes (Disclosure of Information) Regulations 1998 (as amended). These regulations require the level of life cover benefit to be included in an Annual Benefit Statement. They do not require the cost of those benefits to be disclosed".

The Complaint for Adjudication

The complaint is that the Provider maladministered the Complainant's Executive Pension Plan:

- wrongfully allocated the monthly contributions to the Plan to maintain Permanent Health Insurance cover and Death Benefit without authorisation and without reasonably informing the Complainant of same;
- wrongfully used some of the Complainant's accumulated pension fund to pay for Permanent Health Insurance cover and Death Benefit;
- misrepresented or did not reasonably communicate how it had allocated the premium paid each year in its Annual Benefit Statement.

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.

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A Preliminary Decision was issued to the parties on 22nd 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 Complainant's Plan was an Executive Pension Plan. However, it is evident from the documentation and the Terms and Conditions that the plan also provided Life Assurance and Permanent Health Insurance. This means that any payments that were made into the plan are used to cover the cost of providing the additional benefits under the plan. Under section 10 the Provider is allowed to calculate the current mortality charge in respect of any Sum Assured. Premium payments for life cover is generally based on a number of factors including age, sex and smoking habits of the Life Assured.

What would have been helpful here for the Complainant (as is found in similar products with other Insurers) is a table of benefits included in the terms and conditions which sets out the Life Assurance Rates per €1,000 of Death Benefit from a specified age to another older specified age. Such a table would have indicated to the Complainant how the cost of cover increases every year.

I accept that the evidence shows that on a number of occasions over the years the Provider outlined the charges under the Pension Plan at the Broker's request. The Complainant does not appear to have further queried the cost of the cover following the removal of the Broker.

The evidence shows that the cost of life cover had increased (from when the policy was taken out in 1990) from 7.78% of the Total Regular Premium to 92.78% of the Total Regular Premium (in 2012). At that point in 2012 the difference between the Total Regular Premium and the Life Cover + Permanent Health Insurance was a minus figure of -€1,398.35. The position at this point was that there was no element of the Total Regular Premium going towards the Pension itself. This position appears to have first occurred from 2008 when the difference between the Total Regular Premium and the Life Cover + Permanent Health Insurance was a minus figure of -€23.45. This minus figure would have been deducted from the pension fund, so not only was there no payment going towards the pension, the shortfall in what was required for the Life Cover and Permanent Health Insurance was reducing the pension fund that was to be available for the Complainant's retirement.

The Complainant has pointed to correspondence from the Provider in relation to the indexation increases where it advised that increasing the premiums would help to boost

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the eventual retirement fund and ensure the benefits are not diminished by inflation. Those Indexation letters stated:

> *"Choosing to increase the contribution will help to boost your eventual retirement fund, and ensure that the benefits your plan provides when you retire are not diminished by the effects of inflation".*

The Complainant states that the Provider clearly led him to believe that the premiums after indexation would not only be sufficient to cover the benefits promised, but would even boost his eventual retirement fund.

It is the Provider's position that having reviewed the file in full it is satisfied that the plan has been administered in line with the Terms and Conditions of the plan.

I accept that the documentary evidence does not indicate that the cost of providing the benefits would remain fixed, but that the costs involved in providing the Complainant with the benefits increased over the years and upon the indexation of the premiums.

It is clear that the Complainant signed up for the Pension Plan with Life Cover and Permanent health Insurance when the Plan was taken out in 1990.

The Provider would not be responsible for any alleged act or omission of the Independent Broker who arranged the policy.

I accept that from a review of the documents which were provided to the Complainant when he took out the plan that these documents confirmed how the plan works.

I accept that the costs for maintaining the benefits were to be taken by unit deduction from the fund value and the cost of providing these increased as the Complainant grew older and with indexation increases. In that regard the Provider has administered the plan in line with the Terms and Conditions. While I note that the Provider states that the Plan is not subject to the provisions of the Consumer Protection Codes, I do consider that the Provider could have reasonably provided greater information over the years on the increasing cost of the benefits provided under the plan. The Provider has pointed to instances where it did provide this information. These instances are intermittent in nature. It is noted that for the most part, the Provider only communicated this information when it was specifically sought by the Broker or Employer over the years. I consider that the fact that the life cover cost was increasing to such an extent that there was little or no contributions going towards the Pension Fund itself was important information that could and should have been communicated more fully and on a more frequent basis over the years. While I consider this positon, I am also mindful that the Complainant through his Broker should have had knowledge of what was happening up to the time that the Broker was taken off the policy and there does not appear to have been any remedial action taken then. I accept that the Complainant had the benefit of independent advice from his Broker for a time and the Broker was aware of how the policy was operating.

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Overall, I consider that this is a dispute where there could have been better and greater communication between the parties on how the Plan was performing and in relation to the allocation of the payments into the plan.

I accept that a key item of information, that is the cost of the life cover in comparison to what was going into the pension fund, should have been communicated more fully here by the Provider on a more regular basis. I also consider that when the premium for the additional benefits exceeded the amount going towards the pension itself, this should have been clearly notified to the Complainant.

I do not consider that any charges should be refunded. This is because the Provider was acting in accordance with the Terms and Conditions of the plan which the Complainant and the Provider entered into. The Complainant also had the benefit of the Life Cover and PHI Cover over the years, and that cover had to be paid for. The evidence does show that this was information that could be obtained, if specifically sought. In that regard, I consider that if this was advised at any point over the years, that is, that the particular information was available on request, it may have prompted greater and earlier enquiries by the Complainant. I would point out that the decreasing pension value cannot be solely put down to the charging structure, but its performance in investment terms may also have contributed to the low value of the fund. The examinable complaint is whether the Provider correctly or reasonably communicate the benefit charges that were being deducted from the overall payment on annual basis. In this regard, I accept that a compensatory payment is merited for the lack of greater communication from the Provider on the actual allocation of the overall premium payments over the examinable years. This lack of communication was an ongoing conduct.

Having regard to all of the above it is my Legally Binding Decision that the complaint is substantially upheld and that I direct the compensatory payment of €15,000 (fifteen thousand euro).

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 make a compensatory payment to the Complainant in the sum of €15,000, 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.

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- 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

26 September 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.**