An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0323
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Misrepresentation (at point of sale or after)
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint centres around the administration of a Whole of Life policy which the Complainant took out in 1987. At a review of the policy in 2017 the Provider advised of the need for a substantial increase in the premium payments or to continue paying the premium at €92.02 and reduce his benefits.

The Complainant was unaware that the premium payments he was paying was not enough on their own to cover the cost of life cover. The Provider had been supplementing the cost of cover from the policy fund without the Complainant's knowledge or express consent.

The Complainants Case

The Complainant states that in 1987 he purchased an insurance policy with the Provider which would provide both life cover and an investment fund which would appreciate over time.

The Complainant states that he received a letter from the Provider dated **7 April 2017** which set out that a policy review had been carried out

> *"the results of the review indicate that if you wish to maintain your present level of benefits you must increase your premium"*

The Complainant states that the Provider *"demanded in excess of a threefold premium increase"* as one of the options open to him after the Provider had carried out a policy review.

The Complainant states that this letter came as a surprise and disappointment to him, and though he complained to the Provider on **23 April 2017** about the policy contract, terms and conditions, he did not receive a satisfactory resolution.

The Complainant further states that the Provider's final response letter dated **15 May 2017** is *"riddled with factual inaccuracies".* The Complainant details these inaccuracies as follows

> *"the initial premium did not sustain the policy for the initial 10 years – indexation commenced, at the Service Provider's instigation after 5 years;*
>
> *It was asserted by the Provider that this is a flexible whole of life policy. This was news to me and I could find no reference to that particular expression in the policy"*

The Complainant contends that the most shocking aspect of the final response letter was that it was the first time he had been made aware that the policy premiums were insufficient to meet the cost of the life cover, and that the Provider had begun to supplement the cost of cover from the policy fund without the Complainant's knowledge or express consent.

The Complainant submits that the terms and conditions of his policy require full disclosure of all material information and that this requirement should apply to both contracting parties. He contends that the Provider failed to appraise him clearly and directly of any material changes to the contract and failed to appraise him of the intended material changes. The Complainant states that the Provider did not seek his agreement or consent to any changes in the contract, and the Provider denied him the opportunity to make an informed decision on whether the actual policy cost was worth the benefit.

The Provider's Case

The Provider states that the Complainant took out a reviewable unit linked protection policy with the Provider on the life of his wife. The initial cover provided by the policy was life cover of £40,000 (€50,794) for a monthly premium of £20.00 (€25.40).

The Provider states that the policy can provide cover for the whole of the life insured's life provided premiums, which are reviewable, are paid.

The Provider further states that the policy is subject to periodic reviews in accordance with the policy conditions. Condition 10 of the policy conditions set out that reviews take place on the 10th anniversary of the policy and each 5th anniversary thereafter until the life insured reaches 70 when reviews are annual thereafter. Condition 10 of the policy terms and

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conditions further provides that the Provider, acting through its Actuary, shall at the time of review, take factors into account to determine if the policy can continue to provide the basic sum assured until the policy is next reviewed.

The Provider states that Condition 10 states as follows:

> *"In the course of each Policy Review the Actuary at his sole discretion shall decide the Maximum Optional and Minimum Optional Basic Sum Assured which shall be available under this policy up to the new Policy Review Date. Such optional sums will be decided having regard to the then Encashment Value of the Policy and such other conditions as the Actuary at his sole discretion shall deem relevant. If the basic sum assured on the policy review date exceeds the revised maximum or, at the option of the legal owner of the Policy, the basic regular premium shall be increased on such date to such amount as the Actuary at his sole discretion shall decide".*

It is the Provider's position that the first scheduled review of the Policy took place in April 1997. The Provider wrote to the Complainant on 12 April 1997 and advised that the monthly premium of £26.81(€34.05) which was being paid into the Policy at that time was sufficient to maintain the level of cover on the policy for another five years, when the next review was scheduled to take place under the policy conditions.

The Provider states that the review letter provided the Complainant with the option to increase the monthly premium in order to increase the future value of the policy. The review letter in April 1997 reflected a policy value of £2,173 as at **19 March 1997.**

The Provider states that the second scheduled review of the policy took place in July 2002. The Provider wrote to the Complainant on **9 July 2002** and advised that the monthly premium of €43.83, which was being paid into the policy at that time was sufficient to maintain the level of cover on the policy for another five years. The review letter provided the Complainant with the option to increase the future value of the policy. The review letter in July 2002 reflected a policy value of €6,185 as at **8 May 2002.**

The Provider states that the third scheduled review of the policy took place in February 2007. The Provider wrote to the Complainant on **22 February 2007** and advised that the monthly premium of €53.28 which was being paid into the policy at that time was sufficient to maintain the level of cover on the policy for another five years. The review letter also provided the Complainant the option *"to increase your premium either to enhance future surrender values or to sustain the present level of life cover for a longer period".* The review letter in February 2007 reflected a policy value of €8,721 as at **13 February 2007.**

The Provider states that the fourth scheduled review of the Policy took place in March 2012. The Provider wrote to the Complainant and advised that the monthly premium of €68.68 which was being paid into the policy at that time, was sufficient to maintain the level of cover for another five years. The Provider states that the Complainant was again provided with the option *"to increase your premium either to enhance future surrender values or to sustain the present level of life cover for a longer period".* The review letter in March 2012 reflected a policy value of €6,116 as at **24 February 2012.**

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The Provider states that this demonstrates that the policy had decreased since the last review had taken place. The Provider states that at this time, it asked the Complainant to give the review letter his close attention and the Provider invited the Complainant to contact his advisor if he had any questions. The Provider notes that the Complainant did not make contact at this time.

The Provider states that an annual statement issued on **11 June 2013** to the Complainant reflecting the policy value had decreased to €5,992.25 as at **7 June 2013.**

A further annual statement was issued on **12 May 2014** to the Complainant reflecting the policy value had decreased to €5,560.43 as at **8 May 2014.**

The next annual statement issued on **26 May 2015** to the Complainant reflecting the policy value had decreased to €5,067.35 as at **14 May 2015** and included a table setting out how the life cover cost exceeded the premiums being paid at the time. The Provider notes that the Complainant has indicated that he did not read this table at the time, however, the Provider states that its covering letter recommended that the Complainant take time to read the table.

The fifth scheduled review of the policy took place in April 2017. The Provider wrote to the Complainant on **7 April 2017** to advise that to maintain the level of cover on the policy at that time the premium would have to be increased. The review letter provided the Complainant with two of the options that were open to him at that time. These options were:

> *"Increase your premium to €371.25 per month with effect from 1 May 2017. This will allow your benefits to continue at their current level for a further 5 years.*
>
> *Or*
>
> *Leave your premium at €92.04 per month and reduce your benefits from 1 May 2017 to: [Complainant's wife] Life Cover of €62,782*

The review letter in April 2017 reflected a policy value of €2,429 as at **2 March 2017.**

The Provider states that the Complainant submitted a complaint to the Provider relating to the policy review carried out in April 2017 and requested that while the matter was being investigated the life cover benefit under the policy remain at the higher level of €182,139. The Provider states that the Complainant's life cover benefit automatically reduced in July 2017.

The Provider notes that it wrote to the Complainant on **10 July 2017** to advise that life cover benefit had been reduced without reference to his letter of complaint or explaining why it did not hold the level of benefit until his complaint had been dealt with.

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The Provider states that as it failed to deal with the Complainant's request to maintain the higher level until his complaint had been dealt with and the fact that its complaint response contained a number of errors, it would be happy to cover the difference between his current premium and the higher premium required to sustain cover of €182,139 between now and when he meets with an advisor to consider a new policy or until the end of December 2019, whichever is earlier.

The Provider estimates that this will benefit the Complainant in an amount of up to €3,629.73.

The Provider states that when the cost of the life cover exceeds the premium amount the fund value is used to offset the remaining costs of the life cover benefit. The Provider further states that the Complainant was invited to increase his premiums if he wished to build his fund value but he did not do so over the years.

The Provider states that the policy review letters issued since 2012 indicated that the fund value was decreasing and annual statements issued since 2013 reflected this was the case.

The Provider states that as per the review letters sent to the Complainant over the years, to enhance the value of the policy premium increases were recommended. No premium increases took place in the first 30 years which resulted in the fund value eroding to offset the increasing cost of the life cover.

The Provider accepts that there were some inaccuracies in its letter to the Complainant dated **15 May 2017** and the Provider apologises for the errors in its response.

The Complaint for Adjudication

The complaint for adjudication is that the Provider did not clearly and directly convey to the Complainant that the policy fund would be used to offset the increased cost of the benefits of the policy, that the Provider did not administer the policy in accordance with its terms and conditions, that the Provider did not accede to the Complainant's request to keep the monthly premium and benefits at their current level until the dispute was resolved and that the Provider did not handle the Complaint's complaint in a satisfactory manner.

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.

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

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

A Preliminary Decision was issued to the parties 23 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.

Following the issue of my Preliminary Decision both parties made the following submissions:

1. Letter from the Complainant to this Office dated 29 July 2019.
2. Letter from the Provider to this Office dated 16 August 2019.
3. E-mail from the Complainant to this Office dated 20 August 2019.
4. Letter from the Provider to this Office dated 16 August (received 27 August 2019).
5. E-mail from the Provider to this Office dated 22 August 2019.
6. E-mail from the Complainant to this Office dated 28 August 2019.

All of these submissions were exchanged between the parties.

Having considered these additional submissions, and all of the submissions and evidence furnished to this Office, I set out below my final determination.

I accept that the policy document outlined the policy features. The Provider was entitled to review the policy. The Provider was entitled to use the policy fund to supplement the cost of benefits specifically where the premium payments were not meeting that cost. I accept that the documentation sent to the Complainant in respect of their policy did not set any expectation that the protection benefits and premium would remain at the same level throughout the lifetime of the policy.

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However, there have been lapses by the Provider in how it has administered the policy over the years, in particular in relation to communications with the Complainant on the administration of the policy.

Having reviewed the express wording of the policy terms and conditions, I accept that the Complainant was on notice from the time of the commencement of the policy that the policy would be reviewed by the Provider's Actuary on the tenth anniversary of the policy and every 5 years thereafter up to the life assured reaches 70 years of age. The Actuary was to determine during each review process the value of the policy unit account to assess if the level of cover could be maintained at the existing premium until the next scheduled review or whether it was necessary to increase the premium to maintain the level of benefit.

In a post Preliminary Decision submission dated 29 July 2019, the Complainant asserts an error of fact in my Preliminary Decision stating that this office had been misled by the Provider. He points out that in the original Conditions of the policy document from 1987 that there is "***POLICY PREVIEW DATE***" in Condition 10. I have reproduced the full text of Condition 10 below. It can be seen from the reproduction of Section 10 that under the heading "***POLICY REVIEW***" the term "*Policy Review*" appears three times and the term "*Policy Preview*" appears once.

In its letter of 27 November 2018 to this Office the Provider, has written "*Review*" instead of "*Preview*" when replicating Condition 10 as set out in the Provider's Case on Page 3 of this Decision.

The Complainant, in his post Preliminary Decision submission has asserted that this was a deliberate attempt by the Provider to conflate two distinct processes and obligations on the Provider which it has not discharged since one is retrospective and the other forward-looking.

While it is unfortunate and unacceptable that the Provider furnished incorrect wording when quoting Condition 10 of the Policy, I do not believe that this was a deliberate attempt to mis-inform this Office.

I have reproduced Condition 10 below.

10. POLICY REVIEW

> *""Policy Review Date means the tenth Policy Anniversary, each succeeding fifth Policy Anniversary up to the attainment of age 70 years by any Life Assured, each Policy Anniversary thereafter, the date of each Part Encashment, the date of suspension or increase/decrease of Total Regular Premium and the date of exercise of the options provided by Conditions 5.1, 23 and 24.*

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> *In the course of each Policy Review the Actuary at his sole discretion shall decide the Maximum Optional and Minimum Optional Basic Sums Assured which shall be available under this Policy up to the next Policy Review Date. Such optional Sums will be decided having regard to the then Encashment Value of the Policy and such other considerations as the Actuary at his sole discretion shall deem relevant. If the Basic Sum Assured on a Policy Preview Date exceeds the revised Maximum Optional Basic Sum Assured, the Basic Sum Assured shall be reduced to such revised maximum or, at the option of the legal owner of the Policy, the Basic Regular Premium shall be increased on such date to such amount as the Actuary at his sole discretion shall decide. If the Basic Sum Assured is reduced the Accident Benefit shall be reduced to such amount as the Actuary shall decide".*

I would point out, and as can be seen from the wording above, all other references to the Policy Review in the Policy Document and in the complaint file at all times refer to "review" of the policy rather than a "**preview**" of the policy. Therefore I do not believe that I have in any way drawn incorrect conclusions from this one reference to previews. That said, I believe it is both unfortunate and unacceptable that the Provider would not be more careful in setting out such matters. Furthermore, I note the response by the Provider dated 16 August 2019 to the Complainant's post Preliminary Decision submission of 29 July 2019 states:

> "*Our use of the word "review*" as opposed to "*preview*" *when quoting condition 10 of the policy conditions was entirely accidental and in the context of the policy conditions we do not see how the word "preview*" *could be interpreted differently than that of "review*"".

While I am willing to accept that the word preview was accidentally substituted for the word review when the Provider was quoting Condition 10, I find it most disappointing that the Provider would seek to suggest that the words preview and review could not be interpreted differently. I believe the two words have significantly different meanings in any context. That said, given the entirety of the documentation surrounding this complaint, I accept that the one use of the word preview in the document does not alter the Provider's obligations in relation to the reviews which should have been carried out in relation to this policy.

I accept that the value of the Complainant's policy could rise or fall and it was not a guaranteed value. I also accept that there is no policy requirement for the Provider to alert a policyholder when the fund fluctuated in value, other than by way of providing this information in the periodic annual statements.

I believe that where the drop in value of the fund was because of the need to supplement the cost of cover, direct and clear communication of this should been furnished by the Provider to the Complainant.

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It was only in 2015 that the Provider included transactional details such as policy charges and life cover cost together with investment return over the period. It was also the first time that the Complainant was informed that:

> *"the value of your policy, if any, will be used, in addition to your premium payments, to fund the cost of providing the protection benefits over time".*

I consider that during the administration of the policy the Provider incorrectly issued statements to the Complainant as to the adequacy of the premium payments being paid.

In the policy review letter dated **12 April 1997** from the Provider to the Complainant set out:

> *"having carried out the review, we are pleased to say that no revision of your policy is required. Your premium will continue to support your present level of life cover until 1 August 2019".*

In the policy review letter dated **9 July 2002** from the Provider to the Complainant it assured the Complainant that:

> *"We have carried out a policy review to determine if the current premium is sufficient to maintain the current level of life cover for the next five years. We are pleased to inform you that this is the case".*

In the policy review letter dated **22 February 2007** from the Provider to the Complainant it again set out:

> *"We have carried out a policy review to determine if the current premium is sufficient to maintain the current level of life cover for the next five years. We are pleased to inform you that this is the case".*

In the policy review letter dated **14 March 2012** from the Provider to the Complainant:

> *"We have carried out a review to ensure that your current premium is sufficient to maintain your current level of benefits for the next five years. We are pleased to inform you that this is the case".*

These statements were issued on a number of occasions by the Provider to the Complainant over the years when in fact it had been using the policy fund in addition to the premium payments to provide the benefits.

I accept that this would have caused confusion for the Complainant.

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The Complainant has sought by way of remedy in his overall complaint, a full refund of all premiums paid to date or for the investment fund to be restored with interest. I accept that the Complainant has paid a substantial amount in premiums, but it is the case that the Complainant had the benefit of life cover over that period (which could not be provided without a cost).

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

I find that the policy document outlined the policy features. The Provider was entitled to review the policy. However, I consider that there have been lapses by the Provider in relation to how it communicated actions on the policy over the years, in particular in relation to communicating with the Complainant on how it was managing the policy relative to the increasing cost of cover and the need to supplement the premium from the fund.

Following the review of the Complainant's policy in April 2017 where he was given two options of either increasing his premium to €371.25 or leave his premium at €92.02 and reduce his benefits. I note that the Complainant wrote to the Provider on **23 April 2017** and requested that while the matter was being investigated the life cover benefit under the policy remain at the higher level of €182,139. The Complainant did not receive a satisfactory response to this request and his life cover benefit was automatically reduced in **July 2017**. I further note that the Provider has apologised for this however, I find that such a level of customer service falls below the level reasonably expected by a policyholder.

Clear communication of the true cost of cover in comparison to what was being paid in premiums should have been communicated to the Complainant. The Complainant should have been informed that the fund value was decreasing because the fund was supplementing the cost of cover. This would have allowed the Complainant fully to consider his options in respect of his policy.

In light of the above, I find that it was unacceptable for the Provider to not specifically inform the Complainant earlier that the actual cost of cover had begun to exceed the payment, and the reason the fund was decreasing in value was because the excess cost of the benefits was being deducted from the fund.

I consider that the need for the fullest disclosure of information on a policy is particularly important especially when the policy relates to life assurance cover.

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For the reasons set out above, I partially uphold the complaint in that the Provider failed to clearly inform the Complainant that the fund was being used to supplement the cost of the cover and that the Provider did not provide a satisfactory level of customer service to the Complainant. I direct the Provider to make a compensatory payment of €5,000 to the Complainant.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2) (b).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €5,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider.

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

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 October 2019

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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.