An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0331
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Delayed or inadequate communication
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns the Review of a Whole of Life Policy held with the Provider against which the complaint is made. The Policy was taken out in 1993. The policy was taken out through a Bank branch and it is the Provider's position that the Bank was responsible for the sale of the policy and for any advices that should have been given about the workings of the policy. The Complainant did make a complaint to the Bank, but says that the complaint was not successful.

As regards the Complainant's allegations in relation to the sale of the policy in 1993, that is that the policy document was not provided from the outset to the Complainant, or that the initial allocation charge was not explained, these allegations are not being examined due to the passage of time.

The examinable complaint against the Provider is whether it correctly administered the policy, particularly in relation to the Review of the policy over the years.

The Complainant's Case

The Complainant states that in 1993 he took out the Life Policy which he states has now become worthless. The Complainant says that the policy was valued at approximately €38,000 up until 10 January 2017.

The Complainant says that he did not receive a letter from the Provider dated 9th November 2016 stating changes were required to the Policy to maintain the value.

The Complainant submits that the Provider was demanding his monthly subscription, be increased threefold, from €51.30 to €177.05 and that a failure to do so would result in the Plan lapsing without benefits as set out in the terms and conditions.

The Complainant says he complained to the Provider by telephone, but to no avail and then by email on the 24th January 2017, requesting terms and conditions as relied upon. The Complainant's position is that he did not receive any Plan Document / terms and conditions at the outset of the policy in 1993.

The Complainant states that it only came to light when he complained of the value of his policy that in fact it was misrepresented to him as he was never advised nor told that the first 15 months of the policy payments were commission only. The Complainant says that in response the Provider has stated that this is an issue for the Bank that set up the policy. The Complainant submits that a complaint was made to the Bank on 31st March 2017, but to no avail.

The Complainant says that as it stands he took out a Life Policy valued at €38,004, and paid approximately €14,480.71 to the Provider over the last 20 years and he is now told the value of the policy is €7,105 and that it will cease without benefit because he refuses to increase the monthly subscription to €155.00 per month for a Life Policy valued at €12,578. The Complainant says that it makes no financial or economic sense to do so. The Complainant states that he would expect far greater returns for such increased monthly payments in today's economy.

The Complainant submits that he cannot understand how the Provider, a large Assurance Company has failed to make a profitable investment on any of the funds which he paid over twenty years and as experts in the field of investing did not take evasive action as a result of their failed investments.

The Provider's Case

The Provider states that the Complainant's plan was a unit-linked, whole of life protection plan. The plan is designed to provide protection benefits for the duration of the Complainant's life, as long as the required payment is paid.

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The Provider states that when the regular payment is received, the Provider would purchase units in the selected fund (in the Complainant's case, the Provider's Balanced Fund). The Provider says that it would then surrender sufficient units to cover the cost of the benefits and plan fee each month. The remaining units made up the value of the plan on any given day. The Provider states that this process of unit deduction was set out in Condition 9 of the Plan Documents.

Plan Document

> *"9 Policy Charges*
> *A. Once every month on a date the company shall determine, a number of units shall be deducted from the protection account, which at their bid price shall represent the Policy Charges for the current month.*
> *D. Policy charges shall include charges in respect of:*
> *(i) The administration of this policy, for which shall be determined from time to time by the Company;*
> *(ii) Provision for the payment of the Policy Benefits; the charge for these benefits shall be determined by applying rates to the excess, if any, of the sum assured over the policy value and where applicable, to any waiver of premium benefit.*
> *(iii) Any levies or duties payable by the Company".*

The Provider submits that when the plan started, the payments were calculated based on the Complainant's age, health, gender and the level of cover being applied for. The Provider says that with a whole of life plan such as this, it is not possible to factor in the maturity date of the benefits, as to do so over a person's entire lifetime would be too costly. The Provider states rather, it is deemed more beneficial for payments to be set for a certain period, and then to conduct reviews on a regular basis to see whether the payments are still sufficient to cover the cost of the benefits in place. It is for this reason that the Provider carried out Plan Reviews on whole of life protection plans.

The Provider states that in the case of the Complainant's plan, the governing terms allow for a Plan Review after the first ten years and every five years thereafter. However, the plan can be reviewed yearly once the life covered has reached age 70 (this it says was explained in Condition 11 of the Plan Document).

The Provider states that while it notes the Complainant feels the proposed increases following Plan Reviews in recent years have been excessive, it feels it is important to note the risk associated with providing life cover increases as people age.

The Provider submits that the cost of any insurance is directly linked to the risk associated with a claim being made. With life assurance plans, the risk involved is the death of a customer. The Provider says that the cost of cover reflects this and therefore, the level of payment increases required, in order to maintain cover into older age, can be much higher. In this regard the Provider refers to the Mortality Table below, which shows how mortality rates increase as we age.

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Age	Deaths per thousand of population *
30	0.6
40	1.1
50	2.5
60	6.3
65	10.3
70	17.3
75	29.9
80	52.8

* Irish population mortality 2010 - 2012 (from IL T16 table as published by the Central Statistics Office)

The Provider states that for example, the number of deaths (mortality rate) amongst those aged 75 (the Complainant's approximate age) is more than 11 times that of those aged 50 (the Complainant's approximate age when he applied for the plan).

The Provider's position is that the cost of providing the Complainant's life cover (and the proposed increase in payments outlined to him), reflect this.

The Provider states that should the plan reach a point where both the existing fund (the plan value) and the regular payment, are no longer sufficient to cover the cost of providing the benefits, there is a need to adjust the regular payment or the benefits provided. The level of adjustment required, is what the Provider must determine, when carrying out a Plan Review.

The Provider says that should it be determined the plan cannot continue at its current levels until the Plan Review Date, the customer will be given the option to either increase their existing level of cover, to that which can sustain the existing level of life cover, or reduce the level of life cover, to that which can be sustained by the existing payment.

This was outlined in Condition 11 of the Plan Document which states:

> *"d. The purpose of the review shall be to assess whether Units then remaining allocated to the Protection Account and any Units to be allocated thereto in respect of Premiums which may fall due to be paid in the future shall be sufficient to support the Policy Charges until the next scheduled Policy Review. In making such assessment, the Company shall be entitled to take into account such factors as it shall (at is absolute discretion) consider relevant. Following the review the Company may recommend one or more of the following options should be exercised by the policyholder;*
> *(i) that future Premiums are increased; and/or*
> *(ii) that Policy Benefits are reduced".*

The Provider states that in the event that the customer decides not to opt for the recommended increase in payment (or decrease in life cover), and the total plan charges

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come to exceed the plan value, then the plan will automatically cancel and the attaching benefits will cease. This was outlined in Condition 11, d (ii), of the Plan Document where it states;

> *"11 d (ii)*
> *.. if the policyholder does not exercise either of these options, and at some subsequent point in the future, the policy charges exceed the policy value, then this policy shall automatically terminate at the said date and all policy benefits provided hereunder shall be cancelled".*

The Provider states that it is important to note at this stage that while it is the responsibility of the financial adviser to fully explain all aspects of a product (to a customer), it is the responsibility of the customer to ensure that they read all documentation / literature, provided, to ensure that they fully understand and are happy with, the contract which they have entered into.

The Provider says that if, having read through the documentation, it was the Complainant's belief that any of the information contained (such as the fact that his plan would be reviewed and the initial level of payment / life cover was not guaranteed throughout his life), contradicted that which he had been led to understand by his financial adviser, it would be the Provider's expectation that he would have contacted either his financial adviser or the Provider, for clarification.

The Provider says that while it is unable to state if the Complainant did in fact contact his financial adviser (after reading through the documentation), it states that the Provider has no record of such contact being received.

The Provider says that it understands from the submission, it is the Complainant's belief that he did not receive his Plan Document in 1993. The Provider says however, its Schedule of Evidence, includes both a copy of the Complainant's Application Form and the cover letter which accompanied the Plan Document which was sent to him at the time. The Provider states that it will be noted that the documentation, setting out the governing terms, were sent to the address provided by the Complainant some two months prior to them being sent and which was not changed by the Complainant until January 2017. The Provider says therefore, it is satisfied that the Complainant was made aware exactly how his plan worked and that following a review of his plan he may be asked to either increase his level of payment or reduce his level of life cover. The Provider states that while it acknowledges these changes may be unwelcome to the Complainant, the required changes were a fair reflection of the increased cost to the Provider, in providing him with life cover.

The Provider's positon is that it is also satisfied the Complainant was made aware that failure to choose one of these options could result in the cost of the plan exceeding the value in the fund. In the event this was to happen, the plan and its benefits would be cancelled.

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In relation to the Complainant's claim he did not receive the Provider's letter dated 9 November 2018, which set out the Plan Review Options sent to him at that time, the Provider states that it feels it is important to note the following;

- It is standard practice for An Post to return any correspondence they have been unable to deliver; however, the Provider states that this letter was not returned as undelivered to the Provider;
- The letter in question was sent to the address provided by the Complainant in 1993 and which he confirmed in a telephone call on 18 January 2017, was the address of his office;
- The Complainant also advised during this telephone conversation, *"that everything had been going there"* (to the office address);
- The Provider wrote to the Complainant on numerous occasions over the years (at this same address), setting out the fact that in the event that he chose not to avail of the proposed payment increases, his plan could not be maintained long term and as such, the plan and its benefits would be cancelled; and
- The last letter issued to the Complainant prior to 9 November 2016 (in May 2016), advised, estimates showed that at its current levels of payment and life cover (along with the value in the plan), the plan could not be maintained for more than six months past the effective date of the Plan Review (1 July 2016). Therefore, unless action was taken by him, the plan and its benefits would be cancelled. The Provider says the Complainant was therefore, advised that in order to maintain the plan at its current level of life cover, until the next Plan Review in July 2017, the payment would need to be increased to €107.55. Alternately, he could increase his payment to €164.33 and maintain the life cover until age 75.
- However, no contact was received from the Complainant despite the contents of the May 2016 letter. Rather, the Complainant did not contact the Provider until after his plan went out of force in December 2016.

The Provider says that while it is unable to offer an explanation as to why this particular letter was not delivered as directed, it is clear the Complainant was aware that his plan was subject to reviews (from the Provider's various letters over the years) and the level of increase in payment which was required in order to maintain his plan until the plan was due to be reviewed again in July 2017 (from the Provider's letter dated May 2016).

The Provider's position is that taking all of the above into consideration, the Provider feels the complaint should not be substantiated on either of the grounds raised by the Complainant.

The Provider states that being said, it acknowledges the initial Plan Review in 2005 was carried out two years later than scheduled. The Provider submits that while it is clear the Complainant was not financially disadvantaged by the delay (as no change was proposed when it was reviewed), it is offering the Complainant €500 in respect of the delay. The Provider states that in addition, it is offering a further €500 in respect of the fact that the level of life cover noted in the Plan Review Options provided in February 2017, was incorrect. This error resulted in the value of the plan expiring prior to the date of the 2017 Plan Review, following which the Provider applied €337.49 to the plan to correct the unit holding. The Provider states that these offers are exclusive of the €337.49 applied to the plan in July 2017 and the six months payments (total of €307.80) applied, in order to bring

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the plan paid up to 10 December 2017 to give the Complainant the opportunity to consider his options.

The Provider says that unfortunately, the Complainant chose to cancel his direct debit and as such, made no further payments on his plan and it went out of force in March 2018.

Evidence

Correspondence from the Complainant and the Provider

20 June 2018 – the Complainant's response to the Provider's complaint submission

The Complainant states that no details of alternate policies were offered to him when he met with the Advisor. The Complainant states that to the best of his knowledge the Advisor completed the policy forms that he recommended best suited the Complainant's needs.

The Complainant says that the Provider makes the point in their letter dated 6 June 2016 that he did receive the Plan Document and evidence its submission. The Complainant submits that yet the submission is merely the application policy document. The Complainants states that he did not at that time (as previously stated) receive any Terms and Conditions or Plan Document until 2017.

The Complainant says that with regard to the letter dated 9 November 2016 he has no reason or gain to state that he did not receive this letter as he received all other correspondence. The Complainant states therefore he still says he did not receive it despite the Provider stating An Post would have returned it to sender as undelivered.

21 July 2018 – the Complainant's comments on telephone transcript of call dated 18 January 2018, is as follows:

"Further to receipt of copy of transcript regarding telephone conversation with [the Provider] I would like to comment briefly.

As mentioned in transcript this was the only time that I received a copy of the Terms and Conditions which I requested during telephone conversation. Regarding the non delivery of letters from [the Provider] I would emphasize that these deliveries took place during the Christmas period which can be unreliable as temporary postal staff are employed who are not totally familiar with the postal areas, and surely letters of this importance should have been sent as recorded post".

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Policy Documentation

Policy Illustration

> *"Notes*
> *Your [Policy] will be reviewed by [the Provider] after 10 years and every 5 years thereafter(annually after age 70)".*

12 July 1993 – Cover letter said to have been sent with Policy Document

> *"I am pleased to confirm that your [Policy] is now in force and the policy documentation is enclosed for your attention.*
>
> *Please examine the policy to ensure that it satisfies your requirements. If you have any queries whatsoever, please contact our New Business Service Department who will be pleased to assist you"*

Policy Review correspondence

28 February 2005

> *"Results of the Review*
>
> *Based on this review, we expect that the current contribution will support the life cover on your policy until the next review in July 2008.*
>
> *However, we expect that the life cover will not be supported beyond 13 years from now. This is because it is likely that the investment value of your Programme will have been completely used up in providing your life cover by then – so, unless some action is taken before then, your [policy] may lapse, i.e. it may terminate without any benefits.*
>
> *You may therefore wish to increase your regular contribution in order to maintain the life cover for a longer period. … we will contact you again close to the next review date in July 2008, to let you know whether your contribution is still adequate at that time for the life cover provided".*

18 June 2008 – Review

> *"Results of the Review*
> *Based on this review, we expect that the current contribution will support the life assurance cover on your policy until the next review in July 2013.*
>
> *However, we expect that the life assurance cover will not be supported beyond 8 years from the effective date of the review. This is because it is likely that the*

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investment value of your policy will have been completely used up in providing your life assurance cover by then. Therefore, unless some action is taken before then, your policy will lapse and it will terminate without any benefits.

.. Next Review
We will contact you again close to your next review date in July 2013, to let you know whether your contribution is still adequate at that time to maintain the life assurance cover provided".

28 June 2013 – Review

"Results of the Review
Based on this review, we expect that the current contribution will support the life assurance cover on your policy until the next review in July 2014.

However, we expect that the life assurance cover will not be supported beyond 3 years from the effective date of the review. This is because it is likely that the investment value of your policy will have been completely used up in providing your life assurance cover by then. Therefore, unless some action is taken before then, your policy will lapse and it will terminate without any benefits.

Next Review
We will contact you again close to your next review date in July 2014, to let you know whether your contribution is still adequate at that time to maintain the life assurance cover provided."

23 June 2014 – Review

"Results of the Review
Based on this review, we expect that the current contribution will support the life assurance cover on your policy until the next review in July 2015.

However, we expect that the life assurance cover will not be supported beyond 2 years from the effective date of the review. This is because it is likely that the investment value of your policy will have been completely used up in providing your life assurance cover by then. Therefore, unless some action is taken before then, your policy will lapse and it will terminate without any benefits.

Next Review
We will contact you again close to your next review date in July 2015, to let you know whether your contribution is still adequate at that time to maintain the life assurance cover provided."

6 June 2015 - Review

"Results of the Review

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Based on this review, we expect that the current contribution will support the life assurance cover on your policy until the next review in July 2016.

However, we expect that the life assurance cover will not be supported beyond 1 year from the effective date of the review. This is because it is likely that the investment value of your policy will have been completely used up in providing your life assurance cover by then. Therefore, unless some action is taken before then, your policy will lapse and it will terminate without any benefits.

Next Review
We will contact you again close to your next review date in July 2016, to let you know whether your contribution is still adequate at that time to maintain the life assurance cover provided."

20 May 2016 – Review

"Results of the Review
Based on this review, we do not expect that the current premium will support the life assurance cover on your policy beyond 6 months from the effective date of the review. This is because it is likely that the investment value of your policy will have been completely used up on providing your life assurance cover by then. Therefore, unless some action is taken before then, your policy will lapse with no value and it will terminate without any benefits".

9 November 2016 / 25 October 2016 - Letter sent by the Provider to the Complainant.

The Provider's Policy Review letter has two dates recorded on the letter – *"9 November 2016"* and *"25/10/2016".* From a reading of the following text of the letter it is unclear from when the policy would cancel.

The letter states:

"Results of the Review
Based on this review, the current contribution does not support the life assurance cover on your policy beyond the effective date of this review. This is because the investment value of your policy has been completely used up in providing your life assurance cover. Therefore unless some action is taken before then, your policy will lapse with no value and it will terminate without any benefits.

We estimate that the contribution required for supporting the same life assurance cover until the next review in July 2017 is €177.05.

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You may decide not to opt for the above increase. If you continue to pay the present premium of €51.30, this will maintain a reduced benefit of €11,618 up to your next review in July 2017.

It is important to bear in mind that, if you do not take any action on your policy as outlined above, the life assurance benefit under your policy will cease 6 weeks from 25/10/2016".

The two options then set out were:

"1.Increase the contribution under my [Plan] to €177.05 per month, which is expected to provide cover until your next review in July 2017.

Or

2.Reduce my Life Assurance cover to €11,618 with the premium remaining at current monthly premium of €51.30, which is expected to provide cover until your next review in July 2017".

The letter then states:

"Please not that if you choose to change your premium to a lesser amount than recommended, it may not be sufficient to support your life cover for the period indicated".

The Provider's explanation was that:

"The letter in question appears to have duplicated [the Complainant's] address and then pulled in the effective date of the Plan Review. I apologise for any confusion caused by this administration error and I have brought this to the attention of the party involved".

20 December 2016 - letter from the Provider to the Complainant

"Since the payment under the plan is insufficient to maintain the benefits and the unit account is now negative, I wish to advise that your plan will lapse in accordance with the terms and conditions with effect from 10 January 2017".

<u>Annual Benefit Statements</u>

February 2013 – This is the first statement that issued to the Complainant which indicated that the premium he was paying was not enough to cover the cost of the policy charges. For the period 22 December 2011 to 21 December 2012 the payments (premiums) made

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by the Complainant were €615.60. And the "Policy fees and charges" amounted to -€1,056.67.

> *"Important Notes*
> *Where risk benefits are paid for by deduction of units from fund(s), this will have the effect of decreasing your fund value over the lifetime of the policy.*
>
> *Where applicable, reviews will be carried out on whole of life unit linked contracts. The purpose of the review is to check if the premium you pay is sufficient to maintain your policy benefits until the next scheduled review date. If following a review, your current premium is not sufficient to maintain your policy benefits, we will write to you, advising you of your options".*

Annual Benefit Statement for 22 December 2012 to 23 December 2013

For the period 22 December 2011 to 21 December 2012 the payments (premiums) made by the Complainant were €615.60. And the "Policy fees and charges" amounted to -€1,166.18.

Annual Benefit Statement for May 2015 - the payments (premiums) made by the Complainant were €609.44. And the "Policy fees and charges" amounted to -€1,292.76.

Annual Benefit Statement for May 2016 - the payments (premiums) made by the Complainant were €609.44. And the "Policy fees and charges" amounted to -€1,446.95.

Annual Benefit Statement for May 2017 - the payments (premiums) made by the Complainant were €609.44. And the "Policy fees and charges" amounted to -€1,258.43.

The Complaint for Adjudication

The complaint is that the Provider failed to correctly administer the policy, particularly in relation to the Review of the policy over the years.

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.

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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 10th September 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

I accept that there was a continuing failure by the Company up to 2016 to correctly inform the Complainants about how the policy had been administered relative to the Reviews provided for in the Policy Document.

Section 51 (5) of the Financial Services and Pensions Ombudsman Act 2017, allows for the examination of conduct of a continuing nature.

The key point is that conduct of an ongoing nature allows in certain circumstances a consideration of conduct which might initially have started or been caused by conduct that occurred beyond the 6 year period, but which continues up to a more recent point in time. I accept some of the failings by the Provider outlined above were of a continuing nature.

Section 51 (5) of the Financial Services and Pensions Ombudsman Act 2017 states that:

"(a) conduct that is of a continuing nature 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, and

(a) conduct that consists of a single act or omission is taken to have occurred on the date of that act or omission".

I accept that the communications sent to the Complainant in respect of the Policy over the years did not set any expectation that the life cover cost and the premium would remain at the same level throughout the lifetime of the Policy.

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However, I consider that there have been lapses by the Provider in relation to how it has administered the policy over the years, in particular in relation to correct, clear and consistent communications with the Complainant about the policy.

The Policy was scheduled to be reviewed in 2003, 2008, 2013 and annually from 2014, when the Complainant had turned age 70. The Provider acknowledges the initial Plan Review in 2005 was carried out two years later than scheduled (10th anniversary being 2003). The Provider submits that while it is clear the Complainant was not financially disadvantaged by the delay (as no change was proposed when it was reviewed), it is offering the Complainant €500 in respect of the delay. The Provider states that in addition, it is offering a further €500 in respect of the fact that the level of life cover noted in the Plan Review Options provided in February 2017, was incorrect. This error resulted in the value of the plan expiring prior to the date of the 2017 Plan Review, following which the Provider applied €337.49 to the plan to correct the unit holding. The Provider states that these offers are exclusive of the €337.49 applied to the plan in July 2017 and the six months payments (total of €307.80) applied, in order to bring the plan paid up to 10 December 2017 to give the Complainant the opportunity to consider his options.

The Provider says that unfortunately, the Complainant chose to cancel his direct debit and as such, made no further payments on his plan and it went out of force in March 2018.

The evidence shows that the Provider in the Reviews that were carried out advised the Complainant up to 2016 that his contributions (premiums) were sufficient to sustain cover. It is noted that the Complainant had not been specifically advised that his premium payments were no longer, on their own, sufficient to pay for the benefits under the policy.

The Provider states in its complaint submission to this office that in its Review communications the Complainant was advised that: ***"the level of payment at that time, along with the value built up in the plan, was sufficient to maintain the existing level of live cover"***.

However, I do not consider that this is an accurate reflection of what was advised. What was advised by the Provider in the Review communications was that ***"we expect that the current contribution will support the life cover on your policy".***

It is also noted that at each Review and in particular the 2016 Review, the only option given to the Complainant was to increase his contribution to maintain the cover. It was not until after the complaint was made, and the Provider issued its complaint response letter, that an option to reduce the life cover to what the then current premium could support was given by the Provider. It is also noted that the previous Review options did not include a default option. Once the increased option was not chosen and in circumstances where there was no fund value, the Provider's stance was that it was going to cancel the life cover. While I accept that the Provider has commercial discretion as to what it can offer, I have noted that other Providers include a default option, that is, reduced cover for the payment of the then current premium. This practice ensures that the policy would be kept in force where (for whatever reason) the policyholder failed to communicate what Review option should apply.

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Throughout the Provider's submissions it refers to a positon where options were provided to the Complainant at each Review. However, it is clear from the Review correspondence that the only option given to the Complainant was to increase payments. In this regard, it is noted that the Policy provision do allow for another option, that is, "*that Policy Benefits are reduced*". However, the Provider did not exercise its discretion to offer this alternative option to the Complainant in the Reviews that took place up to 2016.

I also note the following:

- It was only from 2013 that the Provider began communicating the actual cost of life cover / benefit charges. Up to this time the Complainant would not have been able to see whether his premium payments were enough to cover the life cover charge.
- It is clear that the Current Value was decreasing in the preceding years and while the Provider has not specifically advised that the life cover cost was exceeding the premium being paid prior to 2013, I accept that this was most probably the situation.
- Despite the above position, the evidence shows that the Provider kept advising the Complainant at Review stage that his contributions (premium) were sufficient to support his chosen level of cover.
- It was not until 2016 that the Complainant was specifically told that his contributions were not enough to maintain his level of benefits.

Thus it can be seen that there was conflicting communications to the Complainant as to the adequacy of the premium payments being made and as to how the Provider would manage the policy.

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 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, the Provider did not clearly communicate on the earlier reviews. I consider that there have also been lapses by the Provider in relation to how it has 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.

As stated above the Provider specifically advised it found it necessary to reduce the policy fund to support the benefits from 2013, but an earlier date is more likely. While the annual statements did highlight for some time that the premiums being paid by the Complainant were less than the cost of the benefit charges, there was also conflicting information being given at Review stage, as outlined above.

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I consider that the need for the fullest and most accurate disclosure of information on a policy at a Review is particularly required, as the cover being provided is Life Assurance cover. While I accept that the Provider had a commercial discretion as to what to offer by way of alternative cover, it is noted that alternative life cover options could have been provided in line with what the Policy allowed for, but were not provided in the Review communications. I cannot interfere with the Provider's exercise of its discretion in such matters.

With regard to the provision of information to a consumer, the Consumer Protection Codes state that a regulated entity must 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.

Having regard to the particular circumstances of this case, in particular the failings that have been noted above, it is my Legally Binding Decision to partially uphold the complaint.

Having regard to all of the above it is my Legally Binding Decision that the complaint is partially upheld and I direct the Provider to pay the Complainant the compensatory payment of €8,000 (eight thousand euro). This compensatory payment is to be made instead of the monetary offers already made by the Provider.

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)(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €8,000, 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.***

/Cont'd…

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

4th October 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.