An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0334
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant holds a Whole of Life Policy. The Policy was taken out in 1988.

The Provider was required to review the policy over the years and communicate whether the premium payments being paid were adequate to provider the benefits under the policy.

Upon a Review of the Policy in 2017 the Provider advised the Complainant that a substantial increase in premiums was required to sustain the level of life cover under the policy.

It is the Complainant's complaint that the Provider is not correctly administering the policy, particularly in relation to the Review of the Policy.

The Complainant's Case

The Complainant states that he bought the policy on the assumption it was a "For Life Plan", with increases in accordance with inflation. The Complainant says that it was life insurance to cover the cost of his funeral arrangements. The Complainant states that he was advised of a huge increase in contributions to €234.00 for the same cover of €50,000 as he had been previously paying €24 for.

The Complainant states that he needs full restoration of the initial payment as he is not in good health and has not been able to pay the increases which has left him without life cover. This he states is causing him anxiety and further difficulty for his family. The Complainant states that he has thought over this since the increase was advised and considers he is unable to take on a big institution such as the Provider.

The Provider's Case

The Provider states that the Complainant's plan was reviewed in line with paragraph 15 of his plan Terms and Conditions in February 2017. The Provider says that at this time the Complainant's review identified that an increase in payment was required in order to maintain the same level of cover on the plan until its next review in March 2018.

The Provider accepts that the Complainant is unhappy about his plan review feature and says that he assumed that his plan provided his life cover benefit at a fixed payment that was subject to indexation for life.

The Provider states that the Complainant's plan is a reviewable unit linked whole of life protection plan. The Provider states that each time a monthly direct debit payment was collected from the Complainant's bank account this payment purchased new units in his plan fund. The Provider submits that separate to this unit buying process units in the fund equivalent in value to the monthly plan costs are cancelled to pay for the plan charges. This includes the charge to provide the valuable plan benefits.

The Provider states that this is the purpose of the plan fund and this is the mechanism by which payments to the plan are made and plan charges collected.

The Provider's position is that any units remaining in the fund after the deduction of the monthly plan charges make up the value of the plan at any given time. The Provider states that this process of units being cancelled each month from the plan fund to meet the plan charges is as set out by paragraph 14 of the plan terms and conditions, a copy of which was supplied to the Complainant when his plan started.

The Provider states that this charging mechanism on the Complainant's plan has always been correctly administered in line with his plan terms and conditions.

The Provider states that the cost of providing protection benefits increases as one gets older and when the value of the plan fund, to which new units are being added each month by the recurring direct debit payment, reduces to a level where it is no longer sufficient to meet the plan charges going forward a plan review is necessary.

Plan reviews are provided for by paragraph 15 of the Complainant's plan Terms and Conditions. The Provider states that when a review is conducted it looks at factors such as the value of the fund (if any), the benefits on the plan, the age of the life covered and current mortality rates. The Provider's position is that from this it establishes the highest level of cover that can be obtained by continuing with the current payment and what

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payment is required in order to maintain the current benefits on the plan to the next review date.

The Provider says that all money paid into the plan is allocated to the plan fund and all plan charges due are deducted from the plan fund. When the value in the fund is no longer sufficient to meet the plan charges a review is conducted. The Provider's position is that this is how the plan was always designed to operate.

Paragraph 15 of the plan Terms and Conditions provide for it to be reviewed on its fifth anniversary, every five years after that and annually from the time the Insured Life reaches age 65. The Provider states that a copy of the Plan's Terms and Conditions were issued to the Complainant when his plan started.

Paragraph 15 — Policy Review

"The sum assured and premium currently in force under this policy shall be reviewed by the actuary on the fifth anniversary thereafter unless and until the life assured attains age 65 following which the review shall be made at each policy anniversary".

Paragraph 15 continues to explain what happens each time a review is conducted.

The Provider states that the Complainant's plan started in 1988 his plan was scheduled to be reviewed in 1993, 1998, 2003, 2008, 2013 and annually from 2017 (when the Complainant was aged 65). The Provider states that reviews can happen sooner if any of the assumptions made at the time that a plan is reviewed are not met — for example the estimated investment return is not met or a withdrawal is made from the plan fund.

The Provider says that the plan would have passed its review in 1993 and similarly in 1998. This meant that the fund values at these times in addition to the future payments due to be collected and applied to the fund value over the next five years would maintain the costs of the plan until it became due for its next review.

The Provider states that it notes from its records that it did not communicate with the Complainant at these times and for this it wishes to apologise. The Provider states that by way of an apology for its lack of communication it would like to offer a Customer Service Award of €500 (€250 for each occasion).

The Provider says that it wrote to the Complainant in 2003 to confirm that his plan had been reviewed at this time and that it had passed its review.

The Provider states that it similarly reviewed the Complainant's plan again in 2008 and wrote to him at this time to confirm that his plan had once again passed its review.

The Provider submits that included with the 2008 correspondence was a Frequently Asked Questions Document which set out in detail what happens when a review is conducted.

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The Provider says that the Complainant's plan was again reviewed in 2013 and like his previous reviews his plan passed its review at this time.

The Provider submits that unfortunately its letter at this time incorrectly noted that the Provider estimated the existing plan payment would maintain the plan until March 2014. This should have read March 2017 at which point the plan would be reviewed annually going forward as the Complainant would be 65 years of age.

The Provider states that it is sorry for the error in this letter and for any confusion that it may have caused.

The Provider submits that the Complainant's Plan was next reviewed in 2017 and at this time the Provider says it identified that the plans fund value in addition to the payments due to be collected and applied to the fund over the next year was insufficient to maintain the plan and its current level of cover until its next review. As such an amendment needed to be made to the plan at this time.

The Provider states that in fact this review identified that the Complainant's fund value had eroded to zero in April 2015. The Provider says that as such a review should have been conducted at this time in line with paragraph 15 of his plan Terms and Conditions.

The Provider submits that as this did not happen the Complainant benefited from being undercharged from this time for the level of cover that he was benefiting from. The Provider says that the undercharge that built up on the plan over this period and which was paid for by the Provider was €2,299.71.

The Provider mentions that the original plan review options issued to the Complainant on 16 February 2017 did not take into account the Provider paying for the undercharge.

The Provider says it issued revised options to the Complainant on 27 April 2017 once it had paid this. This the Provider says had the effect of reducing the payment increase required in order to maintain the same level of cover on the plan until the plans next review.

The Provider states that the first time that the plan fund could no longer meet the plan charges going forward was in 2015. The Provider says because this was not identified at this time the Complainant benefited from a period where he was being undercharged for the life cover that he was benefiting from. An increase in payment would have been required in 2015 to maintain the level of cover that the Complainant was benefiting from.

When this was identified at the 2017 review, the plan was reviewed at this time on the exact same basis as if he was making the correct payment to his plan all along from 2015. The Provider submits that while the 2017 review was the first review which required an increase in payment it was not the first time that the Policy went through the review process.

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The Provider submits that it is worth mentioning that from 2014 it began to include in the Complainant's Annual Benefit Statement a breakdown of how much he paid into his plan over the previous year and a breakdown of the plan charges.

The Provide says it can be noted from these statements that the charges being drawn from the plan fund were greater than the new regular payments being invested in the fund. For illustration the Provider includes the following table setting out the information that was in these statements:

Year	Payments Received	Benefit Charges	Current Value
2014	€384.72	€1,106.78	€885.57
2015	€384.72	€1 ,241.69	€46.05
2016	€349.13	€882.54	€0

The Provider states that at no time did the Provider ever tell the Complainant that the payment on his plan was fixed for life and it is clear from his plan Terms and Conditions and previous plan review correspondence that this is not the case. The Provider states that the plan does of course provide cover over a whole of life term and as such it is subject to review.

The Provider says that it fully appreciates and recognises that while the Complainant's 2017 review was the first that required an unwelcome increase in payment it was not the first time that he went through the plan review process. The Provider highlights that at the time of the 2017 review the Complainant was 29 years older than when he took his plan out in 1988 and that the requested increase in payment to maintain the same level of cover going forward reflected this increase in age and the increased risk being borne by the Provider.

Evidence

Policy Provisions

"14 Mortality Charge

(c) The Cover charge is deducted from the Benefit Fund by proportionate cancellation of units in each Unit Fund. If the charge made on any occasion exceeds the value of the Benefit Fund, the excess shall be carried forward with interest at 10% (ten per cent per annum, or at such other rate as the Actuary may decide, until such time as it may be eliminated by cancellation of units from the Benefit Fund.

15. Policy Review
(a) The Sum Assured and Premium currently in force under the Policy shall be reviewed by the Actuary on the fifth Policy Anniversary thereafter unless and until the Life Assured attains age 65 following which the Review shall be made at each Policy anniversary"

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Correspondence

20 February 2017- Plan Review

> *"A plan review is when we check whether your current regular payments are enough to maintain the cost of the life cover. …We have recently conducted a review of your plan in accordance with the terms of your contract, to calculate if your combined payments and plan fund are still enough to cover the cost of your level of benefits. In your case we anticipate that your payments will not be enough to maintain your current level of benefits from 1 April 2017. It is therefore necessary to make some adjustments to your plan".*

27 March 2017 - letter from the Provider to the Complainant

"If you decide to keep the plan in force, please choose one of the options overleaf".

The Options were to either maintain the existing level of cover at a substantially increased premium or to reduce level of cover for a lesser premium (but a premium that was still in excess of the premium being paid).

5th April 2017 - Providers Final Response letter. Accompanying this letter were a list of options for cover. It is only at this stage that the Provider provided an option for life cover that matched the then current premium that was being paid.

January 2016 Annual Statement

> *"Plan Review*
> *Assuming a future growth rate of 0.00% and our charges for benefits do not change, we will review your plan at the next scheduled review date 1 March 2017. At that stage we will tell you what payment you need to make to cover the cost of your benefits at that time. .. Fund value €-824.72"*
>
> *Charges applied*
> *Protection benefit charges €882.54"*

30 January 2016 – Letter to the Complainant

> *"I am writing to advise you that the negative units which are showing on the Annual Benefit Statement are correct.*
>
> *..*
> *I have outlined the cost of your life cover below:*

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["Current cost of your life cover every month €115.45
Current monthly payment €32.06"]

As you can see from the table above the current payment you are making each month is not sufficient to cover the cost of your life cover therefore we have been taking the balance from the current value of your plan. This has now reduced the value of your plan.

This means that at your next review date which is estimated to take place on 1 March 2017 that your monthly payment will need to increase or you will need to reduce the life cover on your plan to maintain your current payment".

2015 Annual Statement

"Premiums received €384.72
Benefit Charges (€1241.69)
Closing surrender value as at 28/02/2015 €46.05

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

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

2014 Statement

The 2014 Statement showed that the "Closing surrender value as at 28/02/2014" was €885.57 and the "Benefit charges" were €1,106.78 in comparison to the €384.72 premiums that were being paid.

2013 Statement

The 2013 Statement merely showed that:
"As of 02/07/2013 the surrender value of your policy is: €1,269.59"

The "Benefit charges" were not set out on this statement.

2013 Policy Review

"Current Surrender Value €1479.22

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[The Provider] has conducted a review of your policy for 2013. At this review we have calculated that your current premium is sufficient to keep your chosen level of cover until your next policy review in March 2014. This means that no further action is required by you".

2012 Statement

The 2012 Statement merely showed that:

"As of 29/11/2012 the surrender value of your policy is: €1,606.34"

The "Benefit charges" were not set out on this statement.

2011 Statement

"Current Cash Value €1709.09"

No Benefit charges were set out on this statement.

11 August 2008 – Policy Review Letter

"We are delighted to tell you that, at this Review, your premiums are sufficient to sustain your chosen level of cover until the next Review due in March 2013".

Frequently Asked Questions (FAQ)

"1.What is a Policy Review?
As Unit-linked policies such as yours can run for many years, the charges and costs of maintaining them may change. As you get older the cost of providing your benefits increases. Insurance companies will carry out a Policy Review to ensure that the Customer is paying the appropriate premium into his/her policy to maintain the cover they require. Sometimes premiums may be increased, but not always.

2. What happens in a Policy Review?
When the cost to maintain your policy's level of cover reaches a stage where it is greater than your regular premium, the difference is made up from your fund value. During the Policy Review, [the Provider] will calculate whether the premium being paid is enough to maintain your cover until the next Policy Review. [The Provider] will examine the value of the fund attached to the policy and the Life Assured's age, smoker status and health.
..
5. What happens if my usual premium is not enough to maintain my cover?
You then have a choice either to increase your premium or to reduce your cover".

8th August 2005 (two separate letters of this date issued and different valuations were provided) – *"Current Cash Value €3476.16"* and *"Current Cash Value €3944.91"*

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14 August 2003 – Policy Review

"We are pleased to advise you that your policy has passed its review. .. The current premium is estimated to sustain the current benefits for a further 11 years assuming a 5% net growth"

"The Premiums below are projected to sustain the current level of benefits for the terms as specified.

Term Form Now	*5 years*	*10 years*	*20 years*	*Whole of Life*
Premium	*€31.74*	*€31.74*	*€77.71*	*€126.85*

The Level of Benefits below are projected to be sustained by the current premium for the terms as specified.

Term Form Now	*5 years*	*10 years*	*20 years*	*Whole of Life*
Premium	*€50,790*	*€50,790*	*€29,401*	*€19,327s*

7 March 2001 *– "Current Cash Value €3033.52"*

The Complaint for Adjudication

The complaint is that the Provider did not correctly administer the policy, particularly in relation to the Review of the Policy.

Decision

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

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

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally

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Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 9th 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.

The Complainant contacted this office by telephone on **10th September 2019** seeking extra time to make a submission. The Complainant was advised to put this request in writing, for the Ombudsman's consideration. On **11th September 2019** the Complainant contacted this office by e-mail, seeking a change to his e-mail contact details. On the same date the Complainant was advised of two e-mail contacts that he could submit his request for an extension of time to make a post Preliminary Decision submission. On **20th September 2019**, the Complainant contacted this office by telephone and was again advised to submit his request in writing. The Complainant confirmed that he would make a request in writing. The Complainant did not make a further contact, as he said he would, and did not make a post Preliminary Decision submission within the required 15 working day period.

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 Policy document outlined the policy features. I accept that the documentation sent to the Complainant in respect of the Policy did not set any expectation that the protection benefits and premium would remain at the same level throughout the lifetime of the Policy.

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 and clear communications with the Complainant about the policy.

The Policy was to be reviewed in 1993, 1998, 2003, 2008, 2013. The Provider says that the plan would have passed its review in 1993 and similarly in 1998. The Provider states however, that it notes from its records that it did not communicate with the Complainant at these times and for this it has apologised. The Provider states that by way of an apology for its lack of communication it would like to offer a Customer Service Award of €500 (€250 for each occasion).

At the 2017 Plan Review the Provider wrote to the Complainants advising:

> *"We have recently conducted a review of your plan in accordance with the terms of your contract, to calculate if your combined payments and plan fund are still enough to cover the cost of your level of benefits. In your case we anticipate that*

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your payments will not be enough to maintain your current level of benefits from 1 April 2017. It is therefore necessary to make some adjustments to your plan".

In a letter dated 20 February 2017, the Provider advised the Complainant of options available to him. The Options were to either maintain the existing level of cover at a substantially increased premium or to reduce level of cover for a lesser premium (but a premium that was still in excess of the premium being paid).

It is noted that none of the options set out in the Review communications gave an option setting out a level of life cover that the current premium could support.

The January 2016 Annual Statement stated as follows:

"Plan Review
Assuming a future growth rate of 0.00% and our charges for benefits do not change, we will review your plan at the next scheduled review date 1 March 2017. At that stage we will tell you what payment you need to make to cover the cost of your benefits at that time. .. Fund value €-824.72"

Charges applied
Protection benefit charges €882.54"

On 30 January 2016, the Provider advised the Complainant that:

"As you can see from the table above the current payment you are making each month is not sufficient to cover the cost of your life cover therefore we have been taking the balance from the current value of your plan. This has now reduced the value of your plan.

This means that at your next review date which is estimated to take place on 1 March 2017 that your monthly payment will need to increase or you will need to reduce the life cover on your plan to maintain your current payment".

The evidence shows that the Provider merely advised the Complainant up to 2016 that his premiums were sufficient to sustain cover. The Complainant had not been specifically advised at this time or in the intervening years that his premium payments were no longer, on their own, sufficient to pay for the benefits under the policy.

The Provider advises that the first time the value of the Complainant's plan Fund in conjunction with future payments to be collected and applied to the Fund was insufficient to meet the plan cost going forward was in April 2015. The Provider accepts that at this time the Complainant's plan should have been reviewed. The Provider state that as a result of not reviewing the plan at this time there was an undercharge for the benefits.

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I note the following information:

- It was only from 2014 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 2014, I accept that this was the most probably the situation.
- Despite the above position, the evidence shows that the Provider incorrectly kept advising the Complainant in 2008, 2013, and 2016 that his premiums were sufficient to sustain his chosen level of cover.
- It was not until 2016 that the Complainant was told that his payments were not enough to maintain his level of benefits.

Thus it can be seen that there was conflicting communications to the Complainants 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 fully 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.

Not fully knowing of the true positon with his policy, the Complainant was denied an early opportunity to decide what action he would have to take regarding the policy. It could, for example, be the case that the Complainant would have wished to exit the policy, after discovering the true cost of cover was more than what he was paying by way of premiums. It is one thing to set out in the policy document how something is going to be done, but knowing the full implications of when it happens is another matter.

As stated above the Provider specifically advised it found it necessary to reduce the policy fund to support the benefits from 2014, but an earlier date is more likely While the annual statements did highlight for some time that the premiums being paid by the Complainant

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were less than the cost of the benefit charges, there was also conflicting information being given as outlined above.

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

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 complaint, in particular the failings that I have noted above, it is my Legally Binding Decision to partially uphold the complaint.

While the Provider's actions outlined above in relation to the administration of the policy, were unreasonable, I accept that the Complainants did have the benefit of having his level of cover at a reduced cost for a time, that is because a Review should have taken place earlier. This was at a cost to the Provider, and while fortunately it was not tested, the Provider would have paid out on that cover, had a claim arisen. Therefore, I consider that the more appropriate remedy here is that the Provider pay a compensatory payment.

The Complainant must then choose whether to keep this policy in place at the current cost and benefit or apply for alternative cover with the Provider on the Provider's terms, or seek cover elsewhere. Independent advice would be prudent when making those decisions.

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 Provider's two monetary offers of €250.

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 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.

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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

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.