An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0367
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Delayed or inadequate communication Failure to provide product/service information Maladministration (life)
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a whole of life, unit-linked life assurance policy held by the Complainants with the Provider.

The Complainants are unhappy at increase in premium and / or decrease in benefit and the Provider's refusal to provide or delay in giving actuarial calculations justifying such changes to the policy.

The Complainants are also unhappy with the Provider's overall delay and poor communication in reverting to them in relation to their queries.

The complaints are that (i) the Provider incorrectly and unreasonably carried out a review on the policy, and in that regard, delayed or failed to provide the actuarial calculations justifying the suggested changes to the policy (ii) the Provider's communication in response to queries from the Complainants fell below what a customer reasonably would expect from a Provider.

The Complainants' Case

The Complainants are unhappy with policy review correspondence received from the Provider in January 2017 which set out three 'options' to the Complainants.

The Complainants state that: *'The scale of these changes is quite staggering and defeats the whole purpose of the policy.'*

The Complainants are also unhappy with the time taken by the Provider to give an explanation of the revised policy review calculations outlined in the Plan Review carried out in March 2017.

The Complainants believe that the Provider has not adequately explained why the monthly premium on the policy must increase to maintain the current level of the sum assured for whole of life or why the sum assured must reduce to maintain the current monthly premium.

The Complainants are unhappy that the Provider can increase the premium on the policy without providing any explanation as to why this is permitted.

The Complainants hopes that the Provider has simply made an error in its calculations and that the options could be re-calculated on a more equitable basis.

The Provider's Case

The Provider submits that the policy is a: *'regular premium, life assurance contract, the benefit under the [policy[selected by the [Complainants] was to provide life cover on the death of the life assured'.*

The Provider asserts it view that the policy: *'has been administered at all times strictly in accordance with the [policy] Contract Conditions.'*

The Provider submits that the policy was sold to the Complainants by an independent financial advisor in 2001 and was placed into trust. The policy was issued in the Complainants' names on a joint life last death basis. In 2005, the trust was varied with the addition of the Complainants' three children.

The Provider submits that it: *'sent the Complainants the Plan Terms and Conditions at inception. These set out how the Plan would work and that it would be reviewed on a regular basis to assess whether the premium being paid was sufficient to sustain the sum assured.'*

In line with the Contract Conditions Part 5, "Your Regular Payments", Section 5, Plan Reviews were carried out on 1 January 2012 (year 10) and 1 March 2017 (year 15). The

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Provider states that these confirmed that, based on a number of assumptions, which were included with each Review pack, the current premium would not sustain the level of cover throughout life.

The Reviews provided options for the Trustees to either increase their premium or, reduce their sum assured in order to sustain the policy for whole of life based on the then assumptions or, make no change.

If the *'make no change'* option was selected, a warning was included informing the Trustees that the Plan was not expected to remain sustainable throughout life.

The *'make no change'* option was also the default which would be applied to the Plan if no response was received.

The Trustees did not select any option following the 2012 Review and the *'make no change'* option was applied to the Plan. No option has been selected following the 2017 Review and the *'make no change'* option has been applied. The 2017 Review is the subject of this complaint.

The Provider submits that: *'the Plan and benefits are in force and all premiums are paid up to date. The current sum assured is £943,000 and the monthly premiums is £421.13.'*

The Provider states that it has: *'complied with the General Provisions of the Consumer Protection Code specifically: 'Makes full disclosure of all relevant material information, including all charges, in a way that seeks to inform the customer'.*

The Provider goes on to explain that it has: *'sent the Complainants Annual Unit Statements informing them of the position of the Plan and providing them with the opportunity to seek financial advices to ensure the Plan continued to meet their needs.'* The Provider also submits that it: *'sent the Complainants Plan Review correspondence (initial and 2 reminders) informing them that based on our assumptions the premiums being paid was not sufficient to sustain the sum assured throughout the life of the lives assured. The letters provided the Complainants with options, that providing all the review assumptions were met, would make the Plan sustainable throughout life.'*

In response to the Complainants' grievances, the Provider states that it: *'accepts that the figures included in the Review letter sent to the Complainants dated 11 January 2017 were incorrect. [The Provider] wrote to the Complainants and apologised for this error and confirmed that a new Review would be conducted on 1 March 2017 and the revised results sent to the Complainants'.*

The Provider: *'accepts that there were delays in sending an explanation to the Complainants financial advisor regarding the revised figures it provided in the review conducted on 1 March 2017'.*

The Provider: *'also accepts that there were errors in the information sent to the Complainants' financial advisor. In recognition of the delay [the Provider] sent a*

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compensation payment of £100 to the Complainant. The issued cheque became stale in December 2017 and was reissued to the [Complainants] in January 2018.'

The Provider states that it: *'does not accept that it has not provided an adequate explanation to the Complainants as to why the monthly premium on the [policy] required an increase to maintain the level of sum assured.'*

The Provider stated that its letters to the Complainants dated 30 June 2017 and 27 July 2017 provided an explanation as to what factors influenced the need for an increase in premium on the policy.

The Provider notes that the Complainants *'remain unhappy'* with the results of their 2017 review and with the: *'detailed explanation of the assumptions used in calculating the sustainability of the [policy]'.*

Schedule Of Contacts Between the Parties

22 November 2001: The Complainants took out (through an Intermediary) a Whole of Life Policy (Flexible Life Plan) with the Underwriter that first owned the policy, on a Joint Life, Last Death basis. The Sum Assured was £943,000 and the monthly premium was £421.13.

11th January 2017: The Provider wrote to the Complainants saying that it had carried out a review of the Flexible Life Plan. The review date was 1st January 2017. The Options that were presented were:

1. Take no action. In which case all cover would cease at age 86.
2. Increase the premium level. From £421.13 to £2,302.76
3. Reduce the level of benefit. From £943,000 to £280,278

"If your premium was calculated assuming a net growth rate higher than the rate assumed in this review then it will impact your review results making it more likely that the review will show action is now needed".

Early February 2017: The Complainants' Intermediary phoned the Provider on his behalf to challenge the outcome of the 'review'.

24 February 2017: The Provider advised that: *' it recently came to my attention that there was an error in the review calculations'*. The letter informed the Complainants that the Provider would 're-calculate the review using the correct assumed future growth rate on 1 March 2017'.

9 March 2017: The Provider send the Complainants the revised options:

1. Take no action. In which case all cover would cease at age 91
2. Increase premium level. From £421.13 to £1,128.04
3. Reduce the level of benefit. From £943,000 to £559,295

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"Estimated future growth in investments:

The review we have carried out is also based on an estimate of the future growth in investments that support the chosen level of cover.

A future growth in investments of 3.5% per annum (after deducting investment management charges) has been assumed in our calculations. The investment management charges will depend on your choice of fund but can range from 1.5% to 2.1% per annum.

Where funds invest in underlying unit trust /OEICs, additional expenses may be incurred. These are not reflected in the figures.

Investment growth is not guaranteed and actual experience may differ from our assumptions. This will affect the value of your plan. In particular, the value of investments can fall as well as rise.

Other assumptions
This review is based on our current protection charge rates, but rates in the future could increase. If this happens then subsequent reviews will reflect any increase in rates"

"Results of Your Review
This document sets out the results of your review and the options available to you.

The original purpose of the Plan was to provide your chosen level of cover throughout the lifetime of the Lives Assured. As this is potentially no longer the case, we are providing options to you, ***based on our current review assumptions****. Please note that if you choose to take action to make your Plan sustainable and these assumptions are not met, it is likely that you will need to take further action at a future review date to maintain your chosen level of cover".*

19 March 2017: The Complainants to their Intermediary

"To my mind the key data we need are:

1) *What has been the performance of the fund for each of the years since I took out the policy and how does that relate to the level of growth highlighted in the policy schedule.*
2) *From the position established to-date (of over or under performance) what is the detailed calculation that leads them to a reduction in the Life Cover Benefit of nearly a half. I would like to see the precise workings that gets them from a figure of £943,000 as stated in the original schedule to the figure of £559,295. Presumably, if they have carried out the 'Review' they have these figures readily to hand".*

22 March 2017: The Complainants' Intermediary contacted the Provider to establish precisely how these new figures had been calculated.

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31 March 2017: The Provider forwards information to the Complainants' Intermediary, the details of the growth rate on the Fund from when it started until March 2017, a table setting out the breakdown of charges that applied to the plan since inception and a table setting out information on the future life cover charge.

The table setting out the breakdown of charges, gives the following information:

> *"The information on the life cover charges to be deducted into the future was, as follows:*

Policy Year	*Life Cover charges*
*16**	*£643.44*
17	*£942.82*
18	*£1.155.56*
19	*£1,409.21*
20	*£1,710.48*
25	*£4,234.39*
30	*£9,632.97*
35	*£20,834.38*
40	*£45,954.60*
*43**	*£12,513.24*

> **Policy year 16 account for 10 months of charges*
> ***Policy year 43 accounts for 2 months of charges"*

12 June 2017: Reply received from the Provider. The Complainants state that it took the Provider 3 months to reply to a request for how calculations were arrived at. The Complainants say that disappointingly, the reply did not address the issue. Despite the fact that the letter of 24th March had stated that the Provider would 're-calculate the review' and the Intermediary had asked for the specific calculations used, the response from the Provider did not contain the requested calculations. The Complainants state: *"furthermore the letter contained a basic error. It stated that the growth forecast contained in the original contract was 7% pa, when in fact it was 6.75%".*

This letter advised that:

> *"Please note that we are unable to provide the calculation used by our Actuarial Team when carrying out the review of this plan"*

16 June 2017: The Complainants wrote to the Provider's Chief Executive

30 June 2017: The Complainants received a reply from the Provider. This also contained a copy of the *'post sale illustration'* of the contract.

13 July 2017: The Complainants sent a reply to the Provider (incorrectly dated as 13 June)

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27 July 2017: letter from the Provider.

9 August 2017: The Complainants wrote to the Provider expressing disappointment that it had failed to explain the calculations used in the review and that they would be contacting the Financial Ombudsman.

The Complainants' submission in respect of the Provider's response to this office's Schedule of Evidence and Information that was required for the examination of the complaint.

The Complainants state that in the Provider's response to this office's Schedule of Evidence and Information Required, it still did not provide any data or evidence to justify the changes to the Plan following the 2017 review.

The Complainant says that the Provider claims that it has given a *'full explanation'*. In this regard the Provider says that: *"[the Provider's] letters to the Complainants…. provided a full explanation as to what factors influenced the need for an increase in premium on the Plan."* The Complainants' response is that the Provider has, indeed, explained the factors, but that is the fundamental problem. The Complainant says that all that the Provider has done is to explain the factors. The Complainants state that the Provider has done nothing to provide the evidence base for the empirical assumptions used for those factors. The Complainants submit that the Provider has failed to define the precise data that it has used and what calculations it has then made to arrive at its conclusions. The Complainants say that the Provider has failed to send through the detailed actuarial calculations that were repeatedly promised in telephone conversations with the Intermediary. The Complainants say that in summary the Provider has simply not addressed their complaint that it has failed to justify the scale of the changes that it has proposed.

The Complainants' position is that, the scale of those changes is significant. And of the options that the Provider presented, one would have reduced the sum assured by £383,705 or 40%; the other would have increased the total premiums by £212,000 if they lived for another 25 years. The Complainants say that these are material changes, and on the basis of the 2017 Review, the Plan is no longer *'fit for purpose'*. The Complainants state that as is stated in the documents that the Provider has submitted, the Plan was taken out for the purpose of inheritance tax mitigation. The Complainants state that the sum assured was carefully calculated following a detailed analysis of the amount that would be required for those purposes. The Complainants say that the sum assured, that is 40% lower than the one planned, obviously fails to meet that objective.

The Complainants state that despite this substantial impact on their customers, the Provider submitted no data nor evidence to justify the changes. The Complainants' view is that this itself demonstrates that the Provider is not making *'full disclosure of all relevant material information, including all charges, in a way that seeks to inform the customer*'. The Complainants state that the Provider continue to show a complete lack of transparency as to what data it used to justify making such material changes to the Plan.

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The Complainants state that in the Provider's submission, it appears to imply that because it has a right to carry out a Review it has an equal right to decide the quantum of the change that comes out of that Review – entirely at its discretion and without providing any evidence to justify that quantum.

The Complainants state, the situation here would appear to be even more disturbing. The Complainants say that in the submitted documents, the Provider states that the changes that it proposes are '*based on its current review assumptions*'.

Those assumptions are as per letter dated 11 January 2017:

i) The current value of your Plan
ii) Estimated future growth in investments
iii) Current protection charge rates

The Complainants submit that an analysis of the limited data that the Provider has supplied suggests that on assumptions i) and iii), there is no justification to make any changes at Review.

The Complainant says as regards the current value of the Plan data that the Provider provided in relation to the price of the units from 2004 (it says that it cannot provide earlier data) show that the unit price has risen by 2.4 times. The Complainant states that the original contract was based on an annual growth in the fund of 6.75%, and if this factor is applied from 2004 the increase would have been 2.5 times. The Complainants state that this is not a sufficiently large difference to justify a material adjustment at Review.

As regards the increase in charges, the Complainant state that the information provided by the Provider gives no data on any **increase** in charges. But says however, it does provide a table of actual charges. This shows a total figure of £21,899.90 for the 16 years 2001 to 2017. The Complainants submit that this is well within the guidelines included in the illustration (the original contract) which shows planned deductions after 10 years of £33,000. The Complainants say that the Provider present no evidence, based on an increase in charges, to justify any change at Review.

As regards the estimated future growth in investment, the Complainants submit that, it would appear that the changes proposed at Review are entirely dependent upon the estimated future growth in investments. The Complainants state that at the 2017 Review, the Provider forecast that the fund would grow by 3.5% pa in the future – rather than the 6.75% pa included in the original contract. The Complainants state that this is a major change. The Complainants state that on the basis of this assumption, the Provider renders the Plan no longer 'fit for purpose.' And yet the Provider supplied no evidence to support this dramatic change in assumptions - despite being asked repeatedly for the information. The Complainants state that again, the reason for this is likely to be that there is no

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evidence to support its conclusions. The Complainants say for example, at the 2012 Review, the Provider reduced the forecast of future performance from 6.75% pa to 6% pa. The Complainants state that the actual growth in the value of the unit price over the last 5 years has been over 10% (based on the data the Provider supplied).

The Complainants submit that more importantly, he questions whether the Provider even have the right, contractually, to behave in this way. The Complainants say that there is no obvious place, in all the documentation sent by the Provider, where it makes clear its right to make changes to the Plan based on the estimate of the future growth in investments. The Complainant says that yet, if this factor could indeed change to such an extent that it could render a customer's Plan 'not fit for purpose' a consumer could reasonably expect the Provider to want to ensure that this point was given due prominence in the contract and was well understood by a consumer before they signed up to the Plan.

The Complainants submit that it is also unclear what happens if the Provider's forward forecast is too pessimistic. And the Complainants ask if the 'actual' performance of the fund exceeds the revised forecast, is a positive adjustment made at the next Review. The Complainants state that they cannot find any answer to this in any of their documentation.

The Complainants say furthermore, changing such a Plan based on an 'estimate' – in other words, a guess - is fundamentally flawed as a principle. The Complainants consider that it means that these changes depend entirely on the opinion of the Provider and that this presents a potential conflict of interest. The Complainants say it is not difficult to see how all this could be open to abuse. The Complainants submit that as investors, they are familiar with the cautionary phrase that the 'value of your investments can go up or down'. The Complainants state that they never previously came across a situation where the value of the investment is dependent upon the whim of the investing agent rather than the performance of the underlying investment. The Complainants' position is that it is this conduct that is the core of the complaint. The Complainants say that the Provider appeared to recognise this as it states in its submission that '*the complainants are unhappy that [the Provider] can increase the premium on the Plan without providing any explanation as to why this is permitted*.' The Complainants state that the Provider recognises it, but fail to address it. The Complainants say that perhaps the Provider believes it does not have to and perhaps it truly believes that behaving in this way – treating ordinary consumers as if they have signed blank cheques to the Provider – is entirely reasonable behaviour.

The Complainants state that in their view this conduct is unreasonable, unjust and oppressive and may be based wholly or partly on an improper motive.

Evidence

Original Illustration

> *What happens if your contributions stop?*
> *"The Later Years*

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At end of year	*Total paid in to date*	*Total actual deductions to date*	*Effects of deductions to date*	*What you might get back*
10 *20* *27*	*68760* *234625* *512889*	*35800* *108000* *263000*	*53400* *198000* *502000*	*41200* *213000* *504000*

What are the Deductions for?

- *The deductions include the cost of life cover, expenses, charges, any cash-in penalties and other adjustments.*
- *When Protection Benefits are established or increased, an Acquisition Charge is made based on the amount of cover, or increase in cover. The initial Acquisition Charge amounts to 0.6% of the original sum assured. The charge is recovered through an increase to the mortality deductions made under your plan in the early years.*
- *The last line in the table shows that at the 27th anniversary of the commencement of the Plan the effect of the total deductions could amount to £502,000.*
- *Putting it another way, leaving out the cost of life cover this would have the same effect as reducing the overall investment growth used from 7% p.a. to 2.2% p.a."*

…
What the Benefits might be
…

- *The fund is expected to support the sum assured throughout life until the last death of the lives assured assuming units allocated to the fund grow by 6.75% p.a. after all fund charges.*
- *These figures are only examples and are not guaranteed – they are not minimum or maximum amounts. What you will get back depends on how your investment grows.*
- *You could get back more or less than the examples shown.*
- *All insurance companies use the same rates of growth for projections but the charges vary".*

Policy Provisions

The Complainants' policy document sets out, among other things, the following:

Part 5 Regular Premium Payments:

'2.3 The Protection Cover – 10 year guarantee

Please note that we do not give any guarantee that the regular premium level you are paying will be sufficient to sustain the protection cover throughout life.

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However we guarantee that provided you do not reduce your regular payments below the initial regular premium level during the first 10 years, we will not reduce the initial level of protection cover during the first 10 years.'

5. Plan Reviews

5.1 Review Dates

We review the Plan on the following Review Dates:

(a) the 10th policy anniversary and every 5th policy anniversary thereafter;

(b) any other date when we consider a review is appropriate for some reason such as a change to the level or type of protection cover or the regular premium level.

The policy anniversaries at (a) above are referred to as 'Standard Review Date'.

5.2 Purpose

The purpose of each review is to assess the likelihood that the value of the units will be sufficient to sustain the then current protection cover through to the next Standard Review Date on whatever assumptions the Actuary considers appropriate. The review will take into account the charges we will be taking from the Plan, in particular our charges for the cost of the protection cover, the Plan is providing, the current value of the regular premium units in the Plan and projected growth in the value of those units.

5.3 Review Recommendations

We will send you details of the review following the Review Date.

If, at a Review Date, we consider the regular premium units are unlikely to be adequate to sustain the protection cover to the next Standard Review Date, we will make recommendations to help safeguard the continuation of the protection cover the Plan is providing. In particular, if a review reveals an unsatisfactory position, we will recommend that you:

- *reduce the protection cover to a level we consider should be sustainable to the next Standard Review Date;*
  or
- *increase the regular premium level to a level we consider adequate to sustain the current protection cover to the next Standard Review Date.'*

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Annual Unit Statements –

'yearly statement'

From November 2004 onwards ...

Current premium amount – confirmed
Current Sum Assured – confirmed
Value of the Plan – confirmed

'This statement shows you what your plan is worth and where your money is invested. This statement gives you an opportunity to review your financial needs.'

January 2012
Policy review correspondence
Value of plan included in Policy Review correspondence - £37,008.96

'The review indicates that your premium no longer supports your chosen level of cover throughout the lifetime of the Lives Assured'.

November 2012 Annual Unit Statement
The same year as first policy review correspondence was sent to the Complainants.

November 2013 – November 2015:
No reference contained in the 2013 to November 2015 Annual Unit Statement indicating that the premiums are no longer at a sufficient level to provide cover.

November 2016

'YEARLY STATEMENT FOR YOUR FLEXIBLE PLAN
Here is your statement for your Flexible Life Plan. It shows the value of your Plan, your premium, any withdrawals taken and any increase in premiums in the last 12 months. This allows you to assess whether it is meeting your aims. Please read it with your policy document and product literature.

PLAN VALUE
Current Cash-in value on 24/11/2016 …. 88,266.48GBP

PROTECTION BENEFIT
Investment based life cover … 943,000GBP

PAYMENTS DETAILS AND CHANGES FOR THE STATEMENT PERIOD 25/11/2015 TO 24/11/2016
Regular Premium … 421.13GBP
Premium Frequency … Monthly
Withdrawals … 0.00GBP

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YOUR INVESTMENT FUNDS
The following table show the price of units in the currency of each fund …

Charges – the life cover charge is not set out here

January 2017

Policy review correspondence (contained error of 0.00% net growth rate)

'The review indicates that the current premium level no longer supports the chosen level of cover throughout the lifetime of the Lives Assured.'

March 2017
Policy review correspondence (confirmed net growth rate to 3.5%)
Value of plan included in Provider correspondence - £96,704.89

'The review indicates that the current premium level no longer supports the chosen level of cover throughout the lifetime of the Lives Assured.'

The Provider's email of 12 June 2017

*'This Plan was set up on a Standard Cover basis, which is designed to build up a significant fund value over the lifetime of the plan, assuming certain conditions are met. Standard Cover guarantees a level of cover in the first ten years of the plan. After that it is reviewed every five years to ensure the premium level, **together with the fund value**, are sufficient to cover the life cover charges both now and in the future.'*

'Life cover rates increases dramatically with increasing age. Another big factor affecting the level of charge for the life cover is the difference between the life cover and the current fund value (also known the sum at risk). The monthly charge for life cover is the product of a mortality rate multiplied by the sum at risk. As a fund value builds up, the sum at risk gets smaller and so the mortality charges reduce. This helps counteract the increased cost due to older age in the later years.
…
The higher the fund value, the lower the sum at risk and hence the lower the life cover charges will be. Were the plan to have a small fund value at older age, the life cover charges would become extremely large due to the combination of old age and the large sum at risk. Any remaining fund value would quickly become depleted.
…
The investment performance of the fund the plan was invested is worse than projected in the original projection … Therefore the fund value of the plan was much lower than would have expected at the point of review.

The net growth rate of 7.00% was used as an industry standard when setting the original premium. As economic conditions have changed, our future expectations of

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performance have been revised downwards to be in line with this. The assumptions used for the review include a lower net growth rate than the assumptions used at inception. The effect of this on the plan is that the investment fund is now expected to grow at a lower rate than previously projected. The growth rate assumed has a big impact on the size of the premium calculated. The original premium of £421.13 was based on a net growth rate assumption of 7.00% per annum; the recent review now assumes a future net growth rate of 3.50%.

The combination of these two factors, the lower than expected historic fund performance and the reduced future fund performance expected, are the reasons why this plan was underfunded at the review. As a result, the level of premium is no longer at a sufficient level compared to when the plan was first taken out to sustain cover throughout life. An increase in the regular premium is required in order to support the chosen level of cover throughout the lifetime of the lives assured.

Please also note that the Trustees opted to make no changes at the last review in 2012 and this has resulted in a higher premium required at this time.'

November 2017

'YEARLY STATEMENT FOR YOUR FLEXIBLE PLAN
Here is your statement for your Flexible Life Plan. It shows the value of your Plan, your premium, any withdrawals taken and any increase in premiums in the last 12 months. This allows you to assess whether it is meeting your aims. Please read it with your policy document and product literature.

PLAN VALUE
Current Cash-in value on 24/11/2016 …. 103,811.15GBP

PROTECTION BENEFIT
Investment based life cover … 943,000GBP

PAYMENTS DETAILS AND CHANGES FOR THE STATEMENT PERIOD 25/11/2015 TO 24/11/2016
Regular Premium … 421.13GBP
Premium Frequency … Monthly
Withdrawals … 0.00GBP

YOUR INVESTMENT FUNDS
The following table show the price of units in the currency of each fund …

Charges – The life cover charge is not set out here.

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The Complaints for Adjudication

The complaints are that (i) the Provider incorrectly and unreasonably carried out a review on the policy, and in that regard, delayed or failed to provide the actuarial calculations justifying the suggested changes to the policy (ii) the Provider's communication response to queries from the Complainants fell below what a customer reasonably would expect from a Provider.

The Complainants' Policy was sold through an Independent Intermediary. In regard to any allegation about the sale of the Policy the Provider would not be responsible for any mis-sale by an Independent Intermediary. Therefore, the sale of the policy does not form part of this investigation and adjudication.

Decision

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

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

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 **23rd 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.

On **27 September 2019**, the Complainants acknowledged receipt of the Preliminary Decision and queried the next steps in the process.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

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Analysis

In order to determine if the Provider correctly carried out the terms and conditions of the Policy in relation to the Review of the Policy, I will first outline the relevant terns and conditions.

Section 5 of the Terms and Conditions of the Policy deals with how the Policy Review ought to operate as follows:

> *"We review the Policy on the following Review Dates:*
> *a) The 10th anniversary and every 5th policy anniversary thereafter,*
> *b) Any other date when we consider a review to be appropriate".*

The Policy documentation also sets out an explanation as to the purpose of the Policy Review as follows:

> *"The purpose of each review is to assess the likelihood that the value of* the *units will be sufficient to sustain the then current protection cover through to the next Standard Review Date on whatever assumptions the Actuary considers appropriate. The review will take into account the charges we will be taking from the Policy in particular our charges for the cost of the protection cover the Policy is providing, the current value of the regular premium units in the Policy and projected growth in the value of the those units".*

What happens following a Policy Review is also set out as follows:

> *"If at a Review Date we consider the regular premium units are unlikely to be adequate to sustain the protection cover to the next Standard Review Date we will make recommendations to help safeguard the continuation of the protection cover the Policy is providing. In particular if a review reveals an unsatisfactory position, we will recommend that you:*
>
> *• Reduce the protection cover to a level we consider should be sustainable to the next Standard Review Date;*
> Or
> *• Increase the regular premium level to a level we consider adequate to sustain the current protection cover to the next Standard Review Date."*

The Review gives an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, the review should give policyholders an up to date picture of their policy fund and provides an indication as to how long that it is likely to sustain the benefits under the Policy. This is particularly important as it allows the Provider to discuss with the policyholder what, if any, action they might wish to take.

The Provider committed itself in the documentation given to the Complainant at inception of policy to issue regular statements and to carry out a Review on the Policy at specific anniversary dates.

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The initial premium payment was not guaranteed to provide cover for the periods indicated; the illustrations provided were assumptions which may not be borne out in practice. This is also true in respect of the Provider's stated indication that the Policy should currently support the chosen level of life cover only until the First Life Assured reaches age 86. This may or may not be the ultimate outcome. The nature of the policy means that the costs associated with the policy cover fluctuates over time.

I accept that the nature of the Policy and the risks attached were set out clearly in the policy documentation.

The Policy was not a guaranteed product and its value is therefore subject to the rises and falls in the market. I accept that the information supplied to the Complainants made this clear.

The life cover has to be paid for and the Provider has the latitude under this Policy to deduct the cost of the life cover from the Policy Fund. The result of this is, most likely to be, if premiums are not increased (combined with fluctuating markets and other deductions) that over time the Fund will most likely decrease. The documentation given to the Complainants from inception clearly sets out what charges would be deducted, the risk attached and the need to Review the Policy in the future.

No automatic increase in premium is made without the policyholders' express instructions. If the Policyholders wish they can choose to do nothing at the time of a Policy Review. In this event the prevailing sum assured and regular premium payment will remain in place. However, should there be insufficient units in the Policy to meet the charges for life cover the Policy will terminate.

I accept for the most part that the Provider has followed the policy provisions in relation to the Reviews and I cannot alter the Review outcome.

The age reference made by the Provider's Actuary as to when the Policy may terminate due to an insufficiency of funds in the Policy to meet the ongoing charges was an estimate only. The age reference was provided to assist the Complainants in considering the sustainability of the Policy. The date when the policy could end is not set in stone, as the termination of the Policy in such circumstances would only be determined by actual fund performance and how much the life cover will cost. I am satisfied that how the Policy operated was not changed in any way by the Provider giving those estimates. However, I do consider that the Provider could have explained these issues to the Complainants in a clearer fashion. I accept that highlighting that cover could cease on the death of one of the lives assured by specifically naming the life assured and the age at which the cover could end, could alarm or frighten a policyholder to this unfortunate prospect. However I also accept the need to alert the policyholder to this possibility and believe it should be done in a sensitive manner.

I accept there were no guarantees given in the documentation indicating that the Policy would support the provision of life cover for life, but that for the cover to continue into the

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future was dependent on a number of factors. That said, I do consider that the Provider could have reasonably and better explained matters for the Complainants.

I accept that the figures included in the Review letter sent to the Complainants dated 11 January 2017 were incorrect. The Provider wrote to the Complainants and apologised for this error and confirmed that a new Review would be conducted on 1 March 2017 and the revised results sent to the Complainants.

I accepts that there were delays by the Provider in sending an explanation to the Complainants' financial advisor regarding the revised figures it provided in the review conducted on 1 March 2017.

I also accept that there were errors in the information sent to the Complainants' financial advisor.

Given the above errors and delays by the Provider I accept that the important element of trust between the Provider and the Complainants was damaged. Further, I consider that given the errors and delays by the Provider, I do not accept that it subsequently provided an adequate explanation to the Complainants as to why the monthly premium on the policy required an increase to maintain the level of the sum assured. The Provider has merely stated that it is unable to provide the level of detail that the Complainants have requested. The Provider has not claimed commercial sensitivity about that information or elaborate further on why it was unable to provide the information.

I accept that the Provider's 'letters to the Complainants dated **30 June 2017** and **27 July 2017** did provide some explanation as to what factors influenced the need for an increase in premium on the policy, but failed to show the actual calculations.

It is noted that prior to the complaint, the Provider had not been showing in its statements what the cost of life cover was from year to year. It is now evident that the premium payments alone are no longer meeting the cost of cover. I consider that it is reasonable for the Complainants to expect that the Provider could show what the increases in the cost of life cover was from year to year. Knowing what the cost of cover is, would show the Complainants if there is going to be a reduction to the fund to cover the extra cost for life cover.

The Complainants question the Provider's use of a low future growth rate in its calculations than that recommended in the industry. I accept that it would be reasonable that the Provider use the figures recommended in the industry, but that it does not prevent the Provider from also using the figures it considers are more realistic, for comparison purposes.

To conclude, I do consider that it is reasonable that a Provider would communicate accurate information in its Review calculations and provide the fullest amount of information to assist a policyholder to better understand and act upon the Review outcomes that have been reached. While accepting that the Provider does have a right to protect some of the information it uses in its calculations, I do consider that due to its

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identified failings it should on this Review outcome clearly show the Complainants how it reached its review figures, that is, show (by providing specific figures it used), how it arrived at the position where the life cover was to be reduced from £943,000 to £559,295.

Having regard to the above, it is my Legally Binding Decision that the complaint is substantially upheld and I direct the following:

(i) the Provider is to clearly show the Complainants how it reached its review figures, that is, show (by providing its calculation figures), how it arrived at the position where the life cover was to be reduced from £943,000 to £559,295.
(ii) the Provider is to show in its annual statements going forward what the cost of life cover is in comparison to the premium being paid.
(iii) for the identified communication failings the Provider is to pay the Complainants a compensatory payment of Stg£3,000 (3,000 thousand pounds sterling).

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to (i) clearly show the Complainants how it reached its review figures, that is, show (by providing its calculation figures), how it arrived at the position where the life cover was to be reduced from £943,000 to £559,295 (ii) show in its annual statements going forward what the cost of life cover is in comparison to the premium being paid and (iii) to pay the Complainants compensatory payment of Stg£3,000 to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

15 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.