An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0419
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Results of policy review/failure to notify of policy reviews
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a Whole of Life policy, incepted 30 years ago in **June 1989**. The Complainants were advised by this Office on **17 June 2019** that any conduct related to the sale of the policy would not be examined as part of the investigation and adjudication of their complaint due to the passage of time since the policy was sold. The complaint is that the Provider wrongfully increased the premiums on the Complainants' policy and that it failed to correctly administer the policy.

The Complainants' Case

The Complainants submit that they purchased the policy in 1989 from an independent intermediary. They further submit that the policy was mis-sold to them and that they were not advised that their premiums would rise in later years to an amount that was *"out of [their] range"*. The Complainants state that they were not told when taking out the policy that it would be reviewed, and that, as a result of these reviews, the premiums could rise. The Complainants contend that they have been paying in to the policy for many years and that they *"should have something"* as a result. They state that they are unhappy with the amount that the premiums have increased by in recent years.

The Provider's Case

In its formal response to this office, the Provider sets out the details of its administration of the policy, including policy reviews and a number of encashments by the Complainants. The Provider submits that it has, on a number of occasions, advised the Complainants that the cost of maintaining life cover increases with age, and that when the cost of maintaining the benefit exceeds the premium amount paid, the difference is made up from the plan fund. The Provider details its admitted shortcomings with regard to the administration of the Complainants' policy including:

- The fact that there are *"no retained records"* of the first and second scheduled policy reviews;
- A miscommunication to the Complainants in 2009 regarding the impact of the return of a withdrawal from their policy fund;
- A default *"Policy Review Option"* being implemented in August 2009 as a result, and a manual intervention being implemented to correct this, which resulted in the Complainants' plan *remaining "un-reviewed until the next scheduled Policy Review which was due in 2014"*.

The Provider states that the Complainants raised a formal complaint in **May 2012**, regarding a course of action suggested by the Provider that would see the Complainants voluntarily increasing their monthly premium *"in order to sustain their benefits beyond the next scheduled review in 2014 to 2018"*. The Provider contends that its above mentioned error resulting in the Complainants' plan remaining *"un-reviewed"* was discovered at this time, and that the Provider *"undertook a manual review and the calculations backdated to 2009 so as not to disadvantage the Complainants financially"*. The Provider submits that as a result of this *"unscheduled"* review in **May 2012** the Complainants accepted an option which reduced their life cover in order to maintain the premium at its current level until 2014, when the next scheduled review was to take place.

The Provider contends that it carried out the 2014 policy review as scheduled, and, as the Complainants did not revert to select which option they favoured, the Provider implemented the default option in line with the policy terms and conditions. The Provider states that this default option reduced the Complainant's cover by more than half but maintained the current premium until *"the next scheduled review in 2020"*.

The Provider submits that the Complainants, on receipt of their annual benefit statement in **May 2018**, decided to voluntarily increase their premium in order to sustain their current level of cover until **May 2024**.

The Complaint for Adjudication

The complaint is that the Provider wrongfully increased the premiums on the Complainants' policy and that it failed to correctly administer the policy.

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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 **11 November 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.

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 Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

The policy which is the subject of this complaint was incepted in June 1989 and is a unit-linked, open-ended protection plan. The policy has the benefit of being a 'whole of life' policy, as long as the premiums continue to be paid and the Complainants can support the cost of the policy benefits. The main benefit of a unit-linked protection contract is that it affords the policyholder the opportunity to pay a premium in the early years that more than covers the cost of the life cover benefit, with the balance of the premium remaining invested in the designated investment fund. This allows the policyholder to build up a fund that is

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accessible at all times, or can help to supplement the cost of the premium paid in future years, allowing the policy benefits to be maintained.

I note the Provider's submission that the terms and conditions of the Complainants' policy provide for *"regular reviews of [the] plan and also following a withdrawal from the fund"*.

The policy document pertaining to the Complainant's policy states the following:

> *"The 'Policy Review Date' means the tenth anniversary of the Date of Commencement of the Assurance and thereafter each fifth anniversary thereof provided always that where the Life Assured or the older of the Lives Assured has attained age 70 and the Policy shall have been in force for not less than ten years the Policy Review Date shall mean each anniversary of the Date of Commencement of the Assurance".*

And:

> *"At each Policy Review date the Company's Actuary will:*
>
> *a) Review the Policy Fee and may adjust it to the level compatible with the scale then being charged by the Company for similar policies or to such level as the Company's Actuary deems appropriate.*
> *b) Determine the maximum Guaranteed Minimum Death Benefit the Company is willing to allow under the Policy until the next following Policy Review Date and in determining the said maximum Guaranteed Minimum Death Benefit the Company's Actuary will inter alia have regard to the Accumulated Fund on the said Review Date future options and Premiums under the Policy and then current mortality rates. If on a Policy Review date the Guaranteed Minimum Death Benefit under the Policy will be reduced to the said maximum or at the option of the Proposer(s) the amount of premium payable in the future will be increased to such amount as the Company's Actuary shall determine.*
> *c) Review the limits and charges specified… and adjust any he deems necessary.*
> *AND*
> *d) Review the rates of premium payable for the Ancillary Benefits."*

The Provider has furnished evidence that it forwarded a copy of the policy terms and conditions to the Complainants with its letter dated **25 August 2009**. I accept that the policy document provides for ongoing policy reviews in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date, and I also accept that though the policy was sold to the Complainants by an independent intermediary in 1989, the Provider made a copy of the policy terms and conditions available to the Complainants in 2009.

It is important to emphasise that even though a unit-linked whole of life policy allows the policyholder, in the early years, to build up a fund value over and above what is needed to

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pay for the life cover, this is generally dependent on the performance of the fund. It can be the case that, after a number of years, the policy will have little or no cash value. Such policies are not intended to be savings plans. Where withdrawals are made from the fund by the Policyholder, this will have an impact on what fund value is available thereafter to support the cost of the policy. In this regard, the Complainants' policy document states the following with regard to encashment:

> *"..... the Unit Account shall be debited with a number of Units equal in value at the then current Bid Price to the encashment requested. On partial encashment the Guaranteed Minimum Death Benefit shall be appropriately amended as determined by the Company's Actuary"*.

The Provider has evidenced that the Complainants made a number of withdrawals from their policy fund:

- In **April 1994**, the Complainants withdrew **£1500** from the policy fund.
- In **January 1999**, the Complainants withdrew **£2700** from the policy fund.
- In **December 2002**, the Complainants withdrew **€400** from the policy fund.
- In **May 2005**, the Complainants withdrew **€800** from the policy fund. This amount was returned to the Provider by the Complainants in **April 2006**.
- The Complainants made a further withdrawal of **€438.21** in **May 2009**. This amount was returned to the Provider in **June 2009** by the Complainants.

The Provider submits that, as per the policy terms and conditions, it carried out *"adhoc reviews"* after each of these withdrawals from the policy fund, and its records indicate that the reviews in 2005 and 2009 required that, due to the withdrawals the Complainants would need to either increase their premiums to maintain their chosen level of cover or to decrease their level of cover in order to maintain their premiums. When a review was carried out on foot of the 2005 encashment, the Complainants elected to return the withdrawn funds to the Provider to be reinvested in the policy fund, thereby maintaining their premiums and cover at the previous level. When the review was carried out on foot of the 2009 encashment, the Complainants received incorrect advice from the Provider, and, as a result, returned the withdrawn funds in the hope of maintaining their premiums and cover at the previous level.

It is important to note that the cost of providing the policy benefits increases as the life assured gets older. Usually, the accumulated fund diminishes the impact of the increasing premium required at each review date. However, if the premium level and the fund value together cannot maintain the policy benefits until the next review date, some action needs to be taken (either the premiums are increased or the sum assured is reduced). If the fund value has been largely/completely exhausted, the level of the premium increase required may be significant. It is for the Provider's actuaries to calculate in each such instance, the correct level of premium which must be paid to sustain the level of cover in place.

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

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the information to furnish 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 to liaise with the policyholder with regard to what, if any, action needs to be taken. This is important for the policyholder.

The Complainants submit that the cost of their premiums has increased so much in recent years that that it is difficult to sustain the payments. The Complaints make the argument, both in their submissions, and during telephone calls with the Provider (submitted in evidence) that the Provider has not correctly administered their Whole of Life Policy.

From the evidence submitted, I note that the Provider wrote to the Complainants on **13 March 2006** and stated the following:

> *"You withdrew money from your plan fund on 23/05/2005 and I wish to confirm that we have carried out a review of your plan. Taking money out of this fund means that the portion of your regular payments, which is used to pay for your protection benefits has increased.*
>
> *The reason for this plan review is to check whether your current payments are enough to maintain the cost of your protection benefits. As you get older the cost of providing these benefits increases. When the cost of maintaining your benefits reaches a stage where it is greater than your regular repayments, this difference is made up from your plan fund".*

I accept, therefore, that the Provider advised the Complainants on **13 March 2006** that the cost of their life cover benefit would increase with the passage of time, and that if the cost of this cover exceeded the premium paid by the Complainants that it would be supplemented from the policy fund.

On foot of a policy review, which was carried out by the Provider following the withdrawal of €800 by the Complainants from their policy fund, the Provider wrote again on **31 March 2006**, setting out its administration of the policy, including the following information:

- The indexation applied to the policy, including the information that the Complainants could *"opt to dispense with this option in any year"*;
- The increasing cost of cover due to advancing age (the Provider explains that the monthly premiums do not *"usually represent the actual cost of cover at that particular time"* and that, as a result, the policy fund value may build up in earlier years and later be used to supplement premiums that are lower than *"the real cost of cover"*);
- The fund performance, which, if it is lower than forecast, could become exhausted sooner than expected, resulting in the need to either increase premiums or decrease cover;
- The impact of the Complainants' recent encashment in the amount of *"€800"*.

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I accept that, in the above letter, the Provider made the Complainants aware of the indexation applied to the policy, and the fact that this was optional. I also accept that the Provider again advised the Complainants that the cost of life cover increases with age, and that changes to their policy fund (including any encashment) could result in the need to increase premiums or decrease cover. I note from the evidence provided that the Complainants elected to return the encashment amount referred to in the above letter in order to maintain their chosen level of premium and benefit.

The Provider wrote to the Complainants on **12 June 2009** to advise that it had carried out a policy review due to their recent withdrawal from the policy fund, and that it anticipated their payments would not be sufficient to maintain their chosen level of benefit from **August 2009**. The Provider enclosed the Complainants' payment and benefit options with this letter, and also noted that they could contact their financial adviser if they had any further queries with regard to the options presented. The Provider states that it incorrectly advised the Complainants around this time that if they returned the encashment amount that this would eliminate the need for a policy review. The Provider further submits that though the Complainants *"returned the cheque in good faith"* that the amount was *"returned to the policy as a one off lump sum and no connection was made"* to the pending scheduled policy review. The Provider submits that as a result of its admitted error, the default option was implemented on **18 August 2009** which reduced the Complainants' life cover benefit. The Complainants made a formal complaint to the Provider about this, and the Provider issued a letter on **25 August 2009** which included revised options that took the returned withdrawal amount into consideration. This letter also included an explanation of how the Complainant's plan operated, again setting out how the cost of providing life cover increases as the life assured gets older and the supplementing of policy premiums from the policy fund when the premiums alone are no longer enough to support the life cover benefit.

The Provider also stated in this letter:

> *"Being 20 years older since the commencement of your plan, means that the cost of cover will inevitably be higher simply because the age-related risk to be insured is greater".*
>
> *"The premium increase is a reflection of your increased age and the charges are a fair reflection of the increased risk being borne by [the Provider]".*
> *"I understand that you are annoyed that the review was not amended due to you returning your partial encashment. Unfortunately, in returning the partial encashment the review was not delayed to May 2010 as expected as the risk costs on the plan had increased and the [returned amount] was insufficient to cover this".*

On foot of a telephone conversation on **23 September 2009**, the Provider wrote to the Complainants on that date, stating that it was *"agreeable to reversing the Plan Review"*, which had taken place on the Complainant's plan, due to *"conflicting information"* they had received from the Provider. The Provider further stated that it was returning the Complainants' benefits to the previous higher level and it advised that as the Complainants' policy review would now take place in **May 2010** *"the additional cost to provide cover"* would be deducted from the policy fund until then. The Provider also mentioned in this

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letter some *"alternative options"* available to the Complainants, including a term plan *"where the cost of Life Cover could be lower"*, and suggested that the Complainants speak to their broker if they were considering switching plans.

The Provider also recommended in its letter dated **21 December 2009** that the Complainants speak to their broker if they wished to consider any options the Provider might have for reducing their payments and helping them to maintain their plan.

In a telephone call with the Provider dated **24 April 2012**, the first Complainant states that the policy premium increases are *"out of [the Complainants'] range"*. In the same call, the first Complainant states that the policy is supposed to be reviewed *"every five years"* but that the Provider has been carrying out reviews *"every four years"*. The first Complainant also states that the Complainants *"should have something"* for paying into the policy since 1989.

The Provider has furnished a copy of a letter to the Complainants dated **24 April 2012**. In this letter, the Provider explicitly states that the monthly premiums paid by the Complainants do not cover the monthly cost of their life cover. The Provider states that, as a result*, "the difference would be deducted from the value of [the Complainants'] plan until the next review on the latest date of 1 August 2014*".

Given the information contained in communications between the parties submitted in evidence, I accept that the Provider explained the administration of their policy to the Complainants on several occasions from 2006 onwards. The Provider has demonstrated that it addressed with the Complainants:

- Scheduled policy reviews
- Policy reviews that are not scheduled
- The increased cost of life cover as one gets older
- Indexation
- Withdrawals from the policy fund and the effects of making a withdrawal
- That advice was available from their broker

The Provider has also admitted that it made errors with regard to advices given to the Complainants about the return of an encashment amount in 2009 and the implementation of a default policy option as a result of these advices. The Provider has evidenced that it rectified this error by reversing the resulting policy review and revising the Complainants' life cover benefit back to its previous, higher, level.

Turning to the administration of the policy in recent years, I note that the Provider carried out a scheduled policy review in **May 2014**, and wrote to the Complainants to set out their premium and benefit options going forward. The Provider wrote twice more to the Complainants during the following weeks without receiving a response. During a telephone call with the Provider on **24 July 2014** (a record of which was submitted in evidence), the first Complainant discusses the recent policy review communication from the Provider, describing the options as *"very unfair"* and stating that the only affordable option for the

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Complainants was to reduce the life cover benefit. He states that he and the second Complainant *"had more than that paid into it"*. Having carefully considered the content of this call, I note that the Provider took the time to explain again to the first Complainant how the policy operates, including the fact that the policy fund is used in later years to supplement the increasing cost of the life cover benefit. I also note that the Provider mentioned during this call that the Complainants had the option of consulting their broker, though the first Complainant emphatically rejected this suggestion. The Provider stated that it had applied the default option to the policy, reducing the benefit in order to maintain the premium at the same level, and the first Complainant agreed with this as he says it was the only option he could afford.

The Provider's submission dated **2 August 2019** states that the Complainants' policy provides that the scheduled reviews were to be carried out on the tenth anniversary of the policy's inception, and thereafter every five years until the life assured turned 70 years of age *"once the previous 5 year review cycle had been completed in 2019 (2020 on)"*. Having examined the policy document, I note that in this regard it states:

> *"… and thereafter each fifth anniversary thereof provided always that where the Life Assured or the older of the Lives Assured has attained age 70 and the Policy shall have been in force for not less than ten years the Policy Review Date shall mean each anniversary of the Date of Commencement of the Assurance".*

Given that the first Complainant turned 70 years of age early in 2016, and that the policy had been in force for more than ten years at that point, I am of the view that the Provider should have carried out policy reviews each year from 2016 to date. While I accept that the Complainants elected to voluntarily increase their premium on receipt of their Annual Benefit Statement in **May 2018**, thereby sustaining their chosen level of cover until **May 2024**, the policy document sets out that yearly reviews apply after the life assured turns 70 and the Provider should have adhered to this. However, there is no evidence before me that the Complainants have experienced any financial loss or inconvenience as a result of some reviews being missed.

I note that the Provider has issued Annual Benefit Statements to the Complainants in recent years, and that in each statement since 2010 the Provider has advised that the value of the policy fund was ***"€0.00"***. The Complainants were also advised by the Provider in these statements that the value of the fund would be used, in addition to the premiums paid, to fund their policy benefit *"in the late, more expensive years"* of the plan. Taken on its own, the meaning of this wording might not be clear. However, the Complainants were advised by the Provider in its letters of **March 2006**, **August 2009**, **September 2009** and **April 2012** that the cost of their life cover would be supplemented from the policy fund once it was no longer covered by their monthly premiums. Furthermore, this was explained in detail to the first Complainant by the Provider during telephone calls in **June 2012** and **July 2014**.

I also note that in each of the Annual Benefit Statements issued to the Complainants since 2008 that the Provider reminded them that they could avail of financial advice from an independent intermediary should they wish to discuss their life cover options.

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For the reasons set out above, there is no evidence before me to show that the Provider has wrongfully sought to increase the Complainants' premium level payable for life cover or administered the policy in a way that resulted in loss or inconvenience to the Complainants in recent years. I accept that the Provider has taken all reasonable steps to inform the Complainants on a number of occasions how their policy works, and in particular, that the cost of life cover increases with age. The Provider has also explained to the Complainants the impact on premiums of a policy fund with no value.

The Complainants appear to be particularly unhappy with the way that the policy was sold to them in 1989, however the evidence shows that an independent intermediary, and not the respondent Provider, was responsible for the sale of the policy. It is important to note that the respondent Provider could not be held responsible for any conduct carried out by an independent intermediary.

The first Complainant, in his call with the Provider on **24 April 2012**, stated that he felt he *"should have something"* for paying into the policy since its inception. I would point out that the Complainants have had the benefit of life cover for over thirty years on foot of paying their premiums. If either of the lives assured had passed away during that time, the remaining policy holder would have received the benefit under the policy.

The Provider submits that it tried to resolve this complaint with the Complainants in **April 2019** by making an offer in full and final settlement of their complaint. The Complainants elected not to accept the Provider's offer at that time, but the Provider has stated in its formal response to this office dated **2 August 2019** that it is *"happy to re offer the amount of €5,000 made during its contact with the Complainants if the Ombudsman feels this may help resolve this dispute"*.

Given that this offer is still open to the Complainants to accept, it is my Decision that the complaint is not upheld and I suggest that the Complainants make contact with the Provider regarding the above mentioned offer.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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

3 December 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.