An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0120
Sector:	Insurance
Product / Service:	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

This complaint concerns the Complainant's life insurance policy with the Provider.

The complaint is that the Provider is not acting in line with the terms of the policy by increasing the annual premium on the policy.

The Complainant's Case

The Complainant took out a life insurance policy with the Provider in **September 1989**.

The Complainant submits that his monthly premium of €39 is being increased to four times that amount over the next two years. The Complainant submits that the premium of €39 per month is *"for life"* and this premium increase by the Provider is not in line with the terms of the policy and is *"sharp practice"*.

The Complainant also queries why the benefits under the policy have reduced so dramatically from €9,017 in **2015** to €8,191 in **2019** when the fund growth was assumed to be 3.5% pursuant to a letter dated **13 June 2019**. The Complainant also submits that a letter dated **5 October 2004** from the Provider stated that *"the increase in monthly payments to maintain end of life cover are stated to be €78.75"* and he asserts that *"this is in contrast to latest statement provided of €213.66 on letter dated **3 July 2019**"*. Furthermore, in this same

response letter the Complainant encloses the front page of his policy which he states he received from his broker and which he submits does not mention any increase in payments.

The Complainant also queries why no reviews took place on the policy between **1999** and **2009**.

The Complainant submitted further information on **16 August 2019** in response to the Provider's letter dated **14 August 2019**. In this correspondence he stated that at no time was it ever brought to his attention that *"the lump sum was to be used to fund the monthly premium"*. He also queried why a *"five fold increase in premium"* was never mentioned and queries whether a *"one page schedule/specification"* inserted in his policy document was designed to fool him. The Complainant states that had earlier reviews been carried out he would have cancelled his policy years ago.

Ultimately, the Complainant wants his premium to remain at €39 per month and retain his existing level of cover under his life insurance policy.

The Provider's Case

By way of response, the Provider submits that the monthly cost of the life cover on the plan depends on several factors including, but not limited to, the age of the Complainant. The Provider submits each time it received a payment from the Complainant in relation to the plan, it purchased units to cover the cost of maintaining the plan and its benefits and any units which remained made up the value of the fund. The Provider submits that over time the plan would have an accumulated fund value. The Provider submits that the fund value of the Complainant's life insurance fund and any other unit-linked life assurance policy is a reflection of the value of the units accumulated in the policy fund by premium allocation, times the unit price, less the cost of providing the cover attaching to the policy and the policy charges. The unit price of the policy fund reflects the performance of the underlying assets that make up the fund and can increase and decrease over time.

The Provider submits that as the Complainant aged, the cost of providing cover to him on the plan increased, due to the greater risks involved, such as death, and it submits that this is the reason the cost of providing life cover to the Complainant has become more expensive. The Provider submits that the fund value is used to fund the life cover during the more expensive years of the plan, such as when the Complainant would reach an older age.

The Provider submits that, in line with the policy terms, the plan was scheduled to be reviewed for the tenth anniversary of the policy, and each subsequent fifth anniversary of the plan, until the plan review scheduled directly before the Complainant's 60th birthday, and thereafter each anniversary of the plan. The Provider submits that it sent the Complainant a plan review dated **5 October 2004** to remind him of the plan reviews and explained that his plan had passed its plan review. The annual reviews from **2014** on have been based on an assumed projected annual fund growth rate of 3.5%.

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The Provider states that the difference in the options provided to the Complainant in **July 2018** was that the review assumptions were calculated over a 10 year, 20 year or whole of life terms, rather than over a 1 year term, as has been the case each year from **2014**.

The Provider stresses that there was no onus on the Complainant to increase his premium at this time and the only action that it suggested was that, should the Complainant wish to have long term certainty over the coming years that he could voluntarily increase his monthly premium to the estimated monthly premiums shown in the **2018** and **2019** reviews.

The Provider states that the option for consumers to voluntarily increase their premiums at the time of a review even if their policy has passed its review in order to pre-empt future increases, was introduced by the Provider in **2018** after this Office made decisions relating to the Provider's administration of its policy review process.

The Provider estimates that no changes will be required to the Complainant's level of premium payments until at least **July 2025** when it is calculated that his fund value will run out. The Complainant's next annual review is scheduled for **July 2020**.

The Provider submits that reviews of the Complainant's policy took place on the 10th anniversary of the policy (**1999**), then every 5 years thereafter (**2004**, **2009**, **2014**) and then annually thereafter once the Complainant had reached the age of 60 (**2015**, **2016**, **2017**, **2018**, **2019**). The Provider acknowledges that there are no retained records for the **1999** or the **2009** policy review but states that it is satisfied that the Complainant's policy passed these reviews as it passed all other reviews and submits that in any event, it does not believe that the Complainant was in any way prejudiced by the two undocumented reviews. The Provider submits that the outcome of all of the reviews, barring the **1999** and **2009** reviews were communicated to the Complainant.

The Provider states that the reduction of the Complainant's fund value from €9,017 as per the annual benefit statement of **July 2015** down to €8,191 as per the annual benefit statement of **July 2019** is wholly due to the fact that the annual charges applicable to the Complainant's life plan have exceeded the amount of the annual premium paid in. The Provider submits that a cursory glance at page 4 of the Annual Benefit Statements will show that by **July 2019** the total charges applicable to this plan amounted to €1,245.84 whereas the total annual premium paid for the previous 12 months amounted to only €475.02, leaving an annual shortfall of €770.82, which was made up from the fund value, thus reducing it by this amount. The Provider submits again that it is this continued disparity between the cost of running the plan and the amount the Complainant is paying in annual premiums which will ultimately make the plan unsustainable and why an increase in premium will be needed. In this letter the Provider also addresses the query from the Complainant concerning its letter dated **5 October 2004**. The Provider states that this letter *"presented the premium that it was estimated was needed to sustain the Complainant's chosen life cover at the time of €39,362, on a whole life basis and based on his age at the time, which was 53. As per the notes at the bottom of the page, the figure was also based on an assumed future fund growth rate of 5% per year"*. Furthermore, the Provider states that the most recent policy review letter dated **3 July 2019** presents a premium of €213.67

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that is estimated to sustain the Complainant's current life cover of €39,362 on a whole life basis and based on his current age, which is 68, a difference in age of 15 years from the **2004** quote.

The Provider submits that as per the attaching notes to that **2019** letter, the figure is based on an assumed future fund growth rate of 3.5% per year, which is a difference in assumed future growth of 1.5%.

In respect of the one page policy schedule/specification submitted by the Complainant from his broker, the Provider submits that this is too limited in size to encapsulate all the terms and conditions of a particular policy and this is why the Complainant was referred to a separate terms and conditions documents for an understanding of the workings of the policy.

The Provider states that customers of life insurance policies have the opportunity to access the value of the accumulated fund at any time in cash but this would impact on the policy in the long terms and result in a requirement for a higher premium payment sooner than would have been the case had the fund remained untouched. In this letter the Provider addresses the Complainant's contention that had earlier policy reviews been carried out, he would have known about expected increases in premiums and would have cancelled the policy long ago. In response to this the Provider states that the Complainant was notified of the outcome of a scheduled policy review in **2014** which included a frequently asked question enclosure which explained in detail that a premium increase would become necessary when the combined value of the fund and the premium were no longer sufficient to cover the cost of providing the death benefit. The Provider also states that from **2015** onwards, annual benefit statements were issued to the Complainant which included a policy review section which again highlighted the review process and when the next review would be carried out. The Provider points out that at no point did the Complainant cancel his policy following these notifications.

The Provider states that it is satisfied that the terms and conditions of the life insurance policy provide for plan reviews and that it is also satisfied that it has regularly reminded the Complainant of those policy reviews.

The Complaints for Adjudication

The complaint for adjudication is that the Provider is wrongfully increasing the monthly premium for the Complainant's life policy and that its communications in relation to the policy were deficient.

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

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

A Preliminary Decision was issued to the parties 20 February 2020, 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, I set out below my final determination.

I note that a review of the Policy should have been carried out on in **1999** and subsequently in **2009** and while I note that the Provider states its belief that these were carried out, on balance, I find it unlikely that these reviews were carried out given the lack of documentary evidence provided. In any event, it is accepted by both parties that these reviews were not notified to the Complainant.

I note that the life insurance policy under dispute is currently in force and the current premium is €38.47 per month (inclusive of the 1% government levy) and the current life cover provided is €39,362. The most recent policy review conducted in **July 2019** has confirmed that the current premium, in combination with the current fund value of €8,191.45 is sufficient to maintain the current level of benefit of €39,362 until the next scheduled annual review in **July 2020**.

The Provider's failure to conduct policy reviews and/or communicate with the Complainant in relation to those reviews as per the terms and conditions of the Policy, is satisfactory. The Provider asserts that regardless of whether the reviews were conducted or not, this has not had any material financial impact upon the Complainant. This however is to ignore the fact that reviews of such policies are an important feature of the policy. They provide an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, the results of such reviews give the policyholder an up to date picture of the level of cover chosen and provides an indication as to how long the policy fund is likely to sustain that cover. This is particularly important as it enables the policyholder to consider what, if any, action needs to be taken. In not carrying out reviews or not communicating the outcome of

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such reviews and thereby depriving the Complainant of the results of the reviews of the policy, the Complainant was denied an early opportunity to decide what action he wished to take regarding the policy.

Indeed, more than fifteen years elapsed during which time the Complainant received no details of any policy review, so that he was considerably older by the time he was alerted to the future cost of maintaining cover at the original level.

While I accept that the value of the fund could rise or fall and it was not a guaranteed value, I do consider it reasonable that a Provider communicates at the earliest opportunity, typically at the review stage, whether or not the premium being paid is sufficient on its own to cover the cost of providing the policy benefits. I believe that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is for the purpose of life insurance.

I note the likelihood that the premium required to maintain the Complainant's policy following future reviews will increase considerably, when compared to the existing premium paid.

That said, I accept that the policy terms and conditions that the parties agreed to from the outset, outlined the policy features. Accordingly, the Provider was entitled to review the policy. I further accept that the documentation sent to the Complainant in respect of his policy did not set any expectation that the protection benefits and premium would remain at the same level throughout the lifetime of the policy.

The Provider has obligations in relation to the quality and accuracy of information it should have provided to the Complainant. I accept that there was a failure by the Provider in **1999** and **2009** to correctly inform the Complainant about how the policy had been administered relative to the review provided for in the policy document and to follow up in those years with regard to the level of cover the Complainant wished to have in place. This is disappointing and of concern, especially given that the information made available to the Complainant over the years failed to alert him to this aspect of how the policy operates. I consider that greater communication by the Provider was required over the years as regard the extent to which the fund value was being used to support the cost of cover and in relation to the reviews that took place over the years and this could have been explained more clearly to the Complainant. I accept that there was a failure by the Provider to adequately inform the Complainant about how the policy was being administered, relative to the contractually required reviews. I also accept and welcome the fact that the Provider's communications in relation to policy reviews seems to have improved based on the information furnished to the Complainant with the 2014 review which included a frequently asked questions enclosure supplied with that correspondence.

While I accept that there were lapses by the Provider in regard to the administration of this policy, I do not accept that these lapses warrant a direction for the Provider to maintain the benefits in perpetuity at the existing premium level. Furthermore, I acknowledge and welcome the Provider's attempts to communicate in advance the future possible impact of reviews at this stage. The issues arising in this complaint are ones that required better

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administration and greater and better communication from the Provider in relation to the policy reviews in the past. Therefore, I accept that a compensatory payment is merited in this complaint.

Having regard to the failings on the part of the Provider in relation to communications surrounding the **1999** and **2009** policy reviews, I partially uphold this complaint and direct the Provider to make a compensatory payment of €1,000 (one thousand euro) to the Complainant.

Conclusion

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

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €1,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider.

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

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

13 March 2020

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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.