Decision Ref:	2020-0135
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Fees & charges applied (life) Delayed or inadequate communication Results of policy review/failure to notify of policy reviews
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns alleged misinformation and misrepresentation by the Provider over the course of a number of years in respect of a unit-linked 'Flexible Last Survivor' life protection plan [a Section 60 (Finance Act 1985) Inheritance Tax Policy].

The Complainants' Case

A third party represents the Complainants in relation to their complaint. Submissions made by the Complainants' representative will be referenced in the course of this Preliminary Decision as those of the Complainants.

The Complainants submit that *'the basis for our complaint relates to the fact that for many years [the Provider] has deducted specific amounts from the saving element of our life policy without our prior knowledge.'* The Complainants refer in this regard to *'the unclear and misleading correspondence received from [the Provider] … which advised explicitly under review an annual premium of circa €7,000 annually and did not clearly disclose the fact that [the Provider] were reducing the savings element of the policy annually'*. The Complainants state that *'the levels at which the fund savings value was reduced annually and the effective 'true premium cost' are and were not clearly disclosed'*.

The Complainants go on to refer to *'… the manner in which [the Provider] notified [them] … about plan payments [which] was totally ambiguous.'*

The Complainants refer, by way of illustration, to the text set out under the heading *'Plan Review'* contained in their Annual Benefit Statements, which reads:

'A review of your plan payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time'. *'We estimate your payments will maintain your benefits'.*

The Complainants ask: *'Why did [the Provider] not state in the annual statement that a review of the plan payments and benefits confirmed that the payment (i.e. €7,110.94) was not sufficient to cover the cost of the benefits?*

The Complainants also submit: *'In addition to the annual payment of €7,110.94 per annum, [the Provider] for many years were deducting between €2,350 and €3,320 per month from the savings element of this policy'.* The Complainants ask '*why did [the Provider] not include in the annual statement under "Your Payment Details" the deductions (between €2,350 - €3,320 per month) from the savings element of the policy … these specific amounts were never disclosed at any stage in any annual statement* **…'**

In addition, the Complainants are unhappy with notification received from the Provider in 2016 stating *'that a substantial increase in the annual payment of €7,110.94 is going to be required in order to maintain the current level of benefit'.* The Complainants submit that they believe this increase to be *'unacceptable'.*

In resolution of their complaint, the Complainants are seeking '*a refund of the amounts deducted from the savings element of the plan.'*

The Provider's Case

The Provider sets out that the Complainants took out an 'Inheritance Tax – Flexible Last Survivor Policy' in **1991** through an independent financial advisor.

The Provider submits that *'it has administered this policy in line with the stated Terms and Conditions.'* The Provider contends that this policy was a flexible protection plan and not a savings plan, and its purpose was to cover the lives assured's next of kin's estimated inheritance tax liability '*as per the duly completed Section 60 Joint Life Last Survivor Trust Form'.*

/Cont'd…

The Provider refers to the Complainants' assertion *'that the basis for the complaint relates to the deduction of specified amounts from the savings element of this policy without prior knowledge'* and states as follows in response:

> *'… the Provider would … point out that the mechanism for how the policy's associated fund value is accumulated by way of Unit Allocation, following payment of the monthly premium and the collection of the various monthly charges, including the risk costs, by way of Unit Deduction is set out in the Terms and Conditions of this policy.*
>
> …
>
> *There is no requirement for the Provider to seek prior permission or agreement from the Policyholders to use the accumulated fund to support the maintenance of the cover attaching to the plan by way of unit deduction, as this is an integral part of the workings of this type of policy'.*

In relation to the disclosure of charges, the Provider refers to *'the relevant sections of the Terms and Conditions relating to how the various fees and charges associated with this Flexible Last Survivor - Inheritance Tax Policy are deducted from the accumulated fund value'.*

In response to the unhappiness expressed by the Complainants with '*ambiguous'* annual statements, the Provider notes as follows:

> *'The Complainants' representative … asserts that the Annual Statements issued by the Provider were unclear and misleading in respect of the Plan Review Section and quotes a number of excerpts relating to the premium being sufficient to maintain the cost of the benefits at this time. What is omitted is the fact that from 2011 on the Provider was reviewing the plan on an annual basis and therefore the review only confirmed that the premium was sufficient to maintain the benefits until the next annual review in 12 months' time'.*
>
> *'Prior to 2011, each Annual Statement (from 2007 to 2010) provided a specific future date when it was estimated that the current premium would cease to be sufficient to maintain the benefits after that date. The reason the word estimate was used was due to the fact that an assumed fund growth rate (4.3%) was being used to calculate the future review date and if the assumed fund growth rate was not achieved in reality, the review date could change. It can be seen from the copy statements … that between 2007 and 2010 the estimated future review date fluctuated between 2013 and 2014. In fact due to a higher fund growth rate being achieved, the actual review date was pushed out until 2016.'*

/Cont'd…

In response to a perceived lack of disclosure on the part of the Provider in relation to the risk cost, the Provider states: *'… with regard to the disclosure of the specific amount of risk cost being deducted from the accumulated fund in these annual statements - prior to the issue of the 2012 Consumer Protection Code, there was no obligation on financial providers to include this level of detail in their annual statements. However, from the statement period 2013/ 2014 on, the total annual Risk Cost amount was included in each subsequent statement'.*

The Provider also addresses the Complainants' unhappiness with the Provider's recommended premium increase following a policy review in 2016. The Provider submits that *'the Review options do not form a part of the Flexible Last Survivor – Inheritance Tax Policy's Terms and Conditions and therefore are not mandatory.'* The Provider goes on to explain that:

> *'The purpose of the recommendations offered in June 2016 as part of the Policy Review process was to give the Complainants the option to either increase their annual premium or reduce their level of benefit in order to maintain the policy going forward, rather than allow the policy to automatically cancel, when the fund went negative, as would be the case if the Provider adhered to Clause 20(ii) of the … Policy Terms and Conditions.'*

The Provider clarifies that, in July 2016, the Complainants elected '*Option A'* contained in its Plan Review Options letter which meant that the Complainants were choosing to pay a higher premium in order to maintain the policy benefits. However it appears that the policy went '*out of force'* in September 2016 due to non-payment of premium. The Provider states that in November 2016 it received notification from the Complainants' broker that the Complainants did not wish to continue with the policy.

I note this policy was sold by an independent third party broker. The conduct of that broker and the sale of the policy does not form part of this investigation. This investigation deals solely with the conduct of the Provider.

Evidence

As part of my investigation, I have reviewed the following evidence on file and have noted, in particular, the following:

1991 Proposal Form

A completed 'Proposal for Life Assurance' Form was signed by the Complainants on 22 May 1991.

/Cont'd…

The type of policy selected was the following:

1. Plan Type

Flexible Savings – Single Life or Joint Life ☐	*Education Fees – Single Life or Joint Life* ☐
Flexible Protection – Single Life or Dual Life ☐	*Flexible Protection – Keyman* ☐
Flexible Protection – Partnership ☐	***Inheritance Tax – Single Life or Last Survivor*** ☑
Other ☐	

(emphasis added)

Section 60 Joint Life Last Survivor Trust Form

A 'Section 60 Joint Life Last Survivor Trust Form' was signed by the Complainants on 22 May 1991. In this document, the following is detailed:

> *'… the policy is … a qualifying policy within the meaning of … Section 60 as amended … to pay the Relevant Tax for which the Beneficiaries shall be primarily accountable in the proportions in which they shall be so accountable.'*

1991 Letter of Acceptance

A 'Letter of Acceptance' was signed by the Complainants on 11 July 1991. In this Letter, the following information is contained:

> *'…*
>
> ***CLASS OF POLICY:*** *INHERITANCE TAX*
>
> *…*
>
> ***BENEFITS:*** *Life Cover*
>
> *…*
>
> ***AGREEMENT AND DECLARATION****:*
>
> *I hereby agree to accept a policy subject to the terms set out above and instruct you to proceed with the preparation and issue of the policy …*
>
> *…*

/Cont'd…

SIGNATURE OF GRANTEE(S):

[the First and Second Complainant signed here]'

Policy Provisions

The Complainants' policy document is entitled 'Flexible Last Survivor Plan Policy Conditions' and sets out, among other things, the following:

ALLOCATION OF UNITS AND UNIT PRICES

15. The funds to which the benefits of this policy may be linked are separate funds maintained by the Company as part of its life assurance fund for the purpose of calculating the benefits, payable in money, under certain policies issued by the Company. Each fund shall consist of one or more categories of unit …

16. Allocations will be made in respect of each Life Premium payable under this policy to units of one or more of the funds to which the Company then permits the benefits of this policy to be linked. The amount so allocated will be divided between the aforementioned funds in such proportions as are determined by the Grantee(s) and the said amount will be allocated to units of these funds at their offer prices on the valuation day next following the Life Premium due date, or the date or receipt by the Company of such Life Premium, if later.

…

18. (i) Valuation day is a day on which the offer and bid prices of [the] Units of the funds are determined. This determination is based on the value of the assets of the funds and takes full account of the expenses of acquiring, managing and selling the assets as well as making appropriate provisions for any taxes that may become payable by the funds.

The offer prices are the value at which the amounts allocated to units in respect of premiums are converted into units of the funds. The bid prices are the values at which units of the funds are converted to determine the benefits, payable in money, under the policy.

(ii) The income from the investments of the funds accrues to and forms part of the funds and all outgoings and expenses in respect of the investments of the funds and any deductions for tax on the funds' investments or investment income are deducted from the funds.

(iii) A monthly charge will be deducted from each fund in respect of each category of unit. The rate of charge in respect of each category of unit will be determined by the Company each month and the rate of charge may differ from one category of unit to another.

/Cont'd…

20. (i) If the number of units attaching to the policy is less than the number of units to be met by a deduction from the units attaching to the policy, a negative balance of units will be attaching to the policy after the said deduction is made. The number of units attaching to the policy after the said deduction is made shall equal the number of units attaching to the policy before the said deduction is made less the number of units to be deducted.

(ii) If at any time after the second anniversary of the Date of Policy the number of units attaching to the policy is negative, then the Company shall have the right to cancel the policy without value and all liability of the Company under the policy shall immediately cease.'

DEATH BENEFIT CHARGES AND POLICY CHARGES

26. A charge shall be made for the Death Benefit once in each calendar month at a time determined by the Company by deduction from the units allocated to the policy.

…

27. A policy fee shall be charged each month by deduction from the units allocated to the policy. The amount of the policy fee will be determined from time to time by the Company.

28. The Company shall charge any stamp duty that is payable to the Revenue Commissioners under this policy by deduction from the units allocated to the policy.'

Correspondence

23 October 1997 to the Complainants' original representatives at the time from the Provider:

'We have set out below as requested the Projected Surrender Value of the above mentioned policy':

Date	*Years from Inception*	*Estimated Encashment Value @7%*
08/07/2001	*10*	*£66,920*
08/07/2006	*15*	*£105,043*
08/07/2011	***20***	***£127,614***
08/07/2016	*25*	*£94,808*
08/07/2017	*26*	*£74,045*
08/07/2018	*27*	*£45,441*
08/07/2019	*28*	*£6,777*

(emphasis added)

/Cont'd…

22 January 2001 issued by the Provider's Life Quotation Department:

'PERSONAL ILLUSTRATION

Projection Date …	*Period from Years …*	*Estimated Encashment Value assuming 6.00% p.a. gross unit growth*
1-Jan-2019	***27***	***£100***

(emphasis added)

….

Note: Under the given assumptions including an assumed gross growth rate of 6.00% p.a., the policy will provide cover until January 2019. However, as this projection is based on the above assumptions, we recommend you apply for re-estimates at least every 5 years. Existing risk benefit cover is assumed to cease at the dates specified in the policy document.'

11/11/2003 Provider Benefit Statement addressed to the Complainants:

Date	*Estimated Fund Value assuming 6.4% gross growth p.a.*	*Estimated Fund Value assuming 4.8% gross growth p.a.*
July 2006	*€107,037*	*€102,653*
July 2011	***€117,412***	***€100,715***
July 2016	***€40,140***	***€5,234***

(emphasis added)

Statements issued by the Provider

May 2007:

*'If your plan does not have a separate savings element we may show your protection plan to have built up a value. **We will use this value to fund your protection benefits in the more expensive later years of your plan**. Please do not think of this as extra savings …*

…

/Cont'd…

Plan Review

*Assuming a future fund growth rate of … and our charges for benefits do not change, **we estimate your payments will maintain your benefits until 8 February 2014**. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time'.*

(emphasis added)

May 2008:

*'If your plan does not have a separate savings element we may show your protection plan to have built up a value. **We will use this value to fund your protection benefits in the more expensive later years of your plan**. Please do not think of this as extra savings …*

…

Plan Review

*Assuming a future fund growth rate of … and our charges for benefits do not change, **we estimate your payments will maintain your benefits until 8 October 2013**. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time'.*

(emphasis added)

May 2009:

*'If your plan does not have a separate savings element we may show your protection plan to have built up a value. **We will use this value to fund your protection benefits in the more expensive later years of your plan**. Please do not think of this as extra savings …*

…

Plan Review

*Assuming a future fund growth rate of … and our charges for benefits do not change, **we estimate your payments will maintain your benefits until 8 November 2012**. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time'.*

(emphasis added)

/Cont'd…

May 2010:

> *'This is a protection plan, so the value is not extra savings.* ***This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan*** *…*
>
> *…*
>
> *Plan Review*
>
> *Assuming a future fund growth rate of … and our charges for benefits do not change,* ***we estimate your payments with the support of the unit account, will maintain your benefits until 8 October 2013****. To avoid your plan ceasing at that time we will at the previous plan anniversary advise what increased payment you need to make to cover the cost of your benefits at that time.*
>
> *If you prefer, you can extend the period of cover by increasing your payment now. For example, we estimate that to sustain benefits until 8 October 2019, you would need to increase your current payment to €51,490.70. If you would like to do this, please contact us or your financial advisor.'*

(emphasis added)

May 2011:

> *'This is a protection plan, so the value is not extra savings.* ***This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan …***
>
> *…*
>
> *Plan Review*
>
> *A review of your plan payments and benefits confirms that* ***your payments are sufficient to cover the cost of your benefits at this time****. This assumes a future fund growth rate of … and our charges for benefits do not change.* ***We will continue to check your payment each year to ensure your payments are sufficient****.'*

(emphasis added)

May 2012:

> *'This is a protection plan, so the value is not extra savings.* ***This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan*** *…*
>
> *…*

/Cont'd…

Plan Review

A review of your plan payments and benefits confirms that ***your payments are sufficient to cover the cost of your benefits at this time****. This assumes a future fund growth rate of … and our charges for benefits do not change.* ***We will continue to check your payment each year to ensure your payments are sufficient.****'*

(emphasis added)

May 2013:

'This is a protection plan, so the value is not extra savings. ***This value will be used, in addition to your regular payment, to fund your protection benefits in the later, more expensive years of your plan*** *…'*

…

Plan Review

A review of your plan payments and benefits confirms that ***your payments are sufficient to cover the cost of your benefits at this time****. This assumes a future fund growth rate of … and our charges for benefits do not change.* ***We will continue to check your payment each year to ensure your payments are sufficient.****'*

(emphasis added)

May 2014:

'Plan Review

A review of your plan payments and benefits confirms that ***your payments are sufficient to cover the cost of your benefits at this time****. This assumes a future fund growth rate of … and our charges for benefits do not change.* ***We will continue to check your payment each year to ensure your payments are sufficient.****'*

(emphasis added)

May 2015:

'Plan Review

A review of your plan payments and benefits confirms that ***your payments are sufficient to cover the cost of your benefits at this time.*** *This assumes a future fund growth rate of … and our charges for benefits do not change.* ***We will continue to check your payment each year to ensure your payments are sufficient****.'*

(emphasis added)

/Cont'd…

May 2016:

> *'Plan Review*
>
> ***The next scheduled review for your plan is due now. This is when we check that the payments are enough to cover the cost of your benefits.*** *We will write to you separately with full details of this review and your options.'*
>
> (emphasis added)

Policy Review Correspondence issued by the Provider

4 May 2016:

> *'As you get older the cost of providing these benefits increases.* ***When the cost to maintain your benefits reaches a stage where it is greater than your regular payments, this difference is made up from your plan fund****.*
>
> *The terms and conditions of your plan state that we will cancel your plan if the value becomes negative.*
>
> *To prevent this from happening, we have recently conducted a review of your plan to calculate* ***if your combined payments and plan fund are still enough to cover the cost of your level of benefits****. In your case,* ***we anticipate that your payments will not be enough to maintain your current level of benefits from 8 July 2016****.'*
>
> (emphasis added)

The Provider then set out in this letter options for continued cover.

> 8 June 2016:
>
> *'… we wrote to you on 4 May 2016. We advised you that we had carried out your plan's review and that* ***your current payment, combined with the plan's fund value, is not enough to keep your current level of cover****. We also advised you of your options for continued cover. The fund value attaching to this plan has now reduced to the extent that the benefits under the plan will be cancelled in accordance with the terms and conditions, if your cover is not reduced or payment level increased.*
>
> *…*
>
> ***The purpose of a review is to determine if your current payments combined with your plan fund are sufficient to maintain the current and future costs of your cover****. When the cost of maintaining your cover reaches a stage where it is greater than your regular payments, the unit balance on your plan expires and goes negative.*

/Cont'd…

It is then necessary to adjust your payment to ensure the valuable benefits attaching to your plan will be maintained. Alternatively, under the plan terms and conditions the cover will cease and the plan terminates.

…

Note in the event that we do not hear from you, please be aware that in accordance with the plan terms and conditions, the plan will terminate when the fund value has been exhausted.'

(emphasis added)

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 March 2020, outlining my preliminary determination 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.

The Complaints for Adjudication

The Complainant is unhappy that the Provider eroded the '*savings element'* of the Complainants' life protection policy over the course of years, without informing them, communicated poorly and sought an unreasonable increase in the premium in 2016.

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Analysis

Having examined the evidence before me, I am satisfied that the policy held by the Complainants was a Revenue approved Section 60 Qualifying policy and that its purpose was to discharge the lives assured's next of kin's inheritance tax liability. This is borne out by the details contained in the Proposal Form, the Trust Form, and Letter of Acceptance all signed by the Complainants in 1991.

I can find no evidence that the Complainants elected to have a separate '*savings element'* to this policy. For example, on the completed Proposal Form referred to above, the only option ticked under the heading '*Plan Type'* was *'Inheritance Tax – Single Life or Last Survivor'.* I note for instance that the option entitled '*Flexible Savings …*' is left blank. I accept therefore that the Complainants' policy was, as put forward by the Provider, '*expressly effected as a Section 60 Inheritance Tax Policy'* at the time of inception. I am of the view that the Complainants' reference in their submissions to the '*savings element'* of their policy relates, in fact, to any built-up value in the plan fund itself, as opposed to a *separate/distinct* savings fund taken out by the Complainants at the time of policy inception.

I consider it appropriate to set out, at this juncture, how the Complainants' particular policy was designed to operate:

The policy that the Complainants took out in 1991 is a unit linked life protection contract, which has the benefit of being in place for as long as the premiums continue to be paid while they can support the policy benefits. The main reasoning behind unit linked protection contracts 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. The purpose of this is twofold, as it allows the policyholders to build up a fund, that is accessible at all times or it can help to supplement the premium paid in future years allowing the policy benefits to be maintained.

I would point out that even though a unit-linked life protection policy allows the policyholder to build up a cash lump sum over and above what is needed to pay for the life insurance, this usually only happens if the fund performs well. It can be the case that the policy will have a little or no cash value. Such policies are not intended to be savings plans.

It is also important to point out that the cost of providing the policy benefits increases as the life assured gets older when the risk of a claim becomes more likely. In effect, the accumulated fund diminishes the impact of the increasing cost of the policy benefits thereby minimising the increase in premium required. However, if the premium level and the fund value cannot together maintain the policy, some action needs to be taken (either increase the premium or reduce the sum assured). If the fund value has been effectively exhausted, the level of the premium increase required may be significant (as experienced by the Complainants when they received Plan Review Options correspondence from the Provider in 2016).

/Cont'd…

Based on my examination of the evidence before me, I accept that the Provider was entitled to extract policy charges (such as death benefit charges and policy fees) from the built-up fund, pursuant to Sections 26, 27 and 28 of the policy.

I also accept that correspondence issued in October 1997 setting out the Complainants' policy's projected surrender values indicated that the value of the policy (based on a number of assumptions) was estimated to 'peak' in 2011, and was estimated to decrease in value in the years thereafter. This projected 'peak' year, 2011, was reiterated in the Provider's 2003 Benefit Statement.

I accept that correspondence issued by the Provider's Life Quotation Department in 2001, put the Complainants on notice of a projected date *of '2019'* at which time the '*estimated encashment value'* (based again on a number of assumptions), would be *'£100',* that is, effectively depleted.

I accept that the Provider's Annual Benefit Statements showed the fund value to be on a downward trajectory from approximately 2011 onwards. I have set out below the fund values described in the Provider's Statements from the period 2007 onwards:

Year	***Approximate Value of Fund***
2007	*€141k*
2008	*€122k*
2009	*€83k*
2010	*€95k*
2011	***€91k***
2012	***€77K***
2013	***€71K***
2014	***€58K***
2015	***€43K***
2016	***€10K***

/Cont'd…

I have noted in particular the Provider's response to a request by this office for "*Evidence of when the Provider had begun to supplement the cost of cover from the policy fund':*

> 'It was **in July 2006** when for the first time since the commencement of [the] policy that the combination of the monthly Risk Cost (€657.24) and the monthly Policy Fee (€5.37) exceeded the monthly portion (€607.24) of the Annual Allocated Premium (€7,286.95) and which resulted in the accumulated fund value being reduced to make up the balance.'
>
> (emphasis added)

The Provider submitted in evidence a *'Screenshot taken from the Provider's Data Systems for the Complainants' specific policy, for the period between July 2005 and August 2006'.* I have copied below the following particular extract, which I am satisfied shows that the fund value was used by the Provider, in addition to the regular payment, from July 2006 onwards, to fund the Complainants' protection benefits.

Date	*Description*	*Amount Added*	*Amount Deducted*	*Accumulative Annual Costs*
16-Jun-06	*Risk Benefit Cost*		*-€540.82*	*€6,526.93*
16-Jun-06	*Policy Fee*		*-€5.37*	*€6,532.30*
	(Monthly Premium Breakdown)	*€607.24*		
14-Jul-06	***Risk Benefit Cost***		***-€657.24***	*€7,189.54*
14-Jul-06	*Policy Fee*		*-€5.37*	*€7,194.91*
	(Monthly Premium Breakdown)	***€607.24***		
11-Jul-06	***Allocated Annual Premium***	***€7,286.95***		
18-Aug-06	*Risk Benefit Cost*		*-€646.82*	***€7,841.73***

(emphasis added)

The Provider in its response to the complaint stated:

> *'The Complainant's representative … asserts that the Annual Statements issued by the Provider were unclear and misleading in respect of the Plan Review Section and quotes a number of excerpts relating to the premium being sufficient to maintain the cost of the benefits at this time.*

/Cont'd…

> *What is omitted is the fact that from 2011 on the Provider was reviewing the plan on an annual basis and therefore the review only confirmed that the premium was sufficient to maintain the benefits until the next annual review in 12 months' time'.*

If the Complainants' premium payments were *'no longer adequate to cover the cost of benefits'* from July 2006 onwards, then it was from this time onwards that the Provider was using the built-up value of the fund in order to maintain the cover, in addition to premium payments. I have noted however that the Provider's subsequent communications with the Complainants failed to make entirely clear that the cost of providing benefits under the policy had exceeded the premium payments paid. Taking the Provider's 2007 Annual Benefit Statement as an example, the Provider references the future tense when describing the time at which the fund would be used: '*We* ***will*** *use this value to fund your protection benefits in the more expensive later years of your plan'*. (emphasis added) The Provider in the same Statement also stated that that it was the Complainants' premium payments *only* which were maintaining the benefits at this point in time: *'… we estimate your payments will maintain your benefits until 8 February 2014.*

We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time'.

I believe these communications were not clear and misled the Complainants into thinking that their payments alone were maintaining their benefits even though the cost of cover had exceeded the Complainants' payments for one year approximately at this stage and the Provider had been using the fund value as well as a result.

The Provider's 2008 and 2009 Annual Benefit Statements set out wording similar to the above indicated that the fund value would be used at some future date but indicating that, for now, the Complainants' premium payments only were sufficient to maintain the benefits (even though, again, it was the premium payment and fund combined which were maintaining the benefits at this time).

The wording contained in the Provider's 2010 Annual Benefit Statement, I have noted, was quite different in comparison to the preceding 3 years' statements. The Provider indicated that it was estimating that the Complainants' '*payments* ***with the support of the unit account****, will maintain [their] benefits* ***until 8 October 2013'****.* (emphasis added) The Provider was making the Complainants aware that it would use **both** premium payments - in conjunction with the fund - to cover their benefits and that it was anticipated that it would need to continue doing this for the 3 years from 2010 to 2013. The Provider went on to say that: '*To avoid [the] plan ceasing at that time we will at the previous plan anniversary advise what increased payment you need to make to cover the cost of your benefits at that time'*. The Provider was therefore projecting that it would be informing the Complainants in its 2013 Annual Benefit Statement, what increased payment they would need to make in order to sustain their benefits going forward.

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However the Provider's 2011, 2012, 2013, 2014 and 2015 Annual Benefit Statements reverted to wording similar to that which had been contained in its 2007, 2008 and 2009 Statements: the Complainants' '*payments [were] sufficient to cover the cost of [their] benefits at this time ... We will continue to check [the Complainants'] payments each year to ensure [their] payments are sufficient'.* There is no clear reference in these Statements to indicate that the Provider was (still) using the fund, in addition to the Complainants' premiums, in order to maintain the level of cover even though I am satisfied that this was happening.

In particular, I cannot identify any correspondence issued by the Provider in/around 2013 clearly advising the Complainants what increased premiums they would need to make in order to sustain their benefits. The Provider had referenced in its 2010 Statement that it would contact the Complainants *'at the previous plan anniversary'* [in 2013] and '*advise what increased payment [they] need[ed] to make to cover the cost of [their] benefits at that time'.* However this does not appear to have been done. I acknowledge that '*a higher fund growth rate [may have been] achieved'* as is asserted by the Provider and that as a result *'the actual review date was pushed out until 2016.'*

Be that as it may, in my view, it still would have been reasonable for the Provider to issue some correspondence to the Complainants, especially in the context of the assurances it had made to them in its 2010 Statement.

On 4 May 2016 the Provider set out in its Policy Review correspondence the following regarding the status of the Complainants' policy:

> *'**<u>The terms and conditions of your plan state that we will cancel your plan if the value becomes negative</u>**. To prevent this from happening, we have recently conducted a review of your plan to calculate **<u>if your combined payments and plan are still enough</u>** to cover the cost of your level of benefits. In your case, we anticipate that your payments will not be enough to maintain your current level of benefits **<u>from 8 July 2016'</u>**.*
>
> (emphasis added)

This correspondence set out a number of options (A-C) to the Complainants. It also referred to the Complainants paying an annual payment of '*€7,110.94'* in 2016, and to the '*current value'* of the fund being *'€10,056.60'*. '*Option A'* set out that '*if you would like to maintain your current level of cover, you will need to increase your yearly payment to €62,983.37 from 8 July 2016'*.

The Provider followed up on its 4 May 2016 correspondence, with a further letter dated 8 June 2016. It included, among other things, the following:

> *'You may recall that we wrote to you on 4 May 2016. We advised you that we had carried out your plan's review and that **<u>your current payment,</u>** **<u>combined with the plan's fund value</u>**, is not enough to keep your current level of cover. We also advised you of your options for continued cover.*

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> …
>
> *The purpose of a review is to determine if **<u>your current payments combined with your plan fund</u>** are sufficient to maintain the current and future costs of your cover.'*

(emphasis added)

The Provider therefore set out in clear terms in its 2016 correspondence with the Complainants, that it was using the premium payment – in conjunction with the fund value – and that the two combined, would soon no longer be sufficient to maintain the level of cover. In my view, the clarity of language used in its 2016 correspondence (as set out in the above extracts) highlights the level of clarity in language required from the Provider in its correspondence from previous years. This level of clarity should have applied to all policy reviews.

I acknowledge that the Complainants were informed in correspondence dating from October 1997, January 2001 and November 2003, all referenced above, that the fund value was anticipated to peak and fall at an estimated future date. I also acknowledge that the current fund value was described in the Annual Benefit Statements sent to the Complainants. However I am satisfied that the Provider, neither in its Annual Benefit Statements nor in other communications, adequately communicated to the Complainants at the earliest opportunity the date from when the fund value had been used, in addition to the regular payment, to fund the protection benefits over the years, or when it was happening in the intervening periods**. Indeed, the opposite information was conveyed to the Complainants by the Provider in many of its communications.** I do not believe that it was reasonable of the Provider to merely advise the Complainants in its Statements in 2007, 2008, 2009, 2011, 2012, 2013, 2014 and 2015 that their premium payments were sufficient to cover the cost of benefits, without telling them that the cost of cover had exceeded the premium payment, and that the fund value was in fact being relied upon to cover the excess cost. It is in this context that I am unable to accept the Provider's following assertion by way of explanation of its conduct:

> *'We at no time issued a specific communication that specifically stated that the Complainants' premium payment was no longer adequate to cover the cost of benefits. However in conjunction with the Terms and Conditions of the policy, the various quotations, illustrations, projected values and details of fund value and charges issued over the duration of the policy, the Provider is satisfied that it provided the Complainants and their agents with sufficient information to monitor the progress of their … policy.'*

I consider that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is life assurance cover. After all, the importance to the Complainants of fully appreciating – at the material time – that the Provider was decreasing the fund in order to pay for the policy cover, was that they would have had the choice at an earlier date, as to whether to continue with the policy or withdraw from the policy and take the benefit of a higher surrender value.

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In this regard I am conscious that the fund was valued at approximately €95,000 in 2010, later valued at approximately €71,000 in 2013, and €43,000 in 2015 and this became a much lower value in 2016 of approximately €10,000. I do not agree that the Complainants were made aware of the full implications of the interaction between the fund and the cover at the material time over a course of years. Therefore, it is my opinion that the Complainants, as a result of poor quality communications on the part of the Provider, were potentially prevented from making an informed decision about their continued involvement in the policy at an earlier time when the value of the policy was much greater.

The Complainants received a notification from the Provider in 2016 stating *'that a substantial increase in the annual payment of €7,110.94 is going to be required in order to maintain the current level of benefit'.* The Complainants submit that they believe this increase to be *'unacceptable'.* From a review of the Plan Review Options Letter dated 4 May 2016 which issued to the Complainants, I note that the Complainants' *'current payments'* totalled a sum of *€7,110.94*.

The Provider set out that in order to maintain the current level of cover, the Complainants needed to increase their yearly payment by approximately 9 times to a sum of *€62,983.37*.

While I acknowledge that the proposed increase in premium was undoubtedly significant, as previously pointed out, it is the nature of these unit linked life protection policies that the cost of cover increases as the insured get older when the risk of a claim is greater. The setting of premiums is a matter for the commercial discretion of the Provider and I will not interfere with that commercial discretion. That said, I am of the view that the Provider has a particular case to answer in respect of the timeliness of its communications in its 2016 Policy Review correspondence. Following receipt of the Provider's 2016 Policy Review correspondence, the Complainants had a mere two months' notice of the impending reality that their plan would soon have a minus value, and that their policy would be cancelled in line with the policy terms and conditions if a nine fold increase in premiums was not paid by them, in order to maintain the cover. It is my view that the Provider left it very late to inform the Complainants that their fund value was eroding to such an extent that it would soon be of minus value.

I note that the Provider was carrying out a review of the policy even though this was not mandated by the policy Terms and Conditions. I also note that Complainants appear to have initially selected to increase their premium payments in order to maintain their benefits ('*Option A'*) following receipt of the Provider's 2016 Policy Review correspondence. However, I note the Complainants ultimately cancelled their direct debit confirming that they wished to withdraw from the policy, with the consequence that the policy was no longer in existence later that year due to non-payment.

Approximately 15 years into the policy's existence, in 2006, the Provider commenced using the fund value on an ongoing basis, in addition to the premium payments, to maintain the policy benefits.

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Other than a cursory reference to this being the case in the Provider's 2010 Annual Benefit Statement, and in its 2016 Policy Review correspondence (which issued just a few months before the policy went out of force), I am of the view that the Complainants were not clearly informed over a period of time, that their fund value had been used in addition to the regular payment to cover their protection benefits.

The overall issue here, therefore, having examined the submissions and the evidence received, is one of a requirement for better, clearer and timelier communication from the Provider – over a consistent number of years.

The Complainants have set out that in resolution of their complaint, they are seeking '*a refund of the amounts deducted from the savings element of the plan.'* Though their policy has been 'out of force' since 2016, I am conscious that the Complainants did have the benefit of life cover for approximately 25 years in all. Therefore, in the event that a claim had arisen, the Provider may have paid out the death benefit so that the lives assured's next of kin would have been in a position to discharge the estimated inheritance tax liability. Therefore, I do not believe that such a refund is merited.

Having regard to the particular circumstances of this complaint, especially the communication lapses that have been noted above, I consider that the appropriate remedy in this instance is that the Provider make a substantial compensatory payment to the Complainants. I therefore substantially uphold the complaint overall and in this regard I direct the Provider to make a compensatory payment of €40,000 (Forty Thousand Euro) to the Complainants.

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) (b) 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 Complainants in the sum of €40,000 (Forty Thousand Euro), 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.***

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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

6 April 2020

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.