An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0146
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews Dissatisfaction with customer service
Outcome:	Partially Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a unit-linked whole of life assurance policy on **1 November 1989** for life cover on a dual life basis in the amount of €12,697 (IR £10,000), at a monthly premium of €50.23 (IR £39.56).

The Complainants' Case

As at **September 2018**, the Complainants' policy was providing them with life cover on a dual life basis in the amount of €57,139, at a monthly premium of €57.12.

In its correspondence dated **4 September 2018** the Provider presented the Complainants with a number of policy review options, namely, to maintain the life cover benefit at €57,139 until September 2019 for an increased monthly premium of €403.38, or to maintain the monthly premium of €57.12 until September 2019 for reduced life cover in the amount of €15,536, or keep the life cover benefit at €57,139 *"for the rest of your life"* for a fixed monthly premium of €521.17.

In his email to the Provider dated 22 October 2018, the First Complainant advised that these policy review options *"are not acceptable to me and I wish to complain at the extreme severity of them"*. In this regard, the Complainants set out the *"extreme severity"* of these policy review options, as follows:

> *"Option A proposed an increased monthly payment of €403.38 for the same life cover. This represents an increase of 700% approx. until the 2019 review.*

> *Option B proposed reducing the life cover to €15,536…for the existing monthly payment. This represents a 73% approx. reduction in the life cover until the 2019 review.*
>
> *Option C proposed an increased monthly payment of €521.17 for the same life cover. This represents an increase of 900% approx.* [not] *subject to future review"*

In their email to this Office on 5 September 2019, the Complainants submit, amongst other things, as follows:

> *"The reviews of 2017 and previous years stated that there were no alterations needed to the policy. One year later in 2018* [the Provider] *demand* [premium] *increases of between 700 and 900% or a* [life cover] *decrease of 73%. If these figures are a true reflection of the cost to the Provider in 2018, it must question the validity of the previous years reviews given the poor performance of the fund over the previous years …*
>
> *The performance of the policy fund over a number of years was poor yet no action was advised or taken by the* [Provider]. *In October 2017 I took action which resulted in the fund growing by 8.4% as outlined in the annual review sent to me in September 18 …*
>
> *Given the massive alterations proposed for the policy in 2018, it must have been clear for a number of years prior to 2018 that these alterations were likely to arise in the future. If corrective action had been proposed/taken much earlier, the magnitude of the alterations would have been greatly reduced and the policy would be in a much stronger position now.*
>
> *The lack of action was not in the best interest of the customer"*.

In this regard, the Complainants note that the performance of the fund which their policy was buying units in, that is, the Liquidity Fund, was -0.8% per the annual statement dated September 2015, -1.08% per statement dated September 2016 and -1.23% per the statement dated September 2017. As a result, the First Complainant arranged for the Provider to change the fund in which their policy was buying units in to the Growth Managed Fund, which he notes had a fund performance of +8.49%, per the statement dated September 2018.

As a result, in their email to this Office dated 24 July 2019, the Complainants seek for the Provider to *"maintain the original policy benefits while applying a premium increase of less than 50%...based on the performance and reviews of previous years"*.

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The Provider's Case

Provider records indicate that the Complainants incepted a unit-linked whole of life assurance policy on 1 November 1989 for life cover on a dual life basis, in the amount of €12,697 (IR £10,000), at a monthly premium of €50.23 (IR £39.56). The Complainants subsequently increased the life cover to €38,092 (IR £30,000) on **28 May 1993** and to €57,138 (IR £45,000) on 5 July 1994. The Complainants incepted this policy with a different Insurer, whose books of business later merged with the Provider during 2014/2015.

By way of background, unit-linked whole of life plans, such as the Complainants' policy, originated in the 1980s and were designed to provide increased flexibility insofar as, for example, people might require more cover as they are raising a family and have a mortgage, but then could reduce this level of cover in later years when the cost of providing the cover is higher and the same level of cover is no longer needed. In this regard, unit-linked protection plans allowed the customer the ability to increase or reduce the level of life cover in response to their differing needs at particular stages in their lives.

When the Complainants incepted their policy on 1 November 1989, the monthly premium was calculated based on their gender, age and the level of cover being applied for. When a fixed term assurance policy is taken out, that is one that has a finite end date, and is not a whole of life policy, premiums are calculated on the same factors, but also taking into account the specified end date. This cannot be done with an open-ended whole of life plan, as to calculate the payments over an entire lifetime would be too costly from the outset. It is more beneficial for premiums on an open-ended whole of life policy to be set for a certain period and then to conduct a review on a regular basis to ascertain whether the premiums are still sufficient to cover the cost of the policy benefits.

When a fixed term policy reaches its end of term date, the cover ceases. Should a customer then want to take out a new protection policy, they will have to complete an application form and the new premium, if they are accepted for cover, will be based on their age and state of health at that time. Although whole of life policies, are subject to reviews at regular intervals, they can be continued indefinitely throughout a lifetime, irrespective of the policyholder's state of health.

Each time the Provider receives a premium, for a whole of life policy, it purchases units in the chosen fund. It then surrenders sufficient units each month to cover the cost of maintaining the policy benefits.
Any remaining units, following the deduction of the cost of the benefits and maintaining the policy, make up the value of the fund and so, over time, the policy accumulates a fund value. However, as the policyholder grows older, the cost of providing the life cover increases as the age-related risk to the insured is greater. The cost of life cover at any age is linked primarily to the proportion of people expected to die at those ages, that is, the mortality rate, which increases substantially at older ages.

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When the premium is no longer sufficient to cover the cost of maintaining the policy and its benefits, due to the increasing cost of the cover, the Provider, in accordance with the policy terms and conditions, relies upon the value of the fund. In due course, this reduces the value of the fund until it eventually becomes nil. This is why a policy review at that time will require either an increase in the premium to cover the cost of providing the life cover, or a reduction in the level of life cover to maintain the premium rate.

The Provider notes that the Complainants' policy is subject to review, in accordance with its terms and conditions. In this regard, the terms and conditions allow for the first policy review on the 5th anniversary of the date of commencement of the policy, with subsequent reviews conducted every 5th anniversary thereafter until such time that the life assured has passed their 65th birthday, when policy reviews are then conducted annually.

Provider records indicate that the first recorded policy review was carried out by the previous Insurer on the 10th anniversary of the policy in **November 1999**, with a further review conducted in **October 2001**. The outcome of both these reviews indicated that the policy had passed the review and that the premium and accumulated fund value at those times were sufficient to maintain the chosen benefits until the next review. The 2001 review also provided some projections as to what premium increases would be needed to sustain the benefits into the future for terms of five, ten and twenty years and for the whole of life.

The next recorded policy review was carried out in **October 2014**. The outcome of this review was that the policy had passed the review again, until the next scheduled review. This review also included a FAQ section explaining the background to policy reviews and why premium payments increase as policyholders get older and what steps should be taken to maintain the policy going forward, as follows:

> *"**Policy Review Frequently Asked Questions***
>
> 1. ***What is a policy review?***
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> *When you hold a unit-linked whole of life plan with* [the Provider] *we will undertake a regular policy review to assess the level of premium you pay and the benefits you receive under your policy.*
>
> *As unit-linked policies can run for many years, the charges and costs of maintaining them may change over time; as you get older, for example, the cost of providing your benefits increases. We review your policy to ensure that you are paying the correct amount into your policy to keep the level of cover you have chosen.*
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> 2. ***What happens in a policy review?***
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> *When we review your policy we will look at a number of factors relating to your policy including the following:*

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- *the age of the life assured under the policy*
- *the value of the unit-linked fund attached to your policy*
- *the cost of providing the level of cover you have selected*

We then assess whether the premium you currently pay is sufficient to maintain your cover until the next policy review.

3. What happens if my usual premium is not enough to maintain my cover?

When your usual premium is no longer enough to maintain your current level of cover and you do not have enough in your unit-linked fund to cover this difference, you can choose either to increase your premium amount or to reduce your level of cover.

Your Financial Advisor will be able to advise on which option is best for you. We recommend that you contact your Financial Advisor to discuss the options available before you make your final decision.

We will write to you to let you know what options are available to you and what changes these will make to your policy. When we write to you we will send a Policy Review Form to you to complete to inform us of the option you have chosen. It is important that you return your completed form by the deadline provided. If you do not inform us of your chosen option we are required to process the default option specified under your Policy Conditions".

From 2015, once the lives assured has passed age 65, the Complainants' policy was reviewed on an annual basis and the outcome of the review was signalled under the Plan Review section of the Annual Benefit Statements issued each year.

Following the 2018 policy review, the Provider, in its correspondence dated 4 September 2018, presented the Complainants with the following policy review options, namely, to maintain the life cover at €57,139 until September 2019 for an increased monthly premium of €403.38, to maintain the monthly premium of €57.12 until September 2019 for reduced life cover in the amount of €15,536 or to keep life cover at €57,139 for the rest of life for a fixed monthly premium of €521.17. As the Complainants did not select one of these options, the default option was implemented on 2 January 2019 and therefore, as at 23 August 2019, the Complainants' policy was providing life cover on a dual life basis in the amount of €15,536, at a monthly premium of €56.55 (excluding 1% Government Levy).

The Provider notes that the actual calculation of the options as outlined in the September 2018 policy review letter was done based on industry wide standard assumptions and projections and while the changes recommended are unwelcome, these are a true reflection of the cost to the Provider of continuing to maintain the Complainants' policy on a whole of life basis. In this regard, the Provider notes that all of its Actuaries are highly trained professionals, who are competent in their abilities to conduct the policy reviews required and to ensure that the outcomes of same are a true reflection of the cost to the Provider of continuing to main the Complainants' policy on a whole of life basis.

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The Provider is unable to comment as to why not all of the scheduled policy reviews were either not carried out or, if carried out, why no record was retained on file by the previous Insurer, prior to that Insurer's books of business merging with the Provider during 2014/2015. However, on the basis that the previous Insurer failed to either carry out the initial scheduled reviews in the early years of the policy or failed to keep a record of the reviews that were conducted, the Provider offers the Complainants a customer service payment of €5,000.

Finally, with regard to the Complainants' preferred resolution to their complaint, which is that the Provider *"maintain the original policy benefits while applying a premium increase of less than 50% based on the performance and reviews of previous years"*, the Provider notes that an increase in premium by anything less than the amount outlined in the September 2018 policy review correspondence would not be sufficient to maintain the level of cover that the Complainants wish to have attaching to their policy on whole of life basis and therefore would render the policy unmanageable and result in its cancellation.

The Complaint for Adjudication

The complaint is that the Provider:

1. Is wrongfully requiring the Complainants to either increase their premium payments or to decrease their policy benefits;

2. Has proffered below-par customer service throughout.

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.

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A Preliminary Decision was issued to the parties on **19 March 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, the final determination of this office is set out below.

The essence of the complaint at hand is that the Provider maladministered the Complainants' life assurance policy. In this regard, the Complainants incepted a unit-linked whole of life assurance policy on 1 November 1989 for life cover on a dual life basis in the amount of €12,697 (IR £10,000), at a monthly premium of €50.23 (IR £39.56). As at September 2018, the Complainants' policy was providing them with life cover on a dual life basis in the amount of €57,139, at a monthly premium of €57.12.

In its correspondence dated **4 September 2018** the Provider presented the Complainants with a number of policy review options, namely, to maintain the life cover benefit at €57,139 until September 2019 for an increased monthly premium of €403.38, or to maintain the monthly premium of €57.12 until September 2019 for reduced life cover in the amount of €15,536, or keep the life cover benefit at €57,139 for the rest of life for a fixed monthly premium of €521.17.

In his email to the Provider dated 22 October 2018, the First Complainant advised that these policy review options *"are not acceptable to me and I wish to complain at the extreme severity of them"*.

The Complainants' assurance policy, like all insurance policies, is subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

In this regard, Clause 16, **'Policy Review'**, of the applicable Policy Conditions booklet [3/89] provides, as follows:

> *"(a) The Sum Assured and Premium currently in force under this Policy shall be reviewed by the Actuary on the fifth Policy Anniversary and on every fifth Policy Anniversary thereafter unless and until the Life Assured attains age 65 following which the Review shall be made at each anniversary.*
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> *(b) At the Policy Review, the Actuary will determine the Maximum Sum Assured which the Company is willing to allow until the next following Review and in determining such maximum Sum Assured the Actuary will have regard inter alia to the value of units allocated to the Policy, to whether or not the Inflation Protector option is in operation, to future allocations of Units to be made in respect of Premiums payable until the next Review and to current rates of mortality.*

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> *(c) If the current Sum Assured under the Policy shall exceed the maximum as determined by the Actuary at Review, the Sum Assured shall be reduced to not more than the said maximum or, at the option of the Policyholder, the amount of Premium shall be increased to such amount as the Actuary may determine"*.

The Complainants' policy is a flexible unit-linked whole of life protection plan, providing life cover payable in the event of death. With policies of this nature, the cost of providing the life cover increases according to the ages of the policyholders and this cost depends on a number of factors, including gender, age and current mortality rates. As a person grows older, the cost of providing life cover increases because the age-related risk to the insured is greater.

A positive policy value may be built up in the earlier years, when the cost of the life cover is less than the premiums, but where the cost of life cover in later years becomes higher than the premium amount, the fund subsidies this difference. In due course, the fund is exhausted, resulting in the need for a policy review, which recommends either an increase in premium or a reduction in life cover.

Policy reviews are an integral part of a unit-linked whole of life policy. The purpose of these reviews is to assess whether the value of the policy and the on-going premium payments will together be sufficient to sustain the cost of life cover until the next review date. The premium calculation takes into account, amongst other things, the level of life cover provided and the ages of the lives assured, hence it may be necessary for the policyholders to make an additional provision to maintain the level of life cover by way of an increased premium. Alternatively, the policyholder may choose to maintain the life cover by decreasing the assured figure. The setting of a premium following a policy review is the prerogative of the appointed actuary and it is not appropriate for this office to seek to modify it.

I note that in their email to this Office on 5 September 2019, the Complainants submit, *inter alia*, as follows:

> *"The reviews of 2017 and previous years stated that there were no alterations needed to the policy. One year later in 2018* [the Provider] *demand* [premium] *increases of between 700 and 900% or a* [life cover] *decrease of 73%. If these figures are a true reflection of the cost to the Provider in 2018, it must question the validity of the previous years reviews"*.

It is important for the Complainants to note that unit-linked whole of life policies are not designed so that the insurer proposes increases in premiums, either gradually or otherwise, in an effort to maintain a fund value or to delay the fund from becoming exhausted. In this regard, as long as the monthly premiums and the fund value combined can meet the cost of providing the policy and its benefits until the next scheduled review date, the policy will pass a policy review.

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I note that the Annual Benefit Statements the Provider issued to the Complainants advised of a fund value of €5,138.95 on 4 September 2015, €3,886.28 on 4 September 2016, €2,395.46 on 4 September 2017 and €674.54 on 4 September 2018. As a result, it is only when the fund attached to the Complainants' policy was expected to reach nil prior to the next scheduled policy review date, in this case September 2019, that the Provider then presented the Complainants with policy review options necessitating either an increase in the premium to cover the cost of providing the life cover, or a reduction in the level of life cover to maintain the premium rate.

I note that the Complainants incepted their policy on 1 November 1989 with a different Insurer. It is for this reason that the Provider is unable to comment as to why all of the initial scheduled policy reviews were either not carried out or, if carried out, why no record was retained on file by the previous Insurer, prior to that Insurer's books of business merging with the Provider during 2014/2015.

This is disappointing, as it is entirely unclear why the policy reviews scheduled were not undertaken. I also note the Provider's reference to a "*10th Anniversary Policy Review*" in November 1999, and a "*12th Anniversary Policy Review*" in October 2001. The policy review clause within the policy provisions however, does not anticipate a "*12th Anniversary*" policy review, but rather refers to a scheduled first review of the premium on the 5th Anniversary in 1994, and every 5 years thereafter, up to November 2014 and from then, once the first life assured turned 65, in August 2015, reviews were scheduled to take place on an annual basis.

There is no evidence however that the Provider had any communications with the Complainants at those times, regarding the outcome of any policy reviews undertaken. I note that on the basis that the previous Insurer failed to either carry out the initial scheduled reviews in the early years of the policy or failed to keep a record of the reviews that were conducted, I note that the Provider offers the Complainants a customer service payment in the amount of €5,000.

When asked to furnish evidence of communications from the Provider to the Complainants, of the fact that the payment was no longer adequate to cover the cost of the benefits, the Provider submitted the 2013 Annual Benefit Statement and highlighted the details of the "*Policy Summary from 01/11/2012 to 31/10/2013*" showing the premiums received in the sum of €685.44, together with the "Benefit Charges" in the sum of €1,281.56. This appears to me to suggest that Provider is of the opinion that the Complainants ought to have drawn a conclusion from these 2 figures, and perhaps the closing surrender value of €6,768.28, (even if not then, perhaps the following year when the closing value on the statement was €6,003.53) to come to the realisation that the premium being paid was insufficient to pay for the cost of the life cover.

I am not however, convinced in that regard. I am satisfied that if the Provider had made this clearer to the Complainants, it would have given them the option of surrendering the policy when the fund was at that higher level.

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Insofar as the Provider was and is entitled to increase the premium as necessary, to facilitate payment of the cost of the life cover provided by the policy, I am satisfied that it did not act incorrectly. I take the view however, that it has a case to answer to the Complainants regarding the manner in which it failed to keep the Complainants adequately informed about the ongoing operation of the policy. Indeed, I believe that the Provider did not meet its obligation to the Complainants regarding the manner in which it provided information to them, contrary to its obligations under the Consumer Protection Code, which requires such information to be made available in a manner which is clear and comprehensible and indeed brings key items to a customer's attention.

Accordingly, I consider it appropriate to partially uphold this complaint. Although the Provider has acknowledged its absence of records and the failure of the previous provider to undertake policy reviews, it has not acknowledged the ongoing failure in 2014 and 2015 to undertake the policy reviews scheduled by the policy provisions in place with the Complainants, or to ensure that the Complainants were kept clearly informed of how the policy was operating.

In those circumstances, in partially upholding this complaint I consider it appropriate to direct the Provider to make a compensatory payment to the Complainants in the sum of €7,000 (to include the €5,000 previously offered) by way of compensation. It will be a matter than for the Complainants to decide which of the options available from the Provider, if any, they wish to accept to enable cover to be continued. Alternatively, it is of course open to them to let the policy lapse in which event, they will have no cover in the future under this policy. I would urge them to take independent financial advice if considering such an option.

Conclusion

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €7,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

15 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.