Decision Ref:	2021-0100
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Lapse/cancellation of policy (life)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant holds a life assurance policy with the Provider. The Provider cancelled the policy in **December 2018**.

The Complainant's Case

In a letter to this Office dated **14 April 2019** enclosing his Complaint Form, the Complainant explains that his complaint relates to the cancellation of his policy *"… on the grounds of no funds."* The Complainant states that he is seeking a refund of premium payments made since **2002** as the Provider continued to accept premiums *"… although they stated in 2002 that there were no funds have [sic] and now cancelled the policy on the basis of no funds."*

The Complainant explains that the policy was originally incepted with a financial services provider in **May 1984** and was subsequently taken over by the Provider, against which this complaint is made. The Complainant says *"… there was never a mention of no funds until 2002, a number of years after* [the Provider] *took over when they stated that there was no funds but would continue the policy if I made certain adjustments i e increase premiums or reduce cover."*

The Complainant submits that the Provider's conduct in cancelling his policy is *very deceitful* and is based on his age.

The Complainant refers to a letter from the Provider's Managing Director dated **March 2018** quoting the renewal figures up to **28 May 2019** which the Complainant states he accepted by letter dated **21 March 2018**.

The Complainant states that he received a letter from a Customer Services Manager on **1 December 2018** acknowledging the cancellation of his policy. The Complainant says he responded to this letter on **2 January 2019** but did not receive a response.

The Complainant says that he believes there are many people like him who have had their policies cancelled in similar circumstances and which the Provider *"… will disclaim to the bitter end."*

The Provider's Case

The Provider explains that the Complainant's plan began on **28 May 1984** which was a protection plan that provided life cover for the Complainant. The Provider has also set out the various providers involved in the plan and states that, at all times, it administered the plan in line with the original terms and conditions.

The Provider states that in the absence of the Complainant selecting an option in his 2018 plan review, the plan correctly cancelled in line with paragraph 13 of the terms and conditions. The Provider advises that prior to cancellation, the plan was providing the Complainant with death benefit of €134,010.

The Provider says it communicated the outcome of the 2018 plan review on **2 March 2018**. In this letter, the Provider states that it presented the Complainant with a number of different options for continued cover. The Provider says the alternative to selecting an option for continued cover was the cancellation of the plan in line with paragraph 13 of the terms and conditions.

The Provider advises that the Complainant's previous review was in 2012 and it wrote to the Complainant on **12 January 2013**, following the application of his chosen option, confirming that his next review would be in 2018.

The Provider also submits that the Complainant is very familiar with how the review process on his plan works. In this respect, the Provider refers to a previous complaint made by the Complainant to this Office and the *extensive* communication it had with the Complainant over the years, and each time the plan was reviewed; being 2002, 2007, 2012 and 2018. The Provider states it understands that the Complainant is a Fellow Chartered Accountant and as such, would easily know that difference between indexation (protecting the cost of benefits from the effect of inflation) and a plan review, and how the two are different and separate items.

The Provider states that its letter of **2 March 2018** which set out the options for continued cover was clear that the plan would cancel if the Complainant did not select an option.

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Referring to a telephone conversation with the Complainant on **22 March 2018**, the Provider states the Complainant confirmed that he received his plan review option letter.

In the absence of the Complainant selecting an option, the Provider says it sent a reminder letter on **25 April 2018**. The Provider states that it received written confirmation on **25 May 2018** that the Complainant wanted his 2018 indexation benefit to be applied. The Provider says it wrote to the Complainant the same day to confirm that indexation would be applied.

On **30 November 2018**, the Provider says it wrote to the Complainant confirming that in the absence of an option being chosen, his plan would cancel from **28 December 2018** in line with the terms and conditions. The Provider advises that this letter gave the Complainant a final opportunity to select an option and maintain his cover as an alternative to its cancellation. However, a plan review option was not selected.

The Provider states that in the absence of an option being selected, its system generated a cancellation letter on **1 December 2018** confirming cancellation from **28 December 2018**. The Provider explains that the Complainant had until this date to select a review option.

The Provider wishes to stress that it provides review options for continued cover as an alternative to cancellation when there is no value in a plan which is provided for in the plan's terms and conditions.

The Provider states that it apologises for any confusion caused by its letter of **1 December 2018** where it was confirmed that it had cancelled the plan *as requested*. The Provider states that it is ultimately the Complainant's decision to continue with the plan by selecting an option or to allow the plan to cancel. By not selecting an option, the Provider says the decision is being made by the plan owner to cancel their cover.

In **2002**, the Provider states that the Complainant's plan was *eroding to zero*, and that paragraph 13 of the terms and conditions provided for plan cancellation where the value becomes negative. As an alternative to this, the Provider says it offered the Complainant the option of continued cover and options were issued to the Complainant on **14 February 2002**.

The Provider states that in 2002, the Complainant's plan was put into a reviewable schedule with reviews taking place every 5 years and annually from the age of 70. The Provider states that these reviews offered the opportunity to maintain cover on the plan as the plan's value had eroded to nil and the plan would never accumulate a value going forward.

On plans of this nature, the Provider advises that it is more beneficial to offer options for continued cover as opposed to automatically cancelling cover in line with the terms and conditions. The Provider explains that in 2002, the Complainant elected to increase his payment, thereby maintaining his plan until the next review in **2007**. The Provider states it received a copy of this acceptance on **21 March 2002**. The Provider advises that the Complainant selected this option in respect of the **2007** and **2012** plan reviews.

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In respect of the **2018** plan review, the Provider states that it was very clear with the Complainant that in the absence of an option being chosen, his plan would cancel as there was no value attaching to it. The Provider states that the Complainant's decision was not to select an option and his plan cancelled.

The Provider advises that the Complainant's plan was not a savings or investment plan but a protection plan designed to pay out a life cover benefit in the event of his death. The Provider advises that while the plan could build up a value in its earlier years, this value was not savings. The Provider states that the Complainant's regular payments between reviews covered the charges to maintain the plan and its benefits.

The Complaint for Adjudication

The complaint is that the Provider wrongfully or unreasonably cancelled the Complainant's policy.

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 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 on 3 March 2021, 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.

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Following the issue of my Preliminary Decision, the Complainant made a further submission under cover of his e-mail to this Office dated 19 March 2021 together with further copy documentation delivered in person by the Complainant to this Office on 19 March 2021, a copy of which was transmitted to the Provider for its consideration.

The Provider advised this Office under cover of its e-mail dated 23 March 2021 that it had no further submission to make.

Having considered the Complainant's additional submissions, which did not raise any issues not previously considered in my Preliminary Decision, and all submissions and evidence furnished by both parties to this Office, I set out below my final determination.

Background

The Complainant incepted a life assurance policy with the Provider in **May 1984**. In the context of this complaint, clause 13 of the Policy Conditions states as follows:

> *"**13.** If at any time the cash value of the policy is negative, then the* [Provider] *shall have the right to cancel the policy without value and all liability of the* [Provider] *under the policy shall immediately cease. …"*

The Provider wrote to the Complainant on **2 March 2018** as follows:

> *"We're writing to you about your* [plan]*. As your* [plan] *is a reviewable protection plan this means we regularly check that the amount you pay monthly and any fund built up on your plan is enough to maintain cover. The cost of providing cover increases as you get older. We recommend that you regularly review the level of cover you need.*
>
> *We've carried out your latest review and your current payments and any fund value you've build up are no longer enough to keep your current level of cover.*
>
> ***Understand your options***
>
> *Below is a summary of the options available to you. You will find more detail on these over the next few pages.*
>
> ***Continue with your existing* [plan] *cover***
>
> ***Change to a Guaranteed Whole of Life plan with no reviews***
>
> *…"*

The options available to the Complainant were set out in the following pages and the Complainant was invited to complete and return the enclosed *Options Form* by **28 May 2018**.

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On pages 2 and 3, it was stated that:

> ***"If you don't reply to this letter, your plan will be cancelled when your fund runs out****."*

The Complainant also received annual statements in March of each year and received one such statement dated **March 2018**. The cover letter to this statement advised:

> *"We are sending you your* [Provider] *statement to keep you up to date with your plan.*
>
> *If you have made any changes to your plan since the beginning of the month, these may not be reflected in your statement over the page.*
>
> *When you started this plan, you chose to increase payments and benefits every year. This is called indexing. By increasing the payments, you are helping to protect the benefits of your plan over the long term. The attached benefit statement shows the increase in your monthly payments from €285.14 to €299.40, from 28 May 2018. …*
>
> *If you decide not to choose to increase this year please call our customer service team on …"*

On the next page it states, in respect of plan reviews, that:

> ***"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. …"*

The Complainant responded to this letter on **21 March 2018**, advising that he wished to accept the increased monthly premium of €299.40.

Subsequent to this, the Complainant raised certain queries regarding the Provider's March correspondence which, as is evident from the documentation submitted, the Provider sought to address.

During a telephone conversation on **22 March 2018**, the Provider's agent attempted to explain the letters sent to the Complainant in March and advised the Complainant that these letters should be read in conjunction with one another. The Complainant refused to accept this and asked where it stated that they were to be read together. The Complainant explained that he had accepted the increased amount in the indexation letter and that was the end of the matter insofar as concerned his premium payments.

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The Provider wrote to the Complainant on **27 March 2018**. This letter explained that:

> *"… We have sent you a Plan Review letter dated 2 March 2018 including options for the continuation of your Life Cover beyond 28 May 2018. Our Plan Review letter includes options to maintain your Life Cover and increase your payments, or to maintain your payments and reduce your Life Cover.*
>
> *As there are no longer a fund value attaching to your plan for us to rely upon, as outlined in your Terms and Conditions document we have the right to cancel your plan.*
>
> *However, we have provided you with Plan Review options as an alternative to automatically cancelling your Life Cover. You are not required to choose any of these Plan Review options. However, if we do not receive any reply to these Plan Review options by 28 May 2018, we will cancel your plan.*
>
> *You have explained that you feel that our Annual Benefit Statement dated March 2018 provides conflicting information to our recent Plan Review letter because it includes details of the upcoming increase to your payments due to indexation. However, the Annual Benefit Statement does also refer to the recent Plan Review.*
>
> *…*
>
> *I am satisfied that your recent Annual Benefit Statement does explain that we send a separate letter including information about the Plan Review and your options. …"*

A reminder letter was issued by the Provider on **28 April 2018** in similar terms to its letter of **2 March 2018**.

In response to a formal complaint, the Provider wrote to the Complainant on **16 May 2018**. In this letter, I note at page 3 the Complainant was advised, in respect of plan review options, that if he did not choose an option, his policy would be cancelled. This letter also referred to the options contained in the Provider's reminder letter of **28 April 2018**.

On **24 May 2018**, the Complainant wrote to the Provider as follows:

> *"I refer to your letter of the 28th April regarding my options under the above Plan and my letter of the 9th May to which I have not had a reply.*
>
> *As previously indicated I will continue with the cover as per your letter i.e.*
>
> *Cover €134010.00*
> *Indexed payments of €299.40 per month*
> *As you state will start from 28 May 2018."*

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It is important to note at this juncture that the amount of €299.40 was not one of the options contained in the Plan Review letter but rather the amount indicated in the March 2018 annual benefit statement/indexation letter.

The Provider acknowledged this letter on **25 May 2018**, advising that payments would increase due to indexation from €285.14 to €299.40.

The Provider wrote to the Complainant again in respect of the plan review options on **30 November 2018**, stating:

> *"… we advised that changes were needed to prevent the plan being cancelled when the unit account went negative.*
>
> *Since the payment under the plan is insufficient to maintain the benefits and the unit account is now negative, I wish to advise that your plan will lapse in accordance with the terms and conditions with effect from 28 December 2018. …"*

The Provider wrote to the Complainant again on **1 December 2018** as follows:

> *"Thank you for your recent request.*
>
> *I can confirm that we have cancelled your plan as requested. This is effective from 28 December 2018. …"*

Analysis

Clause 13 of the Policy Conditions entitles the Provider to cancel the Complainant's plan if its cash value is negative. The Provider's approach to clause 13, rather than cancelling a plan, is to give a policyholder the option to continue their cover subject to an appropriate premium being paid.

The Complainant disputes that the fund value of his plan was zero. However, the evidence shows that the Complainant was informed as early as the plan review letter of **14 February 2002** that his then current premium payments were insufficient to maintain the chosen level of cover under the plan. Further to this, the Annual Benefit Statements issued between **April 2008** and **March 2018** all state that the fund value was €0.00.

In the plan review letters dated **3 October 2007** and **2 March 2012**, the Provider advised the Complainant that his plan could be cancelled if the fund value become negative. In its letter of **6 March 2015**, the Provider informed the Complainant of its right to cancel the policy under clause 13 but that it was offering customers, whose fund value was eroding, the option of increasing their premium or reducing cover. The letter also advised the Complainant that there was no longer any value attaching to his plan.

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In a submission to this Office dated **15 September 2020**, the Complainant refers to a statement from his broker *"… which clearly shows that there was a fund of €5,605."* The Complainant submits that the broker could only get this information from the Provider, yet the Provider claimed there was no value in the plan.

However, I do not accept this submission supports the Complainant's position. On **28 March 2011**, the Complainant's broker wrote to the Provider pointing out that correspondence recently received by the Complainant indicated a fund value of zero but the industry value system indicated a value of €5,695.49. In response to this, on **29 March 2011**, the Provider informed the Complainant's broker that the system relied on to generate the fund value was not to be used for the reasons set out in its letter.

Following this, the Complainant's broker wrote to the Complainant to confirm that the fund value was in fact zero, in the following terms:

> *"As explained in our letter dated 07/04/2011 the information made available to us through the industry/insurer system called* [name] *showed that your policy had a value of €5,605.49 on 28/03/2011 in your meeting at our offices. As you know* [the Provider] *confirmed your value was €0.00.* [The Provider] *in conjunction with ourselves have queried this with the* [industry system] *as to how this error could have occurred. Regrettably this is outside of* [our] *control and we are awaiting an explanation from* [the industry system]*. We can confirm that the value on your policy is €0.00."*

Taking the evidence into consideration, it is quite clear that the fund value of the Complainant's plan was zero for a significant period of time. Further to this, I am satisfied that the Complainant was aware or ought reasonably to have been aware of this.

Following the 2002, 2007 and 2012 plan reviews, the Complainant selected one of the plan review options presented by the Provider. The option chosen meant that the Complainant wished to continue with the cover under his plan.

In **March 2018**, the Complainant received two letters from the Provider, one was the Annual Benefit Statement and the other was the Plan Review Letter.

Having considered each of these letters, I am satisfied that they deal with difference aspects of the Complainant's plan. It is clear that the Annual Benefit Statement dealt only with indexation and further advised that a plan review was due, and it was at that point that the Provider would *"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."*

The Plan Review letter clearly explained that the current premium payments were insufficient to maintain the Complainant's level of cover and that for cover to continue, the Complainant was required to choose one of the options contained in the letter. This letter also stated in bold prominent print that if the Complainant did not reply to that letter his plan would be cancelled.

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As noted above, the Complainant queried these letters suggesting they were confusing and contained conflicting information. It can be seen from the documentation provided in evidence by the parties that the Provider engaged with the Complainant and attempted to explain the purpose of the March letters.

In particular, I note the telephone conversation which took place on **22 March 2018** where the Provider's agent attempted to clarify matters for the Complainant but, it is evident from the recording of this conversation that the Complainant was unwilling to accept what he was being told.

In any event, I am satisfied that any confusion the Complainant may have had arising from the March letters was clarified in the Provider's letter of **27 March 2018**. This letter also highlighted the importance of choosing an option from the Plan Review Letter in order for cover to continue, failing which, the plan would be cancelled. This was followed by further reminder letters from the Provider.

The evidence shows that the Complainant did not choose any of the options contained in the Plan Review Letter. I am satisfied that the importance of choosing an option and the consequences of not doing so were clearly and unambiguously communicated to the Complainant. I am also satisfied that the difference between the Annual Benefit Statement letter and the Plan Review Letter were clearly explained to the Complainant.

While the Complainant responded to the Provider's Annual Benefit Statement letter in respect of the premium increase required for indexation purposes, this is separate from the Plan Review Letter and simply responded to that particular letter and solely in the context of indexation. Furthermore, I do not accept, having regard to the correspondence received by the Complainant, that agreeing to an indexation premium increase was sufficient for the plan (or the benefits under the plan) to continue nor did it negate the need to choose one of the options from the Plan Review Letter.

The Complainant makes the points that his plan was cancelled because there was no value in the underlying fund yet the Provider continued to collect premium payments, and also because of his age. As noted above, the plan was not cancelled because it had no value or because of the Complainant's age, it was cancelled because the Complainant did not choose any of the options outlined in the Plan Review Letter.

Separately and contrary to the Complainant's position, owing to the position adopted by the Provider, benefits under the plan were not contingent on there being a positive fund value; benefits were contingent on the payment of the appropriate premium payment regardless of the underlying fund value. Therefore, so long as the Complainant paid his premium payments, he was entitled to the benefits under the plan and there is no evidence to suggest otherwise.

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I do not accept that the Provider wrongfully or unreasonably cancelled the Complainant's plan. The Provider cancelled the plan due to the Complainant's failure to select one of the options contained in the Plan Review Letter. Accordingly, I am satisfied that the Provider was entitled to cancel the Complainant's plan.

Goodwill Gesture

The Provider states that:

> *"While we firmly believe that* [the Complainant] *fully understood the difference between his plan review options and his annual indexation we accept that his correspondence initially may have caused some confusion. For this we would like to offer a very fair and generous Customer Service Award of €7,000."*

While I do not accept that the Provider's conduct was in any way unreasonable or wrong, I consider this goodwill gesture offered by the Provider to be a very reasonable sum of compensation for the customer service failings it believes to have occurred in the context of this complaint.

It is a matter for the Complainant if he wishes to accept this offer.

For the reasons set out in this Decision, I do not uphold any aspect of this complaint.

Conclusion

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20 April 2021

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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.