Decision Ref:	2021-0125
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Settlement amount (life) Results of policy review/failure to notify of policy reviews
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, a family trust, incepted a life assurance policy in **May 1998**. This policy is now administered by the Provider. The Complainant became aware that in order to maintain the current benefits under the policy, the monthly premium would need to increase from £875 to £2,250. The Complainant is dissatisfied with the manner in which the policy has been administered and the level of communication from the Provider.

The Complainant' Case

The Complainant explains that the Provider wrote to it on **10 August 2018** informing it that it had reviewed its Flexible Life Plan. The Provider concluded that in order to continue with the chosen level of cover, monthly premiums would have to increase from £874.72 to £2,248.90. The Complainant states that if this option was not chosen, cover would either run out or the life cover benefit would be reduced, with the likelihood that further increases would be requested down the line. The Complainant submits that the Plan was not fit for purpose and a jump in monthly premiums of this magnitude is untenable.

In resolution of this complaint the Complainant is seeking the full amount of the Plan contributions over the past 20 years plus interest. It is stated that since the Plan was taken out in **1998**, the Complainant has made monthly contributions totalling £88,947.52. The Complainant has received a *cash-in value* of £58,364.15 which is a loss of £30,583.37 before interest. The Complainant also points out that even with the assistance of its financial advisor, the Provider has proved *extremely difficult* to deal with and it has found this to have been *"[a]ltogether a very unpleasant and confusing process."*

By email dated **17 February 2020**, the Complainant, in addition to the above points, further outlined the *essence* of the complaint, explaining:

> *"b) Silence from the [Provider] in the 5 year period between reviews of the developing huge premium increase. Also silence that their assumed investment growth rate had been reduced from 9% pa to minus 0.9% pa, ie, the heart of the product had disappeared. This is highly questionable behaviour on their behalf.*
>
> *c) Their refusal to enter into true mediation. Instead, they sent many pages explaining internal processes and blaming our Financial Advisor (retired) who sold us the product many years ago. The kernel of our complaint was never addressed. What evidence can [the Provider] provide that our Advisor was made fully aware of the complexity of the product. For example, was he given specific training sessions. Also, what level of information did [the Provider] direct specifically to him that the product was not going to deliver what it was expected to at outset."*

The Provider's Case

The Provider explains that this complaint relates to a Flexible Life Plan sold to the Complainant by an independent financial advisor. The Plan is a regular, unit linked life assurance contract and the benefit selected by the Complainant under the Plan was to provide life cover on the death of the last life assured.

The Provider states that it acts on an execution only basis and is not permitted or authorised to give advice to customers regarding the suitability of a product. All sales advice is provided by independent financial advisors. It is suggested that the Complainant's financial advisor would have carried out a Fact Find in order to recommend a suitable product.

The Provider outlines the method of sale of such plans and the documents which would have been provided to the Complainant. These include a Sales Brochure, Key Features Documents, Plan Contract Conditions, Policy Schedule, Post Sales Key Features Document together with a Cooling Off Notice.

The Plan commenced on **29 April 1998** with a premium effective date of **1 July 1998** and a regular monthly premium of £108.81 with an initial sum assured of £200,000. The Provider advises that the Complainant chose the *automatic sum assured increase option* as part of its application but this option was ceased on **15 June 2018** following the Complainant's request. Under this option, a policyholder is entitled to automatically increase the sum assured by the greater of 7.5% or the UK inflation rate without medical evidence.

The Plan was surrendered on **8 November 2018**. At the time of surrender, the Sum Assured was £683,870. The cash-in value at the time of surrender was £58,364.15 with these funds being issued to the Complainant by direct credit on **14 November 2018**.

/Cont'd…

The Provider states the Plan was subject to regular reviews in accordance with its terms and conditions, in particular, section 5. A first review was conducted on the tenth Plan anniversary and all subsequent reviews were conducted no less than every five years thereafter.

The Provider points out that the Plan may be reviewed at any time the Provider's Actuary deems appropriate, particularly where the fund value is in danger of not being sufficient to cover Plan charges.

The tenth anniversary Plan review took place on **2 July 2008** with two further reviews taking place on **4 July 2013** and **2 August 2018**. The review results were sent to customer by letter with a copy also being sent to its financial advisor. Included with the review letter are details of how the fund has performed and the value of the Plan. The Provider states that a customer is also provided with a number of options and a form is provided for the customer to select the option they wish to take to ensure their sum assured is sustainable. The Provider explains that as the Complainant did not make any selection, the *default option* of *do nothing* was applied at each review and this was confirmed to the Complainant.

Further to this, the Provider states that review documentation advises customers that a number of factors influence the ability of regular premium payments to support the cover in place on a Plan, including investment conditions and the level of monthly protection charges. It states that the purpose of the review is to assess the premium the customer will pay going forward to ensure that it can support the chosen level of cover.

The Provider states that a reminder is sent to policyholders and trustees approximately four weeks after the initial review pack is issued if the Options Letter is not returned. A copy is also issued to the Servicing Financial Advisor. Confirmation of the action taken is also issued to the policyholders.

It is stated that the Plan is a whole of life contract and not an investment contract. Charges are deducted from the units with the assumption that the value will sustain the cost of cover and charges for the whole of life (age 99). Each review clearly identified that the Plan was not expected to sustain for the whole of life period. The Provider advises that an Annual Statement was issued to the Complainant which clearly noted the Value on the Plan.

The Provider states that it regrets the Complainant remains unhappy with the Plan and the results of the Plan reviews. The Provider relies on its response dated **24 September 2018**, along with other communications with the Complainant for the purposes of this complaint. The Provider also states that it is satisfied that the product literature, contract conditions, annual statements and plan reviews clearly detail the purpose of the Plan and how it is administered.

/Cont'd…

The Complaints for Adjudication

This Office wrote to the Complainant on **29 April 2020** informing it of the time limits contained in the ***Financial Services and Pensions Ombudsman Act 2017*** for making complaints.

The Complainant was also informed that as the policy was incepted in **1998**, this Office would not investigate the manner or circumstances surrounding the selling of the product.

Accordingly, the complaints that were investigated and will form the basis of this Decision are that the Provider:

> Failed to correctly administer the policy, in particular, the Provider failed to fully communicate the implications of its policy reviews;
>
> Remained silent in respect of the policy, particularly between policy reviews, and
>
> Provided poor customer service.

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 8 April 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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In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

The Complainant's Plan

The Provider wrote to the Complainant on **27 May 1998** enclosing its Plan schedule and Plan conditions. The Plan Schedule states under *Main Protection Benefits* as follows:

> *"Automatic Increase Option Rate   Maximum Rate (7.5% or UK inflation rate)"*

The Provider confirmed the removal of this option from the Plan by letter dated **15 June 2018**.

It is also stated on one of the Plan documents enclosed with the Provider's May 1998 letter that:

> *"The premium will increase annually by the amount required to support the increase in benefits as a result of indexation. …"*

The Plan Conditions Booklet

Part 4 of the Conditions Booklet relates to *Cover Increase Facilities*. Section 1 states:

> *"(1) Automatic Increase Option   Each Sum Assured the Option applies to is increased automatically on every policy anniversary by a percentage set at the outset. …"*

Section 2 states:

> *"We have the right to increase the regular premium if a Sum Assured is increased. The premium increase we require will be calculated by reference to the increase to the Sum Assured."*

Section 5 describes the Automatic Increase Option as follows:

> ***"5.1 Life Cover***
>
> *The Automatic Increase Option will apply to the Life Cover under the Plan as a standard feature from the outset unless you specifically ask us not to include the Option for this cover.*
>
> *…*

/Cont'd…

5.3 Zero Rate, Flat Rate or Maximum Rate

The Sum Assured increases each year are at the annual rate specified in the policy schedules or related documents for each type of Sum Assured.

…

The "maximum rate" is the higher of:

(a) 7.5% per annum, or

(b) the UK inflation rate for the year.

…

5.4 Sum Assured Increases under the Option

Under the Option each Sum Assured will be increased by the appropriate rate(s) on each policy anniversary.

We will inform you of the increased Sum Assured and increased regular premium before the policy anniversary when the increase will take effect."

Part 5 deals with premium payments. In particular, section 2.3 explains that:

"2.3 ***The Protection Cover – 10 year guarantee***

Please note that we do not give any guarantee that the regular premium level you are paying will be sufficient to sustain the protection cover throughout life.

However, we guarantee that provided you do not reduce your regular premium payments below the initial regular premium level during the first 10 years we will not reduce the initial level of protection cover during the first 10 years."

Section 5 deals with Plan reviews and states:

"5.1 Review Dates

We review the Plan on the following Review Dates:

(a) the 10th policy anniversary and every 5th policy anniversary thereafter;

(b) any other date when we consider a review is appropriate for some reason such as a change to the level or type of protection cover or the regular premium level. …

/Cont'd…

5.2 Purpose

The purpose of each review is to assess the likelihood that the value of the units will be sufficient to sustain the then current protection cover through to the next Standard Review Date on whatever assumptions the Actuary considers appropriate. The review will take into account the charges we will be taking from the Plan, in particular our charges for the cost of the protection cover the Plan is providing, the current value of the regular premium units in the Plan and projected growth in the value of those units.

5.3 Review Recommendations

We will send you details of the review following the Review Date.

If, at a Review Date, we consider the regular premium units are unlikely to be adequate to sustain the protection cover to the next Standard Review Date, we will make recommendations to help safeguard the continuation of the protection cover the Plan is providing. In particular, if a review reveals an unsatisfactory position, we will recommend that you:

- *reduce the protection cover …*
- *increase the regular premium level …*

…

You will not be under an obligation to reduce the protection cover or increase your regular premium level. However, you should bear in mind that the Plan will end and all protection cover will cease at any time there are insufficient units in the Plan to meet the Plan charges."

The First Plan Review

The 10th anniversary Plan review took place on **1 July 2008** and the Provider wrote to the Trustees in respect of the review. These letters state:

*"**We are writing to let you know that [the Provider] has recently carried out a review on your Flexible Life Plan.** As stated in your Plan Conditions, a review is carried out periodically to update you on how your policy is performing based on current market and economic conditions. This review is a valuable exercise as it provides you with an opportunity to look at your protection benefits and see if the product still meets your needs. In addition, it can be helpful to consider this product in the context of your wider financial planning needs.*

/Cont'd…

The aim of your Flexible Life Plan is to provide a lump sum payment on death, as outlined in the assumptions table attached. You selected Standard Cover, which meant that your regular premium was calculated to provide your chosen level of cover throughout life.

A number of factors influence the ability of the regular premium payments to support the cover in your Plan including investment conditions and the level of monthly protection charges. The purpose of the review is to assess the premium you will pay going forward to ensure that it can support your chosen level of cover throughout life.

The review was carried out using a number of assumptions, which are outlined in section 3 of the review pack in the accompanying document.

Contents of this pack

In addition to this letter, the following items are included in this pack:

- *A document detailing the results of your review and the assumptions used*
- *An Options Form*

The results of your review

The Review indicates that your premium no longer supports your chosen level of cover throughout the lifetime of the Lives Assured.

The result is based on certain assumptions made for the review that we have set out in section 3 of the accompanying document. These assumptions may or may not be achieved, but we believe that in the current environment they are a realistic basis on which to review the Plan.

The original purpose of the Plan was to provide your chosen level of cover throughout life. As this is potentially no longer the case, we are providing options to you, based on our current review assumptions, to help you continue your level of cover throughout life.

Why are premiums no longer at a sufficient level to provide cover?

When you purchased your Standard Flexible Life Plan, your premium was calculated to support your chosen level of cover throughout life. This was based on certain assumptions about the expected future growth in investment returns and the level on monthly protection benefit charges.

The assumed growth rate used was higher than the actual growth achieved to date in funds liked to your Plan. Therefore the value of your Plan is lower than we would have expected it to be at this point.

/Cont'd…

As economic conditions have changed, our future expectations of performance have been revised downwards to be in line with this. The effect of this on your Plan is that your investment fund is now expected to grow at a lower rate in future than previously projected.

As a result of these factors, an increase in your regular premium payments is required at this point in time if you wish to support your chosen level of cover throughout the lifetime of the Lives Assured.

What about the future?

Future market and economic conditions may improve or decline. This will continue to affect the value of your Plan and therefore the ability of future premiums to support your chosen level of cover.

To help you monitor the progress of your Plan we will send you a yearly statement indicating the value of your Plan. In addition, we will continue to review your Plan at least every 5 years, at which point we will write to you again with the appropriate options available to you. You next review will be on 1 July 2013.

What you should do next

You should carefully read through the results of your review in the accompanying document and the options that are provided. ***We recommend that you talk to your Financial Adviser about this review letter and the options available to you.*** *Please consider whether you wish to make changes to your Plan and, if so, which Option is most appropriate to suit your circumstances. When you have decided on your chosen course of action, please complete the attached options form and send it to us ….*

We ask that you return the options form to us within ***6 weeks*** *of the issue date of this letter. You are under no obligation to make any changes to your Plan as a result of this review, however,* ***IF YOU DO NOT NOTIFY US OF YOUR PREFERRED OPTION, WE WLL ASSUME THAT YOU WISH TO MAKE NO CHANGE TO YOUR PLAN AT THIS TIME AND COVER MAY CEASE WHEN [YOU] REACH 87.***

IF WE DO NOT RECEIVE A SIGNED AND COMPLETED OPTIONS FORM FROM EACH TRUSTEE OR IF ALL FORMS DO NOT INDICATE THE SAME CHOSEN OPTION, WE WILL MAKE NO CHANGE TO YOUR PLAN AT THIS TIME. YOU MAY WISH TO CONSULT WITH THE OTHER TRUSTEES.

…

If you have any questions regarding this review, please do not hesitate to contact either your ***Financial Adviser*** *or alternatively our Plan Review Helpline …"*

/Cont'd…

The next document forming part of the review letter is titled *Results of Your Review* and explains that the purpose of the Plan, that it was no longer sustainable, and outlined the options available to address this.

Section 2 outlines the following options:

> *"**Option 1: Take no action at this time***
>
> *You can choose to defer any changes to your Plan benefit and premium level.*
>
> *You should be aware that a number of charges, including those for protection benefits, will continue to be deducted from the Plan. These charges will reduce the funds in the Plan. If at any time there are insufficient funds in the Plan to pay these charges the Plan and the cover it provides will cease immediately.*
>
> *Based on the current assumptions, we believe that this will happen when [you reach] age 87. This may occur sooner if investment conditions do not meet our assumed expectations or protection charge rates increase above those assumed in the review. If this situation arises, we will contact you in advance to allow you to take action should you choose to do so. In the meantime, we will review your Plan every 5 years, at which point we will write to you again with the appropriate options available to you.*
>
> ***OR***
>
> ***Option 2: Increase your regular premium level***
>
> *You can increase your monthly regular premium to £542.09.*
>
> *This is the level of premium, which on the assumptions stated in section 3 should support the chosen level of cover throughout the lifetime of the Lives Assured.*
>
> ***OR***
>
> ***Options 3: Reduce the level of benefit***
>
> *You can reduce the Life Cover Benefit to £250,801.00.*
>
> *This is the benefit, which on the assumptions stated in section 3 is supportable by your current premium throughout the lifetime of the Lives Assured, assuming regular premiums are paid in full.*
>
> ***If you do not notify us of your preferred option, we will assume that you wish to make no change to your plan at this time. …"***

/Cont'd…

Section 3 contains details under the following headings *Assumptions we have made about your Plan*; *Assumptions we have used in your review*; *The current value of your Plan*; *Estimated future growth in investments*; *Future Premiums*; and *Other Assumptions*.

The *Options Form* states as follows:

> ***"We recommend that you consult your Financial Adviser before completing this form.***
>
> ***Please clearly indicate your instructions by ticking the box next to your preferred course of action and ensure that all forms indicate the same course of action.***
>
> ***ONLY ONE OPTION SHOULD BE CHOSEN. IF YOU REQUIRE ALTERNATIVE OPTIONS, PLEASE CONTACT YOUR FINANCIAL ADVISER OR ALTERNATIVELY OUR PLAN REVIEWS HELPLINE …"***

The final paragraph of this form sates:

> ***"IF YOU DO NOT NOTIFY US OF YOUR PREFERRED OPTION WITHIN 6 WEEKS FROM THE DATE ON THIS FORM, WE WILL ASSUME YOU WISH TO MAKE NO CHANGE TO YOUR PLAN AT THIS TIME."***

The Provider wrote to the Trustees on **6 August 2008** advising that a completed Options Form had not been received. The letter warned that if a completed form was not received, no changes would be made to the Plan. This letter also enclosed an Options Form. Following this, the Provider issued correspondence confirming that no changes had been made to the Plan on **20 August 2008**.

The Second and Third Plan Reviews

The Provider wrote to the parties on **9 July 2013** in respect of a Plan review that took place on **1 July 2013**. This letter is in very similar terms to the first review letter and advised that to sustain the cover under the Plan, premiums would need to increase to £1,093.69. Correspondence similar to that issued in **August 2008** was issued on **7 August 2013** to the effect that a response had not been received to the review letter, with confirmation that no changes had been made to the Plan on **21 August 2013**.

A third Plan review took place on **1 August 2018** and the Provider wrote to the parties on foot of this review on **10 August 2018** conveying similar information and options regarding the sustainability of the Plan as set out in the previous Plan review letters. Reminder letters were issued on **7 September 2018** advising the parties that a completed Options Forms had not been received. This was followed by confirmation that no changes were made to the Plan on **21 September 2018**.

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Annual Statements

The Complainant was issued with annual statements in respect of the Plan. The Provider has furnished copies of the statements issued between **2004** and **2018**. The cover pages for each statement are essentially the same and state:

> *"Please find enclosed the yearly statement as at [date] for your Flexible Life Plan.*
>
> *This statement shows you what your plan is worth and where your money is invested. This statement gives you an opportunity to review your financial needs.*
>
> *If you have any queries, please do not hesitate to call our Client Services Department or your Financial Adviser."*

The cover pages also state the *Current Premium* and *Current Sum Assured* with each of these increasing year on year.

The *yearly statement* referred to in the above passage from the cover letter was a *Unit Statement* which outlined the fund invested in, unit price, number of units held, exchange rate, and total value. The format of this section of the annual statements changed somewhat from **2016** and conveyed Plan information in a more extensive manner.

<u>Analysis</u>

The Complainant incepted the Plan through an independent financial advisor and, as such, had the benefit of financial advice when it entered the relevant contract. The Plan documentation issued by the Provider, in particular, the Conditions Booklet, outline how the Plan would operate and when reviews of the Plan would take place. It is important to note that the Complainant does not dispute receiving these and other Plan documents.

At the first Plan review, being the 10th anniversary review, the Complainant was advised, based on the current premium payments, that the Plan was unsustainable. The Complainant was also presented with options to address this situation and advised that if no option was chosen, no changes would be made to the Plan. The Complainant was also advised to contact its financial advisor or the Provider if it had any queries. Similar information regarding the Plan was communicated to the Complainant on the second Plan review.

It is clear that on each occasion, the Trustees did not respond to, or engage with the correspondence sent by the Provider. As a result, no changes were made to the Plan. Reminder letters issued which were followed by letters confirming that no changes had been made to the Plan. Having considered the correspondence issued to the Complainant following each review, I am satisfied that each letter was set out in a clear and understandable manner, and conveyed in plain language, important matters regarding the Plan.

/Cont'd…

However, no explanation has been given by the Complainant as to why it did not engage with any of this correspondence especially given the implications (which were explained in the review correspondence) this could have for the sustainability of the Plan.

Further to this, annual statements were issued to the Complainant which contained information regarding the Plan such as the monthly premiums, the sum assured, and fund information. The Complainant was also advised to contact either the Provider or its financial adviser if it had any queries.

Having considered the evidence, I do not consider it is reasonable for the Complainant to assert that there was silence on the part of the Provider between Plan reviews. I accept that the level of communication from the Provider was appropriate and reasonable. Furthermore, the Complainant was provided with a sufficient amount of information regarding the Plan to enable it or its financial advisor to reasonably assess the Plan's sustainability and the performance of the underlying funds; and if it was believed that the information provided was insufficient, it was at all times open to the Complainant or its financial advisor to seek additional information from the Provider.

The circumstances of this complaint suggest that the Complainant did not engage with the correspondence issued by the Provider or give it an appropriate level of consideration. The Provider cannot be held responsible for this. There does not appear to have been any communication with the Provider regarding the Plan until the third Plan review in **2018**, some 10 years after the Complainant was first advised that the Plan was not sustainable.

The Complainant is also dissatisfied with the level of customer service received from the Provider. This appears to relate to the period following the third Plan review. During a telephone conversation on **6 September 2018**, the Complainant's financial advisor requested that the Provider, amongst other matters, issue written correspondence confirming that if the Complainant ceased premium payments, this would not affect its ability to make a formal complaint in respect of the Plan. The Provider's agent confirmed that a letter would be issued. In subsequent telephone conversations during **September 2018**, the financial adviser, while acknowledging that an email had been received on **11 September 2018** on foot of her request, advised the Provider's agents that it did not address whether the Complainant would be able to make a complaint should it cease premium payments.

What appears to have occurred is that the query made on **6 September 2018** was treated as a formal complaint. A Final Response letter then issued on **24 September 2018** even though a formal complaint had not, in fact, been made. Quite understandably, this was a cause of frustration for the Complainant. However, the Provider's agent advised the financial advisor during a telephone conversation on **21 September 2018** that the Complainant' entitlement to make a formal complaint would not be affected by any decision to cease premium payments and that the call in question was recorded in the event there were any issues.

/Cont'd…

The financial advisor accepted this and indicated that the Complainant had been advised of this but wanted it in writing. While the requested correspondence does not appear to have been forthcoming, I am satisfied that the Complainant was sufficiently aware of its entitlement to make a formal complaint.

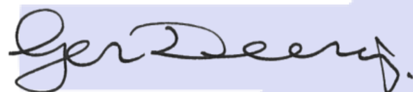
Despite the confusion surrounding the request made on **6 September 2018**, having considered the evidence in this complaint, I am not satisfied the level of customer service given by the Provider fell below the standards reasonably expected of a financial service provider.

For the reasons outlined in this Decision, I do not uphold 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

5 May 2021

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.