An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0191
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Premium rate increases Complaint handling (Consumer Protection Code)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants took out a life plan with the Provider in **1999**. In **2019**, the Provider advised the Complainants that their current premium payments were no longer sufficient to maintain the level of cover under their plan. The Provider also advised the Complainants that it was changing the manner in which it was collecting premium payments.

The Complainants' Case

The First Complainant explains that he is bitterly disappointed with the Provider in respect of his efforts to try reach an arrangement regarding the Complainants' plan. The First Complainant says he is being forced into a situation whereby the options available to him regarding the plan are *"driving me into a no-win scenario."*

Under option 1, the First Complainant says he will have to increase contributions which he cannot afford, in order to protect the sum assured. The First Complainant says option 2 is to reduce the sum assured by almost half, from €8,843 to €3,815.

The First Complainant also says the agreed payment arrangement was unilaterally broken by the Provider and took it upon itself to contact the First Complainant's employer and inform them to cease payments at source in **December 2019**. The First Complainant asks how can an outside agent have authority to infringe on the payroll of an individual without permission from that person? The First Complainant also asks: *"What about Data Protection?"*

After 20 years of contributions and no missed payments, the First Complainant says he will now have to enter a bank direct debit system. The consequences of this, the First Complainants says, are *"*[h]*aving to travel … to pay, extra travel + expenses incurred."* The First Complainant also says that:

> *"One question that needs answering:*
>
> *I maintained my side of the agreement during all of this time. If money invested was not meeting forecasts, not my problem. They were responsible I was still paying in."*

The First Complainant explains that both he and the Second Complainant are over 75 years of age and continue to pay into the plan so that their family would not be burdened with funeral costs. The First Complainant says *"the basic figure if reduced will defeat the purpose it was intended for."*

The Provider's Case

The Provider explains that the plan the subject of this complaint was incepted on **1 August 1999** which was replaced in conjunction with independent financial advice following the 2019 plan review. The Provider says one of the options available to the Complainants when their plan was reviewed in 2019 was to transfer some or all of their cover to what was called a Guaranteed Whole of Life Plan which is similar to the Complainants' original plan with the key difference being that the payments under this product are fixed and not subject to regular review. The Provider says the Complainants' plan was cancelled with effect from **1 April 2020** and the new plan started with effect from the same date.

The Provider says it conducted the Complainants' 2019 review in line with paragraph 33 of the plan terms and conditions and wrote to the Complainants on **5 November 2019** with options for continued cover. The Provider says it asked the Complainants to select an option by **1 January 2020**.

The Provider explains that when the plan was first reviewed in **2009**, the options given to the Complainants were estimated to maintain cover until 2019 when their plan would be reviewed again. The options offered to the Complainants in the 2019 review were to continue with their existing plan for another year after which the plan would become due for its next review. The Provider says options were offered for one year as the Complainants were over 70 years of age. In addition, the Provider says the Complainants were offered the option of transferring their cover to a new non-reviewable whole of life plan.

In the event that the Complainants did not select a plan review option, in order to prevent their cover from terminating, the Provider says the default option was for the plan to be adjusted in line with Option B which provided for the premium to remain the same and cover to be reduced to an amount that could be supported by this premium until the next review. The Provider says the default position was not applied as it granted an extension to the Complainants to review their options until **1 March 2020**.

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Before this happened, the Provider says it paid a serious illness claim in respect of the First Complainant for €8,843 on **2 March 2020**. The Provider says it wrote to the Complainants on **6 January 2020** confirming an extension to **1 February 2020** which was subsequently extended to **1 March 2020**.

The Provider says it continually reviews plans in the background and the outcome of these reviews was contained in the Annual Benefit Statements from 2006. As part of its improved communications on plan reviews, the Provider says it now sends correspondence to clients where a review is conducted and the plan passes this review, meaning no change is needed. Such correspondence issued to the Complainants on **3 August 2018**. The Provider says in the Complainants' 2018 Annual Benefit Statement it did estimate that their current premium at the time would be sufficient to maintain their plan until its next review in 2019.

The Provider says the Complainants' 2019 plan review options should have been issued to them earlier than **5 November 2019** and typically, review options should have been sent in **June 2019** allowing the Complainants the period up to **1 August 2019** to make their decision.

The Provider wishes to stress that the Complainants were not financially disadvantaged in any way by their options being sent to them slightly later than normal. In fact, the Provider says the Complainants benefited by maintaining the same higher level of cover on their plan without any change in payment for this level of cover as normally a premium increase would have been needed for this cover with effect from **1 August 2019**.

The Provider says the costs on the Complainants' plan first exceeded their regular payment in **October 2014** and this was reflected in the 2015 Annual Benefit Statement which set out a comparison of the plan costs for the previous year versus the total payments made to the plan for that year. The Provider says Annual Benefit Statement from 2013 onwards also provided the Complainants with an illustration of all payments versus plan charges for the previous year.

The Provider says the plan was not subject to yearly review on reaching the age of 70. It is only when a review is required and the oldest life covered has reached or exceeded the age of 70 at the time of that review that the plan is subject to annual review going forward. The Provider says when the Complainants' plan was reviewed in 2009, their ages were approximately 65 and 62. At this time, the Provider says it offered options for the next 10 years and on the expiry of this term in 2019, the options offered were on an annual basis as both Complainants were over 70.

The Provider says paragraph 34 of the Complainants' terms and conditions provides for a review to be conducted after its first 10 years. After this time, the terms and conditions provide the right to review on an annual basis. For administrative purposes, the Provider explains that its process is typically to review a plan after 10 years, every 5 years after this and annually once the oldest life covered reaches the age of 70.

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When the plan was reviewed in 2009, the Provider says it identified that an increase in premiums was required in order to keep the same level of cover until the next review. The Provider says it issued options to the Complainants on **5 May 2009**. The Provider says it would typically have offered options over a 5 year term but at this time the Provider says it provided options for cover over the next 10 years thereby giving the Complainants cost certainty over a longer period.

The Provider says it must highlight that its letter of **5 May 2009** was sent to the same address that was provided by the Complainants' independent financial intermediary in the application form. The Provider says this letter was returned undelivered and it wrote to the Complainants' independent financial intermediary on **13 May 2009** to inform them of this and to seek an alternative address but it did not receive a reply to this letter. The Provider says it is the responsibility of the plan owner to keep their address up to date.

The Provider says its system recognised that an option had not been received and on **27 July 2009** a reminder letter was issued to the Complainants which was returned undelivered. The Provider says it again wrote to the Complainants' independent financial intermediary to advise of this and to seek an alternative address but it did not receive a rely to this letter.

The Provider says the default position in the event of an option not being selected in order to prevent cover from terminating is to apply Option B which was to maintain the premium payment at €212.57 per quarter with life and serious illness benefits reducing from €14,093 to €8,843.

On **19 August 2011**, the Provider says it received a call from the First Complainant and at this time the First Complainant had received his 2011 Annual Benefit Statement which was sent to the same address as the **May** and **July 2009** correspondence. During this call, the Provider says the First Complainant explained his townland situation and that there had been postal changes. The Provider said it amended the Complainants' correspondence address. The Provider says the First Complainant understood that there had been a reduction in his level of cover and he confirmed that he understood that the current payment on the plan was estimated to maintain plan benefits until the next review in 2019. The Provider says the call concluded with the First Complainant advising that he would talk to his independent financial adviser about the plan and his 2011 indexation.

The Provider says the Complainants' plan was a reviewable plan as provided for in the terms and conditions and it would be its expectation that this plan feature would have been explained to the Complainants by their independent financial intermediary when the cover was applied for in 1999.

The Provider says it reviewed the plan in 2019 and determined that an increase in premium payments was needed to maintain the same level of cover on the plan until the next review and options for continued cover issued to the Complainants on **5 November 2019**.

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On **11 November 2019**, the Provider says it wrote to the Complainants about its decision to close the facility to pay for the plan through the First Complainant's former employer by way of salary deductions. The Provider says this was a commercial decision and the insurance industry in general is moving away from this payment method. The Provider says it apologises for any inconvenience the closure of this facility caused to the Complainants.

The Complaints for Adjudication

The complaints are that the Provider:

1. Failed to review the policy and the policy benefits; and

2. Unilaterally cancelled or changed the payment method for premium payments.

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 13 May 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.

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

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Plan Reviews

The Provider wrote to the Complainants on **25 July 2008** in respect of the plan review that was due to take place in **August 2009**, as follows:

> *"Your* [Plan] *is a flexible protection plan that was designed to suit you and your family's changing needs. When you took out your plan, your benefits payments and chosen term were at a level that suited you best at that time.*
>
> *A plan review is when we check whether your current regular payments are enough to maintain the cost of your protection benefits.*
>
> *As you get older the cost of providing these benefits increases. A review may also arise if you make a change your plan … When the cost of maintaining your benefits reaches a stage where it is greater than your regular payments this difference is made up from your plan fund until the review date.*
>
> *Your plan review is due on 01/08/2009 and we will write to you with full details of the review before this to advise you of your options.*
>
> *At that time, we will check whether or not your current payment is sufficient to maintain your protection benefits until the next review date. If your current payment is insufficient we will provide you with options for continued cover - these options are usually as follows:*
>
> *a) increase your payments in order to maintain your current level of cover*
> *OR*
> *b) reduce your level of benefits*
>
> *There is no need for you to do anything now; this letter is for information only and to let you know that your payment may need to increase at the review date."*

A somewhat similar was also sent to the Complainants' broker.

By letter dated **5 May 2009**, the Provider wrote to the Complainants, as follows:

> *"Your* [Plan] *is a flexible protection plan that was designed to suit you and your family's changing needs. When you took out the plan, your benefits, payment and chosen term were at a level that suited you best at that time.*
>
> *A plan review is when we check whether your current regular payments are enough to maintain the cost of your protection benefits. 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.*

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We have recently conducted such a review, in accordance with the terms of your contract, to calculate if your combined payments and plan fund are still enough to cover the cost of your level of benefits for your current term. In your case, we anticipate that your payments will not be enough to maintain your current level of benefits from 01/08/2009. It is therefore necessary to make some adjustments to your plan."

The letter also enclosed an options form with two options for the Complainants to choose from. The Provider sent reminder letters to the Complainants on **27 July** and **18 August 2009**. However, each of these letters were returned to the Provider marked 'Return to Sender' with the reason 'Insufficient address'.

The Provider also wrote to the Complainants' financial adviser on **13 May** and **14 August 2009** informing them that correspondence had been sent to the Complainants but had been returned undelivered. I note the 2010 Annual Benefit Statement also appears to have been returned to the Provider.

On **3 August 2018**, the Provider wrote to the Complainants, as follows:

"As your [Plan] *is a reviewable protection plan this means we regularly check that the amount you pay quarterly and any fund built up on your plan is enough to maintain your cover.*

We've carried out your latest review and the good news is that your current payments and the fund built up on your plan are enough to cover the costs of your benefits at this time. We have assumed a future growth rate of 3.45% and that our charges for your benefits do not change. Your plan fund on the next page is being used to pay for some of the cost of your cover. We will continue to check your payment each year to make sure your payments are enough. If there are changes to your plan, we may need to review your plan again before this. …

The cost of your cover will increase in the future

The cost of providing cover increases as you get older. So although you do not need to make any changes to your plan now, it is likely that the cost of your cover will increase significantly in the future. This means you will need to increase your payments or reduce your level of cover.

Below you can see how much it will cost to maintain your current level of cover into the future. These amounts are not guaranteed and may be higher or lower in the future. …"

This letter also outlined the option of switching to a guaranteed plan with fixed payments.

The Provider wrote to the Complainants by letter dated **August 2019**, explaining how a reviewable plan worked and enclosed a document titled 'A journey of a reviewable protection plan'.

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Both this letter and the **August 2018** letter advised the Complainants to contract their named financial adviser if they wished to discuss their cover or alternatively, they could contact the Provider.

By letter dated **5 November 2019**, the Provider wrote to the Complainants to advise them that the current payments under the plan and the fund value were no longer sufficient to maintain the current level of benefits.

The Complainants were presented with three options regarding their plan and a fourth option of switching to a guaranteed plan with fixed payments and no reviews. The three plan options were:

> *"Option A – Keep the same level of cover and increase your payments until 1 August 2020 …*
>
> *Option B – Reduce your level of cover and keep your payments the same until 1 August 2020 …*
>
> *Option C – Aim to keep the same level of cover for the rest of your lives or until the date the benefits end …"*

Annual Benefit Statements

It appears that the Provider began to issue Annual Benefit Statements to the Complainants from **August 2006**. From **2010**, statements advised the Complainants that the plan would be reviewed at the next anniversary, stating this to be **October 2019** and in others, **October 2018**, and also advised the Complainants of premium increases needed if they wished to extend the period of cover while maintaining their current benefit to **October 2025** and beyond. Annual Benefit Statements changed slightly from **2013** and began to provide additional information in respect of payments and charges.

Annual Benefits Statement were generally similar in format. The cover letter to these statements advised that the statement was being sent to keep the Complainants up to date with their plan. It advised that if the Complainants required help reviewing their financial needs to contact their broker, who was named on the cover letter. The letter also advised that if the Complainants had any questions or required more information, to contact the Provider. The Complainants were provided with various details regarding their plan. I note that under the heading 'Plan Review', the Provider estimated the date to which it considered the current premium payments would sustain the benefit under the plan.

The First Complainant telephoned the Provider on **19 August 2011** in respect of an Annual Benefit Statement received that morning. The First Complainant advised the Provider that there had been a change to the townland of his postal address. During the call, the First Complainant queried the level of cover under the plan and compared it to total payments paid to date, which exceeded the amount of cover.

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The parties discussed the level of cover under the policy and the premiums required to maintain or extend cover. The First Complainant also explained he understood that in the Annual Benefit Statement, the Provider was estimating that current payments would be sufficient to maintain the plan benefit until 2019. The First Complainant also indicated that he would speak to his financial adviser (as named in the Provider's correspondence) in respect of the plan and premium payments/increases. I also note that during this call the First Complainant indicated that he was familiar with the terms of the policy when discussing the type of medical conditions covered as part of the serious illness cover.

Analysis

The Complainants incepted a reviewable life protection plan with the Provider in 1999. At this time, the Complainants appear to have had the assistance of a financial adviser. In this respect, I note that the Complainants' application form dated **8 June 1999** contained details of their financial adviser.

Further to this, I note that the Complainants also seem to have had the services of a financial adviser available to them in the years following the inception of the plan.

Paragraphs 33 and 34 of the 'Policy Terms and Conditions' of the Complainants' plan explain that the plan is a reviewable plan and that it would be subject to periodic review. In this respect, paragraphs 33 and 34 of the terms and conditions state, in relevant part, as follows:

> *"Paragraph 33*
> *We may review your premium at certain times and under certain circumstances.*
>
> *At a review date we will look at the premium you are paying, your stabilised profits fund value, any options under your policy, and current death and illness rates.*
>
> *Based on these factors, and any others which are relevant, we will work out the highest life cover or specified illness benefit and other benefits that we will be prepared to provide in return for the premium you are paying.*
>
> *If your benefits on any review date are more than the new maximum we have worked out, we will reduce the level of these to the new maximum.*
>
> *If you want, you may increase the premium you pay to maintain your current level of benefits. … At each policy review date we will also review the charges and change them if there is a significant difference between the costs of maintaining existing policies and the charges that we take from these policies.*
>
> *Paragraph 34*
> *The first review date for your policy is the 10th anniversary of the date your policy started. We may review your premium on each anniversary of your policy after this date.*

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However, if you change your policy in any way, even during the first 10 years, we may need to carry out a policy review to make sure that the benefits you are covered for, and the premiums you are paying are appropriate. …"

Arising from the plan reviews, paragraph 33 states that the Provider would calculate the highest level of benefit it would be prepared to provide based on the premium payments being made. In the event the current premium payments were not enough to sustain the current level of benefits, paragraph 33 provides for a reduction in the level of benefits to a level that could be sustained by the current premium payments, and also provides the option of increasing the premium payment.

Therefore, in accordance with the terms and conditions on which the Complainants accepted their plan, it would appear that the Provider was only required to offer the Complainants the options provided for in paragraph 33 following a plan review.

As can be seen from the correspondence issued to the Complainants following the 2009 plan review, these were the two options offered to the Complainants. These two options were also offered to the Complainants together with two additional options following the 2019 plan review.

With plans of this nature, the Provider is not required to offer the same level of cover at the same premium payments for the life of the plan. In the context of this complaint, the Provider was not in a position to offer the Complainants their preferred level of cover at their current premium payments due to, for instance, the relevant fund value and the amount of the premium payments being made. However, this is something that inevitably arises with reviewable life plans, and the level of benefit under the plan is not guaranteed. This necessitates periodic reviews. These reviews are likely to require certain changes to a plan during its lifetime, such as reductions in the level of cover or an increase in premium payments.

Having considered the evidence, I accept that the Complainants were aware or ought to have been aware that their plan was a reviewable plan and subject to change over time; in particular, following plan reviews. I also accept that the Provider carried out regular reviews of the plan and plan benefits, as can be seen from the Annual Benefit Statements and plan review correspondence. Further to this, while the Complainants are dissatisfied with the options offered by the Provider following the 2019 plan review, I accept that these options are consistent with the options contained in paragraph 33 of the terms and conditions. As noted above, the Provider also offered the Complainants two further options. In the circumstances of this complaint, it is my opinion that the options offered by the Provider in its letter of **5 November 2019** were reasonable, that the Provider was entitled to offer those options and that the Provider was not required to offer any further options other than those set out in its letter.

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The Complainants are also dissatisfied with the Provider's decision to change the method by which their premium payments are collected. In this respect, I note that since the plan was incepted, premium payments have been collected by way of salary deduction from the First Complainant's employer.

However, by letter dated **8 November 2019**, the Provider wrote to the Complainants advising them of an upcoming change in the way premium payments would be collected, as follows:

> *"I refer to the above quoted plan that you currently pay through your payroll in* [your former employer].
>
> *We have recently completed a review of our plans that are paid by salary deduction and I wish to advise that we will no longer be able to offer this method of payment for your plan. We are recommending our SEPA Direct Debit facility as a replacement method of payment.*
>
> *We will be contacting your employer … and requesting that the final salary deduction for your plan should be taken in your December 2019 payroll.*
>
> *Paying by direct debit is convenient as we simply deduct the payment from your bank account as it falls due. Please complete and return the enclosed direct debit mandate. …*
>
> *From January 2020 onwards, your plan will move from the current payroll scheme arrangement and we will no longer accept any premiums paid to us by your employer. In order to facilitate a smooth changeover of payment method, we request that you return the enclosed direct debit mandate by the 4 December 2019. …"*

The First Complainant's former employer also wrote to him on **18 November 2019** to advise that it had been contacted by the Provider regarding the above changes and requested that the First Complainant complete the direct debit mandate. Following this, the Complainants' financial adviser emailed the Provider on **21 November 2019** explaining that the First Complainant had been in contact to express his dissatisfaction with this change and advised that the Complainants' consent had not been sought.

The Complainants have also queried whether the Provider's conduct regarding the change to the payment method was consistent with data protection legislation.

This is not a matter on which I can adjudicate as it is more properly a matter for the Office of the Data Protection Commissioner.

On the application form completed by the Complainants in **June 1999**, under the 'Premium details' section, the following three payment methods were available: 'By direct debit', 'By cheque or cash' or 'Taken from your pay'. The Complainants chose the third option.

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While the Complainants chose the option of a salary deduction, I note that there is nothing in the plan terms and conditions regarding methods of payment. Therefore, I accept that the Provider is entitled to change the way in which premium payments are collected. In doing so, I believe the Provider should give reasonable notice of the change to the Complainants and that the proposed method of premium collection must be a reasonable means of payment collection. However, I do not accept that the Provider was required to obtain the Complainants' prior consent to the change.

Accordingly, I note that the Provider wrote to the Complainants on **8 November 2019** advising them that it would no longer be collecting premium payments by way of salary deductions.

The letter outlined that the Provider intended to collect premiums by way of direct debit and enclosed a direct debit mandate for the Complainants to complete, requesting that it be returned by **4 December 2019**. The letter also advised the Complainants that from **January 2020**, premium collections would move to the new direct debit method.

I accept that the Provider was entitled to change the method by which premiums would be collected. I also accept that the Complainants were given reasonable notice of this change. Furthermore, I accept that the new payment method of direct debit was a reasonable method to introduce.

Goodwill Gesture

In its Complaint Response, the Provider says that:

> *"We acknowledge that we were late in sending* [the Complainants] *their 2019 review options and while they were not financially disadvantaged in any way by this we would like to offer them a €1,000 Customer Service Award by way of an apology for this delay."*

I consider this Customer Service Award to be a reasonable sum of compensation for the customer service failings on the part of the Provider. In these circumstances, on the basis that this offer remains available to the Complainants, 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.

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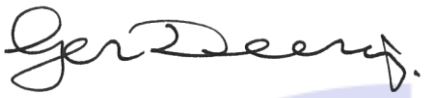
The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.



GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

14 June 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.