An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0210
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Failure to advise on key product/service features Results of policy review/failure to notify of policy reviews Poor wording/ambiguity of policy Maladministration (life)
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint is made on behalf of a trust (the Complainant) by CS who established the trust for her son in **December 1991** (the **Trust**). In **February 2002**, CS purchased a life assurance plan (the **Plan**) from the Provider, against which this complaint is made, through her independent financial adviser (the **Financial Adviser**). The Plan was transferred to the Trust in **May 2002**. Following a Plan Review in **September 2018**, CS and the trustees were informed by the Provider that the monthly Plan premiums were insufficient to sustain the Plan. The Complainant is dissatisfied with the manner in which the Provider administered the Plan.

The Complainant's Case

CS explains that she set up a discretionary trust in **1991** to provide support for her son. Her son sadly passed away during **2017**, and *"… I sought advice on whether to surrender the policy and was advised by [the Provider] that it would continue on and become payable on my death."* The Complainant outlines that *"I was also led to believe this was the case in the beginning when I received advice to set it up originally by [the Financial Adviser] in 1991. [The Financial Adviser] then became uncontactable shortly afterwards and was no longer available to give further advice on the policy".*

CS advises that she was *"… extremely shocked to learn only this year from [the Provider] that in order to retain its original value, action was required by me periodically."* As a result of not being made aware of this, *"… the policy is now almost worthless."*

The surrender value of the policy was UK£99.96 and the Complainant decided to surrender the policy as it would cost too much to maintain and keep it at its original value.

The complaint form states:

> *"I feel I have been left financially out of pocket having paid UK£44 per month for what I believed was a life insurance policy. I do not feel that [the Provider] have looked after my interests as a long standing customer because they did not ensure that I understood that my policy would not produce the original sum unless I increased the premiums, even though I had discussed my policy at length when my son died on [date]."*

In resolution of this complaint, the Complainant seeks:

> *"…reimbursement of the amount of my plan, which would have been paid to my family on my death, as the original beneficiary, my son, is now deceased."*

The Provider's Case

The Provider explains this complaint relates to a flexible life plan sold to CS by the Financial Adviser. At the time of sale, the Provider advises that it traded in the UK under the name of another financial service provider.

The Plan was issued in the name of CS on a single life basis on **26 February 2002**. The Plan was a regular premium, unit linked life assurance contract with the benefit under the Plan being to provide life cover on the death of the last life assured. The premium at issuance was UK£44.21 per month with a sum assured of UK£62,500 payable following the notification of the death of CS.

CS removed the Financial Adviser as her financial adviser in **February 2016** and furnished a letter of authority addressed to her solicitors for the information of the Provider.

The effective full surrender date of the Plan was **31 December 2018**. The Provider advises that no surrender value was paid to the Complainant as the Plan had run out of units at the date of surrender.

The Provider outlines the manner in which the Plan is usually sold to customers. It suggests that this involves the provision of sales brochures to potential customers by a financial adviser; the completion of an application form; the provision of a Key Information Document; when an application is accepted, standard plan contract conditions are issued;

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this is followed by the policy schedule; and finally, a Post Sales Key Features Document and Cooling Off Notice is issued. The Provider submits that the Complainant would have received these documents.

The Plan was placed into the Trust on **9 May 2002** following receipt of the Deed of Assignment from the Financial Adviser noting the trustees as owners in their capacity as trustees of the Trust. The Provider issued an endorsement and letter to the Complainant's Financial Adviser but did not provide a copy of the Deed to the trustees.

The Provider advises that it is not aware whether the Financial Adviser or CS/the Complainant's solicitors furnished the trustees with a copy of the Deed.

The Trust was varied on **18 May 2012** with the retirement of one of the trustees and the appointment of two new trustees.

The Provider explains that the Trust was already in existence prior to the Plan being placed into the Trust. The Provider advises that it did not specifically state in its review correspondence or other correspondence issued to CS or the trustees that they should keep the contact details updated.

The Provider observes that the review correspondence issued by the Provider afforded the trustees the opportunity to contact the Provider to ensure that it had up to date contact details for the trustees on its record. The Provider submits that it would deem it reasonable that the trustees would, as owners of the Plan, contact the Provider to ensure their details were up to date.

The Provider states the responsibility for carrying out the wishes of the Trust rested with the trustees who had a duty of care to execute the Trust in line with its provisions.

The Provider states the Plan was set up on a *Select Term* cover basis which meant the life cover would be in place for an initial 10 year period, assuming that units allocated to the Plan grew by the assumed growth rate from the outset. After the 10 year period had elapsed, the Plan would be reviewed by the Provider's actuary to assess if the premium being paid could allow the Plan, and life cover being provided, to continue for a further 5 year period.

The Provider also states that it has a process whereby it will review a plan at earlier intervals than the scheduled review dates should its actuaries deem, at any time, there are insufficient units held within a plan to continue to meet the ongoing charges until the next scheduled review date and that a plan is at risk of running out of units. In this instance, the Provider advises it would carry out an *ad hoc* review and issue the results to the relevant owners/trustees. This is known as the Provider's *Low Funds Process*.

The first scheduled plan review was carried out on the Plan's 10th anniversary in **2012**. The results of the review were sent to CS and the trustees at the time. The review letters state that there was no need to make any changes to the premium or sum assured, and cover could continue for a further 5 years.

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The Provider advises that the second plan review should have taken place in **2017**, 5 years after the first plan review. The Provider states it *"… has reviewed its records from this time and it is apparent that the Plan review results, and the applicable review options, were not sent to the Complainant or the Trustees as they should have been.*

The Plan had been moved away from [the Financial Adviser] and as a result no Financial Adviser copy of the review was issued."

A third review was conducted in **2018** due to the Plan being on the Provider's list of plans that were low on funds. The Provider wrote to CS and the trustees and provided options in respect of the premium and life cover amount.

The Provider advises that it does not carry out annual reviews on plans once the policyholder reaches the age of 70 but continues to review plans at 5 yearly intervals or earlier should its actuaries deem it prudent to do so.

The Provider states that it sent a secure email to CS on **8 December 2016** confirming receipt of trust documents on **2 December 2016**. The Provider also advised what documents were required from CS and the trustees in order to amend the trustees on the Plan. The Provider attached the relevant documentation to the email to be completed.

The Provider advises that it did not make any further immediate contact with CS or the trustees following the email of **8 December 2016** in relation to amending the trustees on the Plan; explaining that it would not be normal for the Provider to follow up on a request for information on how to carry out a change as it would be for the customer to decide when and if they wished to proceed with any transaction. The Provider did restate its requirement for amending trustees in its complaint response email of **2 October 2018**. The Provider outlines that it did not receive an instruction to amend the trustees or the required documents.

The Provider states that it wrote to CS on **14** and **17 November 2017** following her calls on **1** and **14 November 2017** in which the Complainant requested confirmation in writing as to what would happen following her son's death. The Provider replied to CS's specific queries and did not discuss the sustainability of the Plan in respect of life cover or premium amount. The Provider explains that it would be usual for a customer to refer to their financial adviser for advice as the Provider is not authorised to provide advice and acts on an *Execution Only* basis.

The Provider submits that it does not have a record of receiving any written communications from CS in **2017** either by email or letter in relation to the Plan. The Provider states that it did speak with CS on **1** and **14 November 2017** and discussed the Plan. However, no written communications were received.

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Referring to the telephone conversation on **1 November 2017**, the Provider states that CS contacted the Provider and discussed what would happen to the policy following her son's death. The Complainant referred to a provision in the Trust which meant that her daughter would be a *long stop* beneficiary and the Provider agreed to investigate this and contact CS in writing. The Provider emailed CS on **14 November 2017** to confirm that on the death of her son, the trust allowed that one half of the Plan would be allocated to her daughter and the other half would be appointed to her daughter's children equally at the age of 21.

On **14 November 2017**, CS contacted the Provider by telephone and queried to whom the death benefit would be paid in the event of her passing as the life assured. The Provider wrote to CS on **17 November 2017** to confirm that on her death, the benefit would be paid to the trustees.

The Provider advises that it responded to CS's specific queries following each telephone call and did not discuss the sustainability of the Plan.

The Provider states that Plan Review letters and options forms were sent to CS/the Complainant and the relevant trustees (except one trustee as the Provider did not have a valid address for her on file) in **April 2018**. The Provider has quoted two paragraphs from this letter and states that two reminder letters were issued to CS/the Complainant and the relevant trustees in **October 2018**. As the Provider did not receive a response to these letters, it applied the default option and made no changes to the Plan. The Provider states that it sent confirmation letters to the trustees to advise them that no changes had been made to the Plan.

The Provider submits the Plan Review letters do not state that *'noting about your policy is going to change.'* The letters are headed with the title ***'This is an IMPORTANT NOTICE concerning your [Plan]'*** and informs the reader why the Plan is being reviewed, what factors are being taken into account in the review and what the outcome of the review is, along with any options available to CS/the Complainant and the trustees in respect of life cover and premium.

The 2012 Review Letter stated that the premium being paid at that time was sufficient to continue life cover for a further 5 years and therefore no change to the premium or sum assured was needed. The letter noted that the Provider would continue to send CS/the Complainant an annual valuation statement and would review the Plan in 5 years' time.

The 2018 Review Letter issued to CS and the trustees stated that the premium being paid at the time was not sufficient for the Plan and the life cover to continue. The letter explained why this was the case and what factors had been considered in the review. The Provider explains the letter included options for the trustees and the Complainant to choose from in relation to the level of premium and life cover. The Provider states that it did not receive a response to this letter.

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The Provider advises that it acts on an *Execution Only* basis and is not authorised to give advice. All sales are through regulated financial advisers and the responsibility for ensuring the Plan was the right one for CS/ the Complainant rests with the Financial Adviser.

The Provider regrets that CS/the Complainant remains dissatisfied with the Plan and the results of the Plan reviews. However, the Provider submits that the Plan was administered at all times strictly in accordance with the Plan contract conditions.

The Complaints for Adjudication

The complaints are that the Provider:

1. Failed to clarify and/or advise CS/the Complainant regarding the Plan's sustainability following the Provider's periodic reviews of the Plan;

2. Issued misleading Plan Review Letters; and

3. Failed to inform CS/the Complainant as to the value of the Plan and/or possible changes required to the Plan in **October 2017**.

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 1 June 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.

CS created the Trust on **20 December 1991**, for the principal purpose of providing for her son who had a disability. The parties to the Trust were CS (as the Settlor) and four original trustees. The Complainant's daughter is one of the original trustees (Trustee 1). The provisions of the Trust make clear that the administration and operation of the Trust is vested in the trustees.

Following the creation of the Trust, a number of *Deeds of Appointment and Retirement* of trustees were executed between **February 1993** and **October 1995**. By way of *Deed of Appointment and Retirement* dated **12 August 2008**, one of the trustees retired (Trustee 2) and two new trustees were appointed (Trustee 3 and Trustee 4). A further *Deed of Appointment and Retirement* dated **5 February 2016**, retired Trustee 3 and Trustee 4 and appointed two new trustees (Trustee 5 and Trustee 6).

Pre Sale Key Features Document

This document states in the *Your Questions Answered* section as follows:

> *"Will my benefits always be the same?*
>
> *Included in your Plan is the Automatic Increase Facility under which benefits and premiums are increased without medical evidence each year. This aspect of the Plan allows the value of your benefits to be maintained … Under the terms of the facility you can choose at the outset whether benefits rise by:*
>
> *7.5% per annum …, or*
> *5% per annum*
>
> *(Premiums will rise by an amount sufficient to sustain the cover on the basis on which your Plan was established.)*
>
> *…*
>
> *However if you choose Progressive Standard Cover, your cover will not increase for the first four years but your premium will start at a much lower level and then increase at the end of the first four years. Cover and premiums will then be subject to normal increases.*
>
> *…*

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Why is my Plan reviewed?

Your plan is reviewed at regular intervals to check that your level of cover can be maintained. This is needed because investment performance and charges may not turn out as expected. We will let you know if any premium increase is required (alternatively, you can choose to reduce your cover). …"

Application Form

An application form in respect of the Plan appears to have been completed in **November 2001**. The premium amount is noted as UK£31.15 per month with a life sum assured of UK£62,500. The cover term is 10 years. At the *Automatic Increase Option* section in Section E, option 3, *0% increase p.a. (Level Cover basis)* was selected. A section of the application form has also been completed by CS/the Complainant's Financial Adviser.

Plan Documents

CS was provided with a key features document and a copy of her *Contract Schedule and Conditions* under cover of letter dated **26 February 2002**.

Post Sales Key Features Document

This document outlined various information regarding the Plan and its operation. It also included a *Cooling Off Notice*. On page two, CS is advised that the Plan is expected to support the sum assured for 10 years assuming units allocated to the Plan grow by 6.75% per annum.

Plan Schedule and Conditions

The Plan schedule outlines the cover provided by the Plan and notes that monthly premiums are UK£44.21 with a 0% annual increase option chosen. This option is detailed in Part 4 of the Pan conditions. Part 5 of the conditions state:

*"**2. General***

…

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.

…

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5. Plan Reviews

5.1 Review Dates

We review the Plan on the following Review Dates:

(a) the 10th 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.

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 …*
  or

- *increase the regular premium level …*

The review details we send you will tell you what reduced level of protection cover or increased regular premium level we recommend….”

Assignment of the Plan

Under cover of letter dated **22 April 2002**, the Financial Adviser furnished the Provider with a *Deed of Assignment* dated **22 February 2002** in respect of the Plan. The Deed of Assignment assigned the Plan to the Trust and the ownership of the trustees.

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The Deed was signed by CS and the trustees, which included CS's daughter. The Provider acknowledged receipt of the Deed of Assignment on **9 May 2002**. As pointed out by CS, the Provider's letter contained the names of the incorrect beneficiaries under the Trust. In a submission dated **19 June 2020**, the Provider explains that *"[t]he endorsement letter confirmed the names of 4 beneficiaries that are not linked to the trust. This was an administrative error by the provider at the time and the Provider apologises for any confusion caused."*

Annual Statements

The Provider has furnished copies of annual Plan statements issued to the Trust at CS's address. This first such statement is dated **12 March 2004**. The cover letters enclosing the statements are essentially the same and state:

> *"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 **2004** annual statement (which appears to be the earliest one furnished by the Provider) shows the Plan value as UK£41.73. At its height, the Plan appears to have had a value of UK£865.57 as per the **2014** annual statement. The Plan value then decreased to UK£680.21 as outlined in the **2016** annual statement. This reduced to UK£629.47 in **2017** and UK£351.04 in **2018**.

First Plan Review

A review of the Plan was carried out on its 10th anniversary and the Provider wrote to CS and each of the three trustees on **12 April 2012**. The letter issued to CS states:

> *"Dear [CS]*
>
> ***<u>This is an IMPORTANT NOTICE concerning your [Plan]</u>***
>
> *Plan Number: …*
> *Trustee(s): …*
> *Life Assured: [Complainant]*
>
> *We are writing to you to let you know that [the Provider] has carried out a review on your [Plan]. As stated in your Policy Conditions, a review is carried out periodically to update you on how your policy has performed in the past and how it is expected to perform in the future based on our review assumptions.*

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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.

The aim of your [Plan] is to provide a lump sum payment on death, as outlined in the assumptions table attached. You selected Select Cover Term Cover, which meant that your regular premium was calculated to provide your chosen level of cover until the end of your selected cover term.

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. As you have reached the end of your selected cover term, the purpose of the review is to assess the premium you will be paying going forward to ensure that it can support your chosen level of cover for the next 5 years.
…

The results of your review

You will be pleased to know that based on the current review assumptions, the review assessment indicates that ***your premiums are at a sufficient level to support your level of cover for the next 5 years, assuming that regular premiums are paid in full.*** *Therefore, there is no need for you to make any changes to your Plan at this time.*

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 your 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. Your next review will be on 1 April 2012.

If a future review indicates that the level of your future premiums is unlikely to be sufficient to support your chosen level of cover, we will then provide options to help you continue the level of cover.

Please note: A copy of this correspondence has been sent to each of the trustees listed above.

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

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2012 Trust Variation

The Provider wrote to the Trust at CS's address on **18 April 2012** referring to a previous telephone call and enclosed a *Trust Variation* form which could be used for the appointment and retirement of trustees. The letter also clarified that certain identification documentation was required.

The enclosed form was completed and is dated **18 May 2012**. The form states that Trustee 3 and Trustee 4 were being appointed to the Trust and that Trustee 2 was retiring. The Provider wrote to the Trust at CS's address on **31 July 2012** enclosing an *Endorsement* acknowledging the appointments and the retirement.

This form was completed to reflect the change in trustees brought about by the *Deed of Appointment and Retirement* dated **12 August 2008**.

2016 Trust Variation

CS wrote to the Provider on **26 February 2016**, advising as follows:

> *"I am writing to advise you that I have now changed details of Trustee and am enclosing a copy of the new codicil for your perusal.*
>
> *I would also like to make you aware that I no longer have [the Financial Adviser] as my financial adviser as I have not had contact with them since 2002 and am unable to contact them at all …*
>
> *The Solicitor who set up the Trust originally continues to deal with all matters arising. The details for them are …"*

The Provider wrote to the Trust/CS on **7 March 2016** in respect of her Financial adviser, stating:

> *"We refer to correspondence received advising us that you no longer wish to deal with [the Financial Adviser] in relation to the above mentioned policy.*
>
> *We have now transferred the servicing of this plan to [the Provider] (Execution Only) and this will ensure [the Financial Adviser] will not receive any further correspondence on your policy.*
>
> *Should you wish to appoint a new financial adviser please advise us accordingly. …*
>
> *We trust this is satisfactory but should you require any further assistance please do not hesitate to contact us."*

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The Provider responded to the changes in trustee aspect of CS's letter on **9 March 2016**:

> *"In order to note the changes in Trustee, we will require the following:*
>
> - *Original or certified copy of the [Trust document]*
> - *Original or certified copy of the Deed of Appointment and Retirement of Trustees dated 5th February 2016. On the basis of the documents provided, we are currently unable to ascertain the Trustees being appointed and or removed*
> - *A certified copy of a valid passport/U.K. photo card driving licence for the continuing and additional Trustees*
> - *A certified copy of or an original bank statement/utility bill dated within the last 6 months for the continuing and additional Trustees*
> - *The enclosed Declaration of Residence fully completed, signed and dated by the additional Trustees*
> - *The enclosed Tax Residency Self-Certification form …*
>
> *Furthermore, as the Trust is Discretionary we will require a list of all potential beneficiaries who fall within the definition of the Class of Beneficiaries clause in the Trust Deed. This list needs to detail the names, address and date of birth of all beneficiaries …*
>
> *The documents can be certified by one of the following:*
> *…*
>
> ***What is a Certified Document?***
> *…*
>
> *[The Provider] has an obligation to apply continuing due diligence to its entire book of business and therefore we need to ensure that in all relevant circumstances we have sufficient documentary evidence to demonstrate compliance with the relevant Anti Money Laundering and anti fraud requirements.*
>
> *If we can be of further assistance, please do not hesitate to contact us."*

CS contacted the Provider by telephone on **15 March 2016** to discuss the above two letters. Recordings of a number of calls between CS and the Provider have been provided in evidence and I have considered the content of these calls. CS also advised the Provider's agent that the documentation sought in the letter of **9 March 2016** had already been provided. In terms of the documentation being sought, the Provider's agent explained that the Provider would have its own requirements regarding verification documentation and the need for identification documentation. The Provider's agent explained to CS that it would need to contact the various trustees and that they would be entitled to information regarding the Plan.

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It was also explained that identification documentation was required for regulatory purposes. CS queried whether the Provider could not refer the regulator to her solicitor to which the Provider's agent responded that it could not. CS expressed the view that the process set out in the letter was very complicated. The Provider's agent advised CS that the information was necessary to verify the amendments to the trustees.

The Provider's agent also informed CS that it only received partial documentation from her: a cover letter, the first page of the **February 2016** deed, and a page with the names, addresses, and occupations of the trustees. CS explained that she scanned all the documents prepared by her solicitor and sent it to the Provider but could not understand why it was not received. CS said she would copy the relevant documents again and send them to the Provider. CS queries why the various documents were being sought by the Provider. The Provider's agent proceeded to explain the reason for seeking such documents and information.

A further call appears to have taken place on **24 October 2016**. However, the Provider has not been able to furnish a recording of this call. In the *Schedule of Calls* submitted by the Provider, I note that CS/the Complainant had a query regarding the Tax Residency form, who was required to complete the Non Irish Residency Form, and whose details should be put in potential beneficiaries list.

CS appears to have written to the Provider at the beginning of **December 2016** forwarding a number of documents relating to the appointment and retirement of trustees. These documents were certified by CS's solicitors.

The Provider wrote to CS by email dated **8 December 2016** advising that it was not in a position to update its records with the relevant changes *"… as requirements have not been fulfilled as requested."* The email continued:

> *"We require the following to update our records and to provide you with an endorsement to confirm the changes:*
>
> - *An e-mail or a letter from you to confirm your Tax Reference Number …*
> - *The attached change of address form completed by [the Complainant's daughter/Trustee 1] as we note from the documentation submitted that her address has changed but she has not confirmed this change to us.*
> - *The attached Declaration of Residence completed by [Trustee 5] and [Trustee 6] (the ones you submitted were completed by you)*
> - *An original or certified copy of a bank statement/utility bill dated within the last 6 months for [Trustee 1] and [Trustee 6] …*
> - *A certified copy of a current passport or UK/EU photo card driving licence for you, [Trustee 1], [Trustee 6] and [Trustee 5]. We are unable to accept the documents submitted as they have been certified by professionals that are not on our approved list. …"*

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The Provider wrote to CS and the Trust on **14** and **17 November 2017** respectively, explaining briefly, how the proceeds of the Plan would be distributed.

CS wrote to the Provider on **6 September 2018**, stating, among other things:

> *"… Please be aware that the ongoing Trustees are now [Trustee 1], [Trustee 5] and [Trustee 6]. Please be aware that [Trustee 5] had changed his address to …"*

CS also notified the Provider of the death of her son and that she was taking legal advice in respect of the implication this would have for the Trust. One of the enclosures with this letter was the *Deed of Appointment and Retirement* dated **16 February 2016**.

Second Plan Review

A further review of the Plan was carried out in **September 2018**, 6 years after the 10th anniversary review. The Provider wrote to each of the four trustees on **11 September 2018**. The letter issued to CS/the Complainant states:

> *"Dear …*
>
> ***This is an IMPORTANT NOTICE concerning your [Plan]***
> *…*
>
> *The value of your Plan will soon reduce to zero. In accordance with your Plan Conditions, your Plan will end and all the protection cover will cease when there are insufficient units in the Plan to meet our charges.*
>
> *The results of the review are given overleaf.* ***If you decide to do nothing your current level of cover is expected to cease on 1 February 2019.*** *If you decide you want to continue your cover under this Plan please read the following review letter carefully which outlines the options available to you.*
> *…*
>
> ***The results of your review***
>
> *The review indicates that your premium no longer supports your chosen level of cover for the next 5 years.*
>
> *The value of your Plan will soon reduce to zero. In accordance with your Plan Conditions, your Plan will end and all the protection cover will cease when there are insufficient units in the Plan to meet your charges.*

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The results of the review are given overleaf. ***If you decide to do nothing your current level of cover is expected to cease on 1 February 2019.*** *If you decide you want to continue your cover under this Plan please read the following review letter carefully which outlines the options available to you.*
…

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

When you purchased your [Plan], your premium was calculated to support your chosen level of cover until the end of your selected cover term. This was based on certain assumptions about the expected future growth in investment returns and the level of monthly protection benefit charges.

As you have reached the end of your selected cover term your Plan has now been reviewed to assess whether your current premium will support your cover until your next review date, on the current review assumptions.

When cover is taken out or reviewed, the premium depends on your age at the time. The cost of cover increases as you get other, and this has been taken into account in your review.

If your premium was calculated assuming a net growth rate higher than the rate assumed in this review then it will impact your review results making it more likely that the review will show action is now needed.

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 current level of cover for the next 5 years.

What you should do next

You should read carefully 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 WILL ASSUME THAT YOU WISH TO MAKE NO CHANGE TO YOUR PLAN AT THIS TIME. THIS MEANS THAT COVER IS EXPECTED TO CEASE ON 1 FEBRUARY 2019.***

/Cont'd…

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

A "*Result of your Review*" document was enclosed with this letter. This document states:

"This document sets out the results of your review and the options available to you.

…

Section 1 – Results of Your Review

The review indicates that the current premium level no longer supports the chosen level of cover for the next 5 years.

Section 2 – Options From Which You May Choose

Option 1: Take no action at this time - Cover is expected to cease on 1 February 2019.

…

If you decide to do nothing your current level of cover is expected to cease on 1 February 2019 *and it would then be no longer possible to make a claim. However, if a claim is accepted before cover ceases, then the claim will be paid based on the Plan Conditions.*

OR

Option 2: Increase your regular premium level

You can increase your monthly regular premium to UK£126.91.

This is the level of premium, which on the assumptions stated in section 3 should support the chosen level of cover for the next 5 years. At this point it is likely that further action will be required to maintain this level of cover.

OR

Option 3: Reduce the level of benefit

You can reduce the Life Cover Benefit to UK£15,983.00.

…

/Cont'd…

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. *…"*

The *Options Form* states:

*"**We recommend that you consult your Financial Adviser before completing this form.***

Please clearly indicate your instruction by ticking the box next to your preferred course of action and ensure that all forms indicate the same course of action.

…

We will write to you to confirm that we have received your instruction. If you decide to make a change, you will also receive a copy of the Plan Endorsement where the change to your Plan will be shown.

If you have any questions regarding this review or are uncertain about anything contained in this form, please do not hesitate to contact your ***Financial Adviser*** *or alternatively our Plan Review Helpline …*

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 CS/the Complainant and all trustees on **9 October 2018** as it had not received a response to the above correspondence.

This letter states:

"Dear …

<u>This is an IMPORTANT NOTICE concerning your [Plan]</u>

…

We wrote to you recently with details of the review carried out on your [Plan]. As we have not received a consistent response from all Trustees, we would be grateful if you could please give this your urgent attention.

…

It is important that you let us know your preferred course of action, and we ask that you complete the options form (copy enclosed) and send it to us … within 2 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, and we will take no action in relation to your Plan without express instruction.

/Cont'd…

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. THIS MEANS THAT COVER IS EXPECTED TO CEASE ON 01 FEBRUARY 2019.

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.

Please note: A copy of the original review correspondence was sent to each of the trustees listed above. ***Each*** *trustee must sign and return an options form and each must indicate the same course of action. …"*

The Provider returned a call to CS on **26 September 2018**. CS informed the Provider that it was sending correspondence to the wrong trustees as certain trustees had retired and new ones had been appointed. The Provider's agent advised CS that the relevant section within the Provider was updating its records in respect of the trustees. CS also expressed her dissatisfaction with the Provider not updating her on or making her aware of the value/sustainability of the Plan. A complaint was logged during this call.

The Provider wrote to CS and each of the trustees on **23 October 2018**, advising as follows:

"We wrote to you recently with details of the review carried out on your [Plan]. As we have not received a consistent response from all trustee, we have not made any changes to your Plan at this time. …"

During a telephone conversation on **5 November 2018**, CS maintained the position that she had sent the necessary documentation to the Provider to enable it to process the changes in respect of the trustees. The Provider's agent explained this was not the case and referred to and quoted from its email of **8 December 2016**. CS requested that this be sent to her again. Following this, CS states: *"I will track that down. If I've got it. I can't understand why it's been overlooked at all but I will try and track that down."* CS then made the point that despite her previous calls and letters regarding the trustees, no one within the Provider referred to this email. In a further telephone call on the same date, CS advised another of the Provider's agents that she never received this email.

Analysis

Receipt of Correspondence

CS maintains that she did not receive certain correspondence from the Provider. It is not entirely clear which correspondence was received and which was not. There is also conflicting evidence surrounding whether or not correspondence was in fact received. CS states at paragraph 2 of Item 14 in a submission dated **30 March 2020** that neither she nor any of the correct trustees received the **2018** review letters.

/Cont'd…

In a submission dated **28 March 2020**, CS states:

> *"… Some time after this policy was in place, I am unable to remember when, I received letters from [the Provider] telling me that my Policy had been switched to them."*

In the same submission, CS outlines that:

> *"… and I continued to receive letters yearly from [the Provider] explaining details of my plan."*

In a subsequent submission dated **12 May 2020**, CS states under *Complaint Item 1* that:

> *"I did receive letters from the Provider **after** 2016 whenever my plan was reviewed …"* [My emphasis].

In the next paragraph, CS states:

> *"With regard to 'letters sent by myself throughout the life of the plan', as stated by the provider, I am unable to relate to these as I do not recall receiving communications, from the Provider **prior** to 2016 I had no reason to contact the provider prior to my letter of 26.02.2016 which was to advise them that I had made changes to Trustees…."* [My emphasis].

The Provider appears to have used an address for CS which contained an incorrect spelling on the second line with the use of two incorrect letters. However, the other aspects of the address appear correct. This is evident on all correspondence issued to the Complainant from around **February 2002**. Notwithstanding this, I do not accept the minor spelling error was likely to be the cause of certain correspondence not being received by the Complainant.

Having considered the evidence and submissions I find there is insufficient evidence to support CS's position that she did not receive certain correspondence from the Provider. There are a number for reasons for this conclusion. First, contradictory statements have been made by CS as to the periods during which correspondence was not received.

Second, CS acknowledges receiving correspondence from the Provider, such as annual statements and the *Trust Variation* letter dated **18 April 2012**. Further to this, CS had furnished several original letters issued by the Provider dated between **2002** and **2018** to this Office. Additionally, letters dated **11 September 2018** and **9 October 2018** regarding the **September 2018,** review which CS appears to assert she did not receive, are amongst the original documents submitted by CS to this Office. Third, almost all correspondence issued by the Provider contained the same address for CS/the Complainant.

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2012 Plan Review

The first review of the Plan was scheduled to take place on its 10th anniversary. The Provider carried out this review in **April 2012** and wrote to CS and each of the trustees to advise that the premium under the Plan was sufficient to support the level of cover under the Plan for the next 5 years. Having considered the letter issued to CS and the trustees, I am satisfied that the Provider appropriately advised CS/the Complainant regarding the sustainability of the Plan.

2017 Plan Review

Following the 10th anniversary plan review, generally speaking, reviews would then be carried out every 5 years. This meant the next review was due to take place in **April 2017**.
Conflicting statements have been made by the Provider surrounding the **April 2017** review. In the Provider's Final Response email to CS dated **2 October 2018**, the Provider advised the CS that:

> *"A further review was carried out 5 years later on 1 April 2017 and these results indicated that your premium no longer supported your chosen level of cover for the next 5 years. Options were provided to increase your premium or reduce your level of cover to make your Plan more sustainable. However, as no response was received from the Trustees the default option to make no changes was applied to your Plan."*

It is formal response to this complaint dated **3 March 2020**, it is stated by the Provider that it:

> *"… has reviewed its records from this time and it is apparent that the Plan review results, and the applicable review options, were not sent to the Complainant or the Trustees as they should have been."*

In a submission dated **19 June 2020**, it is stated:

> *"The Provider has explained in a previous submission that it did not carry out a scheduled review of the Plan in 2017. This was an administrative error by the Provider at the time and the Provider apologises for this error. …"*

The Provider has not produced any evidence to demonstrate a 5 year review was carried out in **April 2017**. Accordingly, I am not satisfied any such review was carried out by the Provider.

It appears it was not until after its Formal Response to this complaint that it became apparent that no review was conducted in **April 2017**. This is extremely disappointing for a number of reasons. A formal complaint was made to the Provider in **September 2018**.
The Provider purportedly investigated this complaint and issued a Final Response advising that a review had taken place and issued letters regarding the Plan which were not responded to.

/Cont'd…

The letters allegedly not responded to have not been furnished by the Provider. In its Formal Response to this Office, it maintained that a review had taken place but review options were not issued. This clearly highlights that an inadequate investigation was carried out by the Provider both in respect of the formal complaint and when the Provider was preparing its response for the investigation by this Office.

This supports the conclusion that the Provider was totally unaware that a review had not taken place or if one did take place, that CS and the trustees were not issued with the appropriate review correspondence. This also suggests that the Provider failed to have sufficient oversight mechanisms in place to identify that a scheduled review did not take place or that review correspondence did not issue to the appropriate parties.

The Provider's conduct surrounding the **April 2017** review is extremely disappointing and falls well below the standards expected of a regulated financial service provider.

Further to this, I am satisfied, on the basis of the evidence outlined above, it was reasonably likely that the Plan was unsustainable in **April 2017** or it would have been reasonably apparent to the Provider had a review taken place that the Plan was not sustainable and required action on the part of the trustees.

As such, I am satisfied that the Provider failed to carry out the 5 year review at the appropriate time, being **April 2017**, and unreasonably delayed in conveying important information regarding the Plan to CS/the Complainant. Consequently, CS/the Complainant were not made aware of the likely state of Plan when it ought to have been.

2018 Plan Review

The second Plan Review was carried out in **September 2018**. The correspondence issued by the Provider clearly advises that the value of the Plan would soon reduce to zero, explained why the Plan was not sustainable, and that action was required of all trustees. Having considered this letter, I am satisfied the Provider appropriately advised, on this occasion, in a clear and comprehensive manner regarding the sustainability of the Plan and the options available to regarding the continuation of the Plan.

Sustainability of the Plan

In terms of the two review letters issued by the Provider, I do not accept that these contained any misleading or ambiguous information as asserted by CS/the Complainant. Further to this, I am not satisfied the Provider was necessarily obliged to advise CS/the Complainant as to the sustainability of the Plan following the period reviews. The manner in which the Plan would be reviewed was set out in the Plan documentation and, as far as the Provider was concerned, until **February 2016**, CS/the Complainant had the assistance of the Financial Adviser.

/Cont'd…

CS/the Complainant were also provided with annual Plan statements which outlined the value of the Plan and gave the opportunity to review the Plan and raise any queries.

In a submission dated **28 March 2020**, CS outlines that:

> *"As by now I was unable to contact [the Financial Adviser], there was no one to ask advice about the change so I'm afraid due to lack of financial advice, I did not contest or query this and I continued to receive letters yearly from [the Provider] explaining details of my plan. I did not feel the need to query these updates as I had assumed that should there be any problems I would get a separate letter explaining this. The letters always stated on the front page over a red background* ***'Nothing about your Policy is going to change'*** *and on seeing this reassuring statement which stood out, I filed them away as usual."*

I do not accept this was a prudent approach to take especially when CS/the Complainant did not have the assistance of the Financial Adviser.

I also do not accept that the Provider was obliged to review the Plan in an *ad hoc* manner prior to responding to any of CS/the Complainant's specific and unrelated requests in order to determine and/or advise CS/the Complainant as to whether any action might be required in respect of the Plan.

Furthermore, CS/the Complainant have not identified the precise letters which contain the statements ***'Nothing about your Policy is going to change'***. In the documentation furnished by the Complainant however, there is one letter dated **27 August 2018** which states:

> ***"Your Insurer, [the Provider], is taking in transfers of policies from its parent company. Noting about your policy is going to change, we're just writing to let you know.***
>
> *[The Provider] has reviewed its operations across Europe since the UK voted to leave the European Union. … [The Provider] has decided to consolidate all of its long term European Business (excluding they UK) into one entity.*
> *…*
>
> ***Nothing about your policy is going to change***
>
> *The terms and conditions of your policy, and the way it's run, will all stay the same. …"*

This letter simply advised CS/the Complainant about a restructure within the Provider. It appears to be a one off and stand-alone letter. I do not believe that it supported the conclusions arrived at by CS/the Complainant regarding the operation the Plan. It appears CS/the Complainant misunderstood the information contained in this letter and read it out of context. This letter should not have been read in isolation and should have been viewed in the context of all other correspondence issued by the Provider.

/Cont'd…

The Financial Adviser

CS/the Complainant's submissions outline that CS was unaware of or did not understand certain aspects of the Plan. CS purchased the Plan through the Financial Adviser. It was not until **February 2016**, that CS informed the Provider that she no longer had a financial adviser and that she had not been in contact with the Financial Adviser for quite some time. CS also maintains the position that at different points in time, she did not have sufficient opportunity to appoint a financial adviser.

During a telephone call on **14 December 2018**, CS informed the Provider's agent that she was not particularly well advised by her Financial Adviser in that she was not aware she would have to increase the Plan's premium after 10 years.

In a submission dated **1 June 2020**, CS states, referring to the Provider's letter of **7 March 2016**:

> *"The letter did not provide any explanation of 'Execution Only', for the benefit of the layperson, such as myself, who was unlikely to have any understanding of this term.*
>
> *In addition to this I wish to state that I did not have enough time to appoint another financial adviser as there were less than 6 working days from my letter of the 26.02.2016, advising the Provider that I had lost contact with [the Financial Adviser], to the Providers letter dated 07.03.16 informing me that my plan had been transferred."*

An almost identical observation is made in a submission dated **3 June 2020**.

Responding to the Provider's Final Response email, CS states in an email dated **28 December 2018**:

> *"At no time did I say you should have written to me every year, this would not have been helpful as the changes to my premium were only due to increase after ten years, which only fell recently.*
>
> *I was misinformed regarding this by the financial adviser who set up the policy in the first place. …"*

It is not clear to me why CS/the Complainant did not have sufficient time to appoint a new financial adviser. CS/the Complainant was well aware of the lack of engagement from the Financial Adviser for quite some time (from around **2002**) but took no steps to seek advice from or appoint another financial adviser. Furthermore, the evidence indicates that any misunderstandings CS/the Complainant had regarding the Plan emanated from the advice or lack thereof, from the Financial Adviser and not the Provider.

/Cont'd…

Execution Only

CS notified the Provider that she no longer had a financial adviser in **February 2016**. The Provider wrote to CS in **March 2016**, essentially acknowledging the position and advised that the servicing of the Plan was being transferred to the Provider on an *Execution Only* basis. The meaning of this phrase and its implication for the Plan and CS/the Complainant were not explained by the Provider. Furthermore, it is not clear whether the Provider was aware of CS/the Complainant's level of understanding when it came to such matters or that it sought to determine CS/the Complainant's understanding in this regard. CS/the Complainant states in a submission dated **1 June 2020**, *"[t]he letter did not provide any explanation of 'Execution Only', for the benefit of the layperson, such as myself, who was unlikely to have any understanding of this term."*. However, I note that CS/the Complainant did not query what was happening or what this meant for the Plan. Notwithstanding this, I am not satisfied it was reasonable for the Provider to simply advise that CS/the Complainant's Plan was being serviced on an *Execution Only* basis without explaining this concept.

CS/The Complainant's Understanding of the Trust

The Trust deed and the various documents amending the trustees clearly express that the trust property is vested in the trustees, and the operation and management of the Trust is the responsibility of the trustees. This would include a decision from each trustee in respect of the options contained in the Provider's options form issued in **September 2018**. CS does not appear to have understood this and believed that the trustees would not have a role to play until her death. This misunderstanding, despite the assistance a solicitor from the time the Trust was created, is apparent from a number of statements made by CS in her submissions. For example, in a submission dated **30 March 2020**, CS states:

> *"It was never the responsibility of Trustees to liaise with the provider as they had no legal role until after my death when the Trust became active. As the Trust owner and Settler it was my role to appoint and retire Trustees during my lifetime. Clearly the provider was misinformed by [the Financial Adviser]. Trustees were not owners of the policy, it belonged to me and until my death the Trust did not have any duties to perform. … Furthermore, the decision to choose options regarding renewal of the plan was mine alone to take as the Trust was not activated until my death. … I am perplexed as to why the provider continually chose to communicate with Trustees particularly retired Trustees …"*

Trust Variation

The evidence suggests that CS understood that she was required to write to the Provider to advise it of any changes in trustees and furnish the relevant *Deed of Appointment and Retirement*. However, CS does not appear to have clearly understood the Provider's requirements in this regard.

/Cont'd…

While a *Deed of Appointment and Retirement* was executed in **August 2008**. There is no evidence to demonstrate this was made known or forwarded to the Provider. In particular, in a submission dated **30 March 2020**, CS states:

> *"I was not under the impression that the policy Provider required updating every time a Trustee retired although I did comply with requests to furnish this information when it was requested, please also see my letter dated 06.09.18. However [the Provider] continued to write to [Trustee 3] and [Trustee 4], after I confirmed their retirement in 2016."*

In a further submission dated **3 June 2020**, CS states:

> *"The Provider was furnished with the original … Trust deed in 2002 and this deed was superseded by the 2008 Deed changes. As far as I recall a copy of this was sent to the Provider for their records. However the Provider states they have not received the 2008 copy. This documented the appointment of [Trustee 3] and [Trustee 4] and the retirement of [Trustee 2].*
>
> *I was then requested by the Provider in 2012 to complete their own 'change of Trustees' form. As no further changes were made to the trust between 2008 and 2016, I remain unclear what prompted the Provider to send to me their 'Trust Variation Form' four years later on 18.04.12. However this was then duly dated and signed on the 18th May 2012 and returned to the Provider."*

The Provider wrote to the Trust at CS's address on **18 April 2012** referring to a previous telephone call and enclosed a *Trust Variation* form which could be used for the appointment and retirement of trustees. A recording of this telephone call has not been provided nor has either party given an account of this call. Therefore, it is not entirely clear what motived the Provider's letter. CS completed this form but no queries were raised regarding any failure on the part of the Provider to update the list of trustees at an earlier point in time. Furthermore, CS has not been able to identify when she sent a copy of the **2008** deed to the Provider.

CS wrote to the Provider in **February 2016** advising it of a change in trustees and enclosed the relevant *codicil*. The Provider wrote to CS in **March 2016** to update her on what was required to perfect the change in trustees. This was followed by two telephone calls regarding the completion of the requested documentation in **March 2016** and **October 2016**. CS appears to have written to the Provider at the beginning of **December 2016** forwarding a number of certified documents relating to the appointment and retirement of the trustees.

The Provider responded to this by email dated **8 December 2016** outlining certain outstanding matters. The Provider advises in a submission dated **19 June 2020** that a *Trust Variation* form was not required as CS had submitted a deed drawn up by her solicitor confirming the changes to the trustees.

/Cont'd…

There appears to have been no further correspondence between the parties on this particular issue until CS wrote to the Provider in **September 2018**. CS was referred to the Provider's email of **8 December 2016** which CS maintains she did not receive.

As noted above, during the telephone call on **5 November 2018**, the CS states: *"I will track that down. If I've got it. I can't understand why it's been overlooked at all but I will try and track that down."* In a later telephone call on the same day, CS advised another of the Provider's agents that she never received this email. During the calls, the Provider's agents explained that the email was sent in a secure format and may have ended up in CS/the Complainant's *Junk* or *Trash* mailboxes. Having reviewed a copy of this email supplied in evidence, while CS may not have seen it, I accept it was sent to her correct email address. Additionally, there is nothing that would have made it apparent to the Provider that it was not received or ended up in CS/the Complainant's *Junk* or *Trash* mailboxes. Furthermore, I am not satisfied that the Provider was necessarily obliged to follow up on this email or seek a response to it.

While the Provider was aware of a change in trustee in **2016**, there is no evidence to suggest that CS/the Complainant furnished the required documentation to the Provider to allow the Provider to update its records. From the Provider's perspective, the trustees as at **April/July 2012**, where the correct trustees under the Trust, and Plan correspondence continued to issue to these individuals. Therefore, I do not accept the Provider's conduct in issuing correspondence to these individuals was wrong or unreasonable. The Provider requested specific documentation from the CS/Complainant, and this was not furnished.

Trustee 1's Address

Trustee 1 is CS's daughter. In the Provider's email dated **8 December 2016**, the Provider states:

> *"We require the following to update our records and to provide you with an endorsement to confirm the changes:*
>
> *…*
>
> - *The attached change of address form completed by [the Complainant's daughter/Trustee 1] as we note from the documentation submitted that her address has changed but she has not confirmed this change to us. …"*

It appears the Provider began to issue correspondence to Trustee 1 at its own address, that is, the address of the Provider's registered office. It is not clear how the change in Trustee 1's address came about.

However, it appears CS/the Complainant was provided with a change of address form to complete and there is no evidence of this being returned to the Provider. I note that CS/the Complainant maintain that she did not receive the email enclosing this form.

/Cont'd…

Further to this, there is no evidence of Trustee 1 notifying the Provider of her correct address. If a trustee changes address, is it incumbent on CS/the Complainant and/or the relevant trustee to inform the Provider of this. This must also be weighed against the Provider's knowledge that it was issuing correspondence intended for Trustee 1 to its own registered address and that, in terms of the options contained in the **2018** review letter, it would not have been possible to obtain a completed options form from each trustee.

I would consider it reasonable for the Provider to have made some effort to alert or advise CS/the Complainant or the other trustees of the absence of a correspondence address for Trustee 1 especially given the present circumstances of the Plan and the need for relatively immediate action.

Concluding Comment

Having considered the evidence and submissions of the parties I am not satisfied with the Provider's conduct regarding certain aspects of its administration of the Plan. Accordingly, I partially uphold this complaint.

In particular, I have concerns that the Provider did not adequately communicate over the years, the linkage between the premium being paid and the cost of providing the life cover. The Annual statements did not outline the cost of providing the life cover as a comparison to the premium being paid. I consider that when the premium being paid no longer covers the cost of providing the life cover, this should be brought to the policyholder's attention, at the earliest opportunity. The annual statements should reasonably provide this information. I accept that the missed review in 2017, or the lack of communication about this review, did not assist CS/the Complainant in the decisions that had to be made at that time.

For the reasons outlined in this Decision, I partially uphold this complaint and direct that the Provider pay the sum of €4,000 to the Complainant (the trust).

<u>Conclusion</u>

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)(b) and (g)*** on the basis of the Provider's unreasonable and improper conduct.

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 Complainant (the trust) in the sum of €4,000, to an account of the Complainant (the trust's) choosing, within a period of 35 days of the nomination of account details by the Complainant (the trust) to the Provider.

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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.***

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

23 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.