An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0270
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Poor wording/ambiguity of policy Failure to provide correct information Failure to provide product/service information
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the Complainants' Whole of Life Policy, with a savings element, which was incepted in 1987. The Complainants' complaint concerns the Provider's non acceptance of their request to enact a provision of the policy, in and around **May 2019**.

The Complainants contacted the Provider **21 May 2019** to *"convert the Life Assurance policy into a **'Free Policy'** in accordance with the Terms and Conditions*" of the Policy, as issued to them by the Provider in 1987.

The Complaint is that the Provider has failed to allow the Complainants avail of an option, applicable to their policy and "*in accordance with the Terms and Conditions*" of the policy.

The Complainants' Case

The Complainants say the policy wording of *"paragraph 19(c)"* in their policy documents states: "*At any time after the Policy has been in force for two complete years the Policy may be continued in force free from future premiums and assuring a sum not exceeding the then current Guaranteed Minimum Death Benefits".* The Complainants insist that they should be able to rely on this provision, and convert the Plan, without future monthly premiums but with a continued *"Guaranteed Minimum Death Benefits" of €59,845 on both [their] lives*".

The Complainants want the Provider to allow them to *"enact the Provision of paragraph 19 (c) of the Terms and Conditions"* of their policy.

The Provider's Case

The Provider's Final Response Letter, of **29 May 2019** states it: *"regrets to advise that [the Complainants] plan is not eligible to avail of this option".* The Provider says that the Complainants were informed that the policy fund was *"insufficient"* to cover the monthly cost of providing *"Guaranteed Minimum Death Benefits' associated with their current plan".* The Provider submits the Complainants were advised that monthly premiums would need to be continued and paid into the policy fund to assure that future benefits remain.

Evidence

Policy Provisions

Paragraph 7

> *"Non Payment of Premiums*
>
> *....if any premium due remains unpaid at the expiration of the Period of Grace the Policy shall lapse with effect from the date the first unpaid Premium fell due for payment unless the Policy has acquired an encashment value in accordance with paragraph 19 and the Company has received no prior notice of Encashment whereupon the Policy shall be converted to a paid up assurance without Endorsement with effect from the date the first unpaid Premium fell due for payment and the Guaranteed Minimum Death Benefits shall be adjusted to such amounts as the Company's Actuary shall decide".*

Paragraph 15

"Death Benefit Charge and Policy Charges"

> *"the Policy will expire at the end of the month in which the Unit Account first registers a negative balance If (i) it is in paid up form .."*

Paragraph 19

"Encashment / Partial Encashment / Free Policy".

> *(a) Encashment*
> *The Policy may be encashed at any time after it has been in force for two complete years.*

/Cont'd…

Subject to these Provisions, Privileges and Conditions the encashment value payable, which shall be in lieu of all other benefits under the Policy, shall be an amount equal to the then Accumulated Fund.

(b) Partial Encashment
The Policy may be encashed in part at any time after it has been in force for two complete years provided that

(i) *The value at Bid Price of the Units encashed is not less than IR£250.*

(ii) *The value at Bid Price of the Units remaining after encashment is not less than such amount as the Company's Actuary shall decide.*

(iii) *The premiums continue to be payable in full.*
Subject to these Provisions, Privileges and Conditions in the event of partial encashment the Unit Account shall be debited with a number of Units equal in value at the then current Bid Price to the encashment requested. On partial encashment the Guaranteed Minimum Death Benefit shall be appropriately amended as determined by the Company's Actuary.

(c) Free Policy
"At any time after the Policy has been in force for two complete years the Policy may be continued in force free from future premiums and assuring a sum not exceeding the then current Guaranteed Minimum Death Benefits".

Paragraph 22

"Expiry"
"The Policy will expire at the end of the month in which the Accumulated Fund Value first registers a negative balance if (i) it is in paid-up form or (ii) an option specified in sub-paragraph 19 (b) or paragraph 21 has been exercised".

The Complaint for Adjudication

The Complaint is that the Provider has failed to allow the Complainants avail of an option, applicable to their policy.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's

/Cont'd…

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 **31 May 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

The Complainants made a post Preliminary Decision submission on **14 June 2021** and in response the Provider made a submission dated **18 June 2021**.

In their post Preliminary Decision submission, the Complainants point out that their policy was not only a life policy, but that it also included savings. They state it was described to them by the Provider as follows:

> *"The … Account is a unique combination of life assurance and savings. It is the ultimate in flexibility-changing as your needs change throughout life. The … Account is the only long term life assurance or savings Account you will ever need"*

The Complainants state that they have paid all contributions required of them by the Provider as decided on by the Provider's Actuaries to keep this Account in funds since commencement of the Policy on the **01 December 1987** and have not availed of encashment or partial encashment during the lifetime of the Policy.

The Complainants point to an error in my Preliminary Decision where I quote Sub-paragraph 19(c) of the *"Provisions, Privileges and Condition Booklet"*. The Complainants question whether this error had a direct bearing on the determination reached in my Preliminary Decision.

The correct quotation is as follows:

> *"At any time after the Policy has been in force for two complete years the Policy may be continued in force free from future premiums and assuring a sum not exceeding the then current Guaranteed Minimum Death Benefits".*

/Cont'd…

The incorrect version included in my Preliminary Decision stated: **“assuming a sum assured”** and referred to **“Minimum Death Benefit”** (singular not plural).

In addition, the Complainants consider that the reference to a previous complaint with the Provider should not have been included.

The Complainants submit the Provider has stated that *"The Terms and Conditions of the Complainants plan have not been changed since their plan started in 1987",* the said conditions being drafted as conditions of Adhesion.

The Complainants state that Paragraph 19 of the *"Provisions, Privileges and Condition Booklet",* being without preamble, has three separate elements and say Paragraph 19(c) stands alone as a clear ***"Defined Legal Article",*** unencumbered by any endorsements or conditions and not linked to other Sub-paragraphs or Paragraphs. The Complainants therefore say the Provider cannot now state that ***"Paid up"*** and ***"Free Policy"*** mean the same thing.

The Complainants reiterate that they have consistently **"Paid up"** the Consideration the Provider required of them, relying on the Provider to manage the Policy in a prudent manner, in *Utmost Good Faith*.

The Complainants refer to the Analysis section of my Preliminary Decision where it is stated that a single condition in a contract should not be read in isolation, and that all the terms and conditions of a contract need to be considered to understand its overall purpose.

The Complainants state that this is not legally correct, and that a single condition of a contract which stands alone as a clear *"Defined Legal Article",* can define the whole or part of a contract.

The Complainants submit that for me to state that, to expect an Insurer to provide a guaranteed death benefit indefinitely on two lives free of any cost once a contract had been paid into for just two years would be unreasonable, is to ignore the fact that this is what is clearly written in the *"Provisions, Privileges and Conditions"* provided by Insurer, written by the Insurer under the Doctrine of Adhesion, a fact also confirmed in the letter of Acceptance from the Provider in November 1987.

The Complainant states that the I further state that I did not consider that this was the intention of the contracting parties.

The Complainants state that they, as Contracting Parties, understood from their acceptance of the contract, that this was the position.

The Complainants states that in relation to the Paragraph 19(c) *"Free Policy",* I state the Policy had to have a fund value. The Complainants’ response is that the lack of a fund value clearly rests in the hands of the Provider its management of the Policy, which was entrusted to the Provider’s care in Utmost Good Faith, as described in the Policy Booklet.

/Cont’d…

The Complainants quote the following from the *"Provisions, Privileges and Conditions"* document, with regard to how the funding of claims are to be met:

> *"THIS POLICY is issued out of the Ordinary Branch of the Company and the Ordinary Branch Fund together with the Capital Stock of the Company shall alone be answerable for any claims made under the policy".*

The Complainants submit that in reaching the Preliminary Decision, I appear to lean heavily on the Commercial standpoint, introducing a consideration of the costs involved for the Provider regarding *"mortality charges and monthly plan fee",* not acknowledging the clear *"Defined Legal Article"* that is Paragraph 19(c), written into the *"Provisions, Privileges and Conditions"* by the Provider's Legal Draft people, under the Doctrine of Adhesion.

The Complainants state that they, the Complainants, along with this office, appreciate the Commercial implications of implementing the clear legal terms of the Contract in relation to a *"Free Policy",* but say, nevertheless 19(c) is an enforceable "Defined Legal Article" and must be upheld.

The Complainants states that while they, the Complainants, accept the integrity of this office, they do not agree with my Preliminary Decision and believe that this complaint would be better dealt with by the holding of an Oral Hearing, to resolve the obvious conflict of legal facts.

In the Provider's post Preliminary Decision submission of **18 June 2021**, it states it has no further comment to add other than to clarify the correct wording of paragraph 19 (c), which the Provider had incorrectly quoted in its response to the complaint.

I have corrected the errors as noted by the Complainants in relation to Paragraph 19 (c).

In its submission the Provider acknowledged its inclusion of the incorrect wording of this paragraph in its response to the complaint. The correct wording of this paragraph was set out in the background section of my Preliminary Decision.

While this error of including the incorrect wording in the "Evidence" section of the Preliminary Decision, is regrettable, I can confirm that it did not have a bearing on the determination reached in my Preliminary Decision.

I also note the arguments put forward by the Complainants for an Oral Hearing. The content of the post Preliminary Decision submissions however has not persuaded me of the need to hold an Oral Hearing as I remain of the view that the evidence and submissions furnished are sufficient to enable me to arrive at a decision. Accordingly, my final determination is set out below.

The Complainants' plan started on **01 December 1987** and was taken out

/Cont'd…

through their independent financial intermediary. It is a whole of life protection plan with a savings element which is subject to regular reviews.

The Provider states the policy includes life cover on each life of €59,845. The Provider states that the payment on the Complainants' plan was €221.07 per month and as the Complainants are over the age of 70 their plan is subject to annual reviews in line with paragraph 20 (b) of their plan Terms and Conditions.

The subject of this complaint is the application of paragraph 19 (c) of the Complainants' Terms and Conditions.

The Provider states that the Complainants were very much aware that their plan ceased to have a value. In this regard the Provider refers to copies of the Complainants' Annual Benefit Statements from 2009 to date and samples of some of the significant correspondence that it engaged in with the Complainants over the years on their plan value and reviewable nature of their plan.

With regard to the single core issue of this complaint which is the enactment of paragraph 19 (c) of the Terms and Conditions the Provider notes the following.

The Provider submits that Paragraph 19 (c) describes when the option to make a plan 'paid up' or converted into a 'free policy' becomes available (after the policy has been in force for two complete years). The Provider states that it needs to highlight that 'paid up' and 'free policy' means the same thing.

In this policy paragraph the Provider states:

> *"At any time after the Policy has been in force for two complete years the Policy may be continued in force free from future premiums and assuring a sum not exceeding the then current Guaranteed Minimum Death Benefits".*

The Provider says that Paragraph 19 (a) and (b) of the plan Terms and Conditions is in relation to making a withdrawal from the plan fund. It further states that in order to make a withdrawal the fund must have a value.

The Provider states that making a plan 'paid up' or converting to a 'free policy' means stopping the plans regular monthly payment and allowing the value that is on the plan meet the plans ongoing costs each month. The Provider says that similarly to exercising paragraph 19 (c) the plan must have a value.

The Provider states that once there is a fund value, paragraph 19 (c) can be enacted if elected by the plan owners and typically it would stay in place until such a time as the plan owners decides to recommence their regular direct debit payment or until the value has depleted to a level where it is no longer sufficient to maintain the plan costs going forward.

The Provider submits that the latter is provided for by Paragraph 22 of the Terms and

/Cont'd…

Conditions which provide for the expiry of the plan once this happens.

The Provider states that the Plan's ongoing charges must be met in order for the plan to do what it was designed to do, that is, provide life cover benefit. The Provider says if the plan's charges, which include the monthly mortality cost which pays for the life cover benefit and its monthly plan fee, are not met each month by a regular payment or a fund value then the plan falls into arrears and the cover expires.

The Provider refers to Paragraph 7 of the Terms and Conditions under the heading "Non-payment of premiums" which it states describes the process of a plan being 'paid up' which it says is the same as being converted to a 'free policy'.

The Provider's position is that the Complainants' plan does not have a value and as such they cannot exercise paragraph 19 (c). The Provider says the absence of a value on their plan has been resolved to their satisfaction under the previous complaint to this office.

The Provider states that Paragraph 19 (c) describes when the option to convert the plan into 'paid up' plan or 'free policy' becomes available and Paragraph 7 describes the process of doing this. The Provider says that Paragraph 19 should be read in conjunction with paragraph 7, 22 and all other references to 'paid up' throughout the contract.

The Provider submits that the Complainants are reading paragraph 19 (c) in isolation to the rest of their terms and conditions document and in doing so are interpreting that they can simply stop paying into their plan as it is over two years old and benefit from life cover of €59,845 indefinitely at no cost to them.

The Provider says that a condition of a contract should not be read in isolation like this and the whole terms and conditions document needs to be considered to understand its overall commercial purposes.

The Provider says that from a commercial viewpoint the Complainants' isolation of a single clause in their Terms and Conditions and their interpretation of this out of context with the rest of their contract would make no sense for any insurer and is not reasonable to expect a life insurance provider to furnish a guaranteed death benefit worth tens of thousands of euros indefinitely on two lives free of any cost once the contract has been paid into for two years.

The following is the Complainants' response of **19/08/2020** to the Provider's stated position:

The Complainants state that this Plan has been paid for by Direct Debit, since the inception of the Plan in 1987, therefore reference to Paragraphs 7 & 22 have no relevance, having no direct legal link to Paragraph 19(c).

The Complainants say they have consistently paid what the Provider requested of them following the Actuary's Review, either by selecting an option offered or the default offer.

/Cont'd…

The Complainants state that if they failed to meet the obligations regarding payments, required by the Provider after the Actuary's Review, the Provider would not act as the Benevolent Body and would be enforcing the relevant Paragraphs of the Contract.

The Complainants submit that in the Provider's response it makes reference to Paragraph 19 (c), ascribing the words ***"paid up"***, as being part of 19 (c).

The Complainants contend that this is clearly not correct, and the Provider cannot take liberal views of the contractual terms of 19 (c), framing them in its favour.

The Complainants submit that Paragraph 19 (c) stands alone as a clear legal contractual entity, unencumbered by any special conditions or endorsements attached to it.

The Complainants refer to the Provider's statement that: *"The Terms and Conditions of [the Complainants] plan have not been changed since their plan started in 1987".*

The Complainants' position is that Paragraph 19 (c), in standing alone has clear contractual obligations for the Provider and Legal Counsel advises that as such, the Provider should now meet its legal obligations by enacting the terms of 19 (c) as stated.

The Complainants made the following further submission dated 31/08/2020:

> *"Paragraph 19 (c) of the Terms and Conditions of our … Plan, stands alone as a clear legal entity of the .. Plan as drafted by [the Provider] when developing this Plan, unencumbered by any other Terms and Conditions.*
>
> *Failure by [the Provider] to fulfil this element of the Contract, is a violation of the Terms and Conditions of the Agreement entered into with us in 1987".*

Analysis

I accept that a single condition in a contract should not be read in isolation, and that all of the terms and conditions of a contract need to be considered to understand its overall purpose.

I also accept that to expect an Insurer to provide a guaranteed death benefit indefinitely on two lives free of any cost once the contract has been paid into for just two years (and as in this complaint with a Policy that has no fund value) would be unreasonable. I do not consider that this was the intention of the contracting parties.

On a reading of the entirety of the Policy document, I accept that to exercise the options under Paragraph 19 (a) "Encashment" (b) "Partial Encashment" and (c) "Free Policy", the Policy had to have a fund value.

/Cont'd…

As regards the "Free Policy" option there had to be a fund value in place to pay for the ongoing charges (which included a monthly mortality charge to pay for the life cover benefit and a monthly plan fee) that had to be met in order for the plan to do what it was designed to do, that is, provide life cover benefit for the Complainants.

Having regard to all of the above, I do not uphold this complaint.

Conclusion

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

6 August 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