An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0414
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Mis-selling Delayed or inadequate communication Failure to advise on key product/service features
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a Unit Linked Whole of Life Policy, incepted by the Complainants on in **January 1998** with the Provider.

The Complainants' Case

The Complainants say they incepted a Unit Linked Whole of Life Policy on **01 January 1998** with the Provider, following an earlier meeting between the parties in 1997.

The Complainants were not happy with the options given to them in a policy review letter, dated **30 November 2017** and state they were not aware of the possible premium increases or the potential reduction of benefits applicable to the policy over its lifetime of cover.

They were informed that a premium increase was now required to sustain the benefits until the next review date.

The Complainants were disappointed at the level of the requested premium increase, and were not happy with the reduced benefit options. The First Complainant states that they were notified by a letter date **30 November 2017**, *"imposing 3 options to choose from, which we received on the **6th of December 2017,** given us very little time before Christmas to get back to [the Provider] by the 1st of January with a decision"*. The Complainants say they were expecting a *"normal increase on the life cover/death benefit"* which had

remained at a *"standard yearly indexation rate of the 5%".* The First Complainant says they were *"shocked and very frustrated at the unjustified 75% increase in [their] quarterly premium payment and even more shocked that if we didn't accept the increase we would automatically lose €30,055.00 off the life cover/benefit".*

The Complainants brought the matter to their solicitor who raised a complaint with the Provider. As the Complainants felt *"backed into a corner"* they indicated *"Strictly without prejudice"* option B which left the premium at €319.23 per quarter and reduce the benefits from January 2018. The Provider acknowledged their letter on **21 December 2017**. By return, the Provider responded to their complaint and confirmed their chosen option (Option B) in its letter of **08 January 2018**. The Complainants were surprised to receive a 2nd letter some 5 months later dated, **16 May 2018**, also confirming the policy changes.

The Complainants are not happy with the changes in the policy benefits and did not 'agree' with the options given to them, although they believe they had little choice but to accept one of the options. The Provider is also criticised for issuing an *"important life changing decision"* document, received by the Complainants' on **06 December 2017**, *"technically two weeks"* before the Christmas period and New Year. The Complainants were advised to indicate their choice and return the notice before commencement of the automated default change to the policy on **01 January 2018.**

The Complainants state that the Provider continuously highlighted the information within the policy, about policy reviews on the 10th and subsequent 5 year reviews none of which indicate with any real clarity and or transparency what would and has happened to their life cover. The Complainants submit that in 1997, they were much younger and were not financial experts, so in reading the policy documentation in 1997, with the 14 day cancelation limit and without a full clear transparent explanation of what the policy was, and would become over it's lifetime, by any of the Provider's Sales Agents, whether in 1997 or in 2012, or in any correspondence from the Provider, they were left in the dark.

The Complainants state, with all the highlighted correspondence from the Provider as to what the reviews would mean and the Provider deciding outcomes in recent years, that somehow they both should have had expert financial knowledge in their 20s and 30s when reading the policy documentation. They state that without any other information or explanation from all or any respective agents involved, that they, dispute that they should have known the outcome of the changes to the policy 20 years after the original documentation was signed. The Complainants state that if they had had known any of this before they signed the policy document they would have had an outside financial advisor to take a look at the policy and explain what exactly they were signing. The Complainants say that this is why they have decided to decline the Provider's goodwill offer of €500.

The Complainants want the Provider to re-instate the level of benefits to the policy that they enjoyed prior to January 2018 and continue with the current monthly repayment. The Complainants want a reassurance that similar policy options will not be applied in the future. Alternatively, the Complainants request *"all monies paid over the years to be returned".*

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The Provider's Case

The Provider states that the Complainant's took out a reviewable unit linked protection policy with the Provider on **1 January 1998**. The initial cover provided by the Policy was life cover of IR£30,000 (€38,092), additional critical illness benefit of IR£25,000 (€31,743), additional total and permanent disability benefit of IR£25,000 (€31,743) and premier hospital cash benefit of IR£50 per day on each of their lives for an initial quarterly premium of IR£107.39 (€136.36).

At the date of the Provider's letter of **26 August 2020**, the Policy had the following benefits: life cover of €61,163.55, additional critical illness benefit of €50,970.15, additional total & Permanent Disability Benefit of €50,970.15 and premier hospital cash benefit of €154.53 per day. The current quarterly premium is €335.18 (inclusive of a 1% Government Levy). The Provider states that the Policy has a value of approximately €1,780 at the date of the letter.

The Provider submits that the Policy is subject to periodic reviews in accordance with Condition 10 of the policy conditions issued to the Complainants in1997. The Policy states:

> *"a policy review shall take place on the following occasions:*
> *1. The 10th policy anniversary;*
> *2. Every subsequent 5th policy anniversary;*
> *3. Every policy anniversary after a life assured reaches his or her 70th birthday;*
> *4. If a claim for Death Benefit, Critical Illness Benefit or Total and Permanent Disability is paid;*
> *5. If you either decrease the premium or increase the level of protection benefits;*
> *6. If you suspend payment of the premiums;*
> *7. If you revive the policy after it has lapsed or been made paid up;*
> *8. If you encash part of the policy;*
> *9. If a second life assured is added to the Policy."*

The Provider states that the Policy (under condition 7 of the Policy conditions) also allows for indexation, meaning both premiums and benefits increase yearly to offset the effect of inflation. Indexation, which is separate to the periodic review process, provides for an increase each year to both the sum assured and the premiums being paid at the time.

As set out in condition 7 the increase shall be:

> *"5%, or the percentage increase, if any, in the Consumer Price Index for the previous year. If the Consumer Price Index ceases to exist the Actuary will choose another relevant index to replace it."*

The Provider states that Indexation letters issue each year, and it is open to a policyholder to notify the Provider on receipt of an annual indexation letter that they do not wish for

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indexation to apply in that year. The Provider says it is also open to a policyholder to remove indexation from the Policy at any time. The Provider states that records reflect that the Complainants instructed the Provider not to apply indexation to the Policy for 2019 by telephone call in December 2018. The Provider submits that the indexation feature was reactivated in 2020 and currently applies on the Policy.

The Provider states that in accordance with the Policy conditions, the first scheduled review of the Policy took place in November 2007, just prior to the 10th anniversary of the Policy.

The Provider says it wrote to the Complainants on **10 November 2007** and advised that the quarterly premium of €194.05 which was being paid at that time was sufficient to maintain the level of cover on the Policy. The Provider states that the review letter also included premiums and benefits on the basis of the following assumptions:

> *"The premium and benefits shown above assume that you accept indexation of 5.00% at 1 January 2008. If you do not wish to accept these please inform us. You should notify us immediately if any of the above details are incorrect.*
>
> *The current value is based on unit prices and on the number of units at the price date stated. The value assumes that premiums are fully paid to date. If premiums have not in fact been paid, the value will be reduced accordingly."*

The Provider states that the review letter in November 2007 reflected a policy value of €2,562.

The Provider says that the second scheduled review of the Policy took place in December 2012. The Provider states that it wrote to the Complainants on **14 December 2012** and advised that the quarterly premium of €247.66 which was being paid that that time was sufficient to maintain the level of cover on the Policy. The Provider submits that the review letter also included premiums and benefits on the basis of the following assumptions:

> *"The premium and benefits shown above assume that you accept indexation of 5.00% at 1 January 2013. If you do not wish to accept this please inform us. You should notify us immediately if any of the above details are incorrect.*
>
> *The current value is based on unit prices and on the number of units at the price stated. The value assumes that premiums are fully paid to date. If premiums have not in fact been paid, the value shall be reduced accordingly."*

The review letter in December 2012 reflected a policy value of €2,997.

The Provider states that its records reflect that it wrote to the Complainants on **16 November 2017** enclosing a guide to remind them of the features of the Policy. The Provider says this guide explains why periodic reviews are carried out and why increases occur.

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It is the Provider's position that shortly after the guide had been issued, the third scheduled review took place. The Provider says it wrote to the Complainants on **30 November 2017** and advised that in order to maintain the cover on the policy at that time the premium would have to be increased. The Provider submits that with the premium increase it was estimated that the benefits under the Policy would be sustained for the next five years. The review letter provided the Complainants with three options that were open to them at that time. These options were:

> *(a) You can increase your premium to €569.71 per quarter with effect from 1 January 2018 and maintain your current level of cover until the next policy review date in January 2023…*
> *Or*
> *(b) You can reduce the level of cover and maintain your current premium level of €319.23 per quarter. Your protection benefits from 1 January 2018 would reduce as outlined below…..Revised life cover €58,251…*
> *Or*
> *(c) Change the level of benefits to those below and increase your premium to €472.95 per quarter from 1 January 2018 which will allow the reduced level of benefits to continue for a further five years ….Revised life cover €73,278…"*

The Provider states that the review letter in November 2017 reflected a policy value of €2,624.

The Provider says that while it understands the level of premium increase required after 22 years is disappointing for the Complainants, the cost of life cover increases with age and indeed further premium increases can be expected in the future if the Complainants wish to maintain cover. The Provider submits that it is important to set out that the policy has given valuable protection benefits over the last 22 years and if the Complainants wish to maintain cover and are willing to pay premiums due in the future, it continues to provide those benefits for the remainder of their lives.

The Provider states that many policies available today have cover for a fixed term only and cover often ceases at a certain point with no ability to extend the term of cover beyond that point. The Provider says that taking out a new policy at that point will more than likely be more costly as the lives insured will have aged, medical underwriting will apply and the health of the lives insured may have deteriorated by then.

The Provider says it would strongly recommend that the Complainants meet with their local Investment Manager who will be able to assess the Complainants' current needs and provide them with any options open to them in light of those needs.

The Provider states that it is important to understand that the Complainants have a number of options available under their existing policy due to the flexible nature of the policy and they also have the option to take out a new policy which would be subject to full medical underwriting.

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The Provider says that a further option which may be of interest to the Complainants, and which their Insurance and Investment Manager could explain in greater detail, is a new protection product which the Company has made available to holders of unit linked protection policies such as the Complainants.

The Provider says this new product has the potential to provide the Complainants with life cover only up to the age of 85 and without the necessity for any periodic reviews or for any medical information to be provided. The Provider states that this would give the Complainants certainty on what the premium and level of life cover would be for the entire term selected. The Provider states that while this new product has life cover only, it would be important to note that the Complainants would still have the option to retain their existing policy for their additional critical illness, additional total and permanent disability benefit and hospital cash benefit if they decided the new product was right for them. The Provider says that the Insurance & Investments Manager could provide further details on how this would work.

The Provider states that while the new product is currently available to the Complainants, it is important to note that it will not be available indefinitely.

It is the Provider's position that Policy reviews have taken place in accordance with the Policy conditions and that the outcome of the reviews was notified to the Complainants on each occasion.

The Provider states that in the run up to a periodic review, it issues correspondence to policyholders approximately one month prior to the policy anniversary so that they have time to consider the options available to them. The Provider states that the Complainants' policy anniversary is 1 January each year and so it is inevitable that review correspondence will be issued on or about the end of November. The Provider submits that its records reflect that it issued the outcome of the 2018 policy review to the Complainants on **30 November 2017**. The Provider states that in accordance with condition 8 of the policy conditions, policy holders *"must inform us within 30 days of receiving this information which of these options [they] wish to implement".*

The Provider says while it understands that the level of increase was disappointing for the Complainants, it can be seen from its submission and evidence submitted, in response to the complaint, that, at all times, it acted in accordance with the Policy terms and conditions in carrying out the review.

However, the Provider accepts that the Complainants asked during the complaint process for some additional time to make up their minds in relation to the review and that the complaint response letter issued by the Provider did not make reference to that request at the time.

The Provider has offered a gesture of goodwill to the Complainants for this lapse in the sum of €500.

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The Provider states that if the Complainants are willing to meet with an Insurance and Investment Manager to discuss options with them, the Provider would be happy to arrange such a meeting. In addition, the Provider states that its goodwill gesture of €500 will remain open to the Complainants until this office has adjudicated on the complaint.

Evidence

Annual Statements

The Provider was unable to furnish the Annual Statements for 2011, 2012 or 2013. The Complainants advised that the only statements they received for those years were Indexation Letters.

The Annual Statement for 2014 did not show the cost of benefits relative to the premiums being paid.

Annual Statements from 2015

> *"Your policy is reviewed at least every five years to make sure the premium being paid by you is sufficient to cover the cost of the protection benefits provided by your policy and takes into account the value of your policy at the time of review".*

The Annual Statements from 2015 show that the cost of benefits were greater than the premium being paid by the Complainants, for example, the cost of benefits in 2015 was stated to be €1,142.29 and the premium being paid was €1,053.16.

The Annual Statements also set out that:

> *"The value of your policy, if any, will be used, in addition to your premium payments, to fund the cost of providing the protection benefits over time. The total premiums paid to date …"*

Policy Reviews

The 2007 Policy Review

The review letter dated **10 November 2007** advised that:

> *"We have carried out a review to ensure that your current premium is sufficient to maintain your current level of benefits for the next five years".*

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The 2012 Policy Review

The review letter dated **14 December 2012** advised that:

> *"We have carried out a review to ensure that your current premium is sufficient to maintain your current level of benefits for the next five years".*

The 2017 Policy Review

The Review letter dated **30 November 2017** advised that:

> *"We have carried out a review on your policy to determine if the premiums payable and the current fund are sufficient to maintain your present level of benefits".*

The Complaints for Adjudication

In a letter dated **26 June 2020**, the Complainants were advised by this Office that:

> *"Owing to the elapse of time, any complaints concerning the suggested mis-selling of the policy in 1997, fall outside the jurisdiction of this office".*

Therefore, the Complaint for adjudication is that the Provider:

> Implemented an "*unjustified 75% increase*" to the Complainants' Unit Linked Whole of life quarterly premium payments;
>
> Failed to notify the Complainants in a reasonable time frame, of the implications of its 5 year review, effective from 1st January 2018.

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 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

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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 **11 October 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.

On **11 October 2021**, the Provider acknowledged receipt of the Preliminary Decision.

In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

<u>Analysis</u>

With regard to the sale of the policy, in a letter dated **26 June 2020**, the Complainants were advised by this Office that:

> *"Owing to the elapse of time, any complaints concerning the suggested mis-selling of the policy in 1997, fall outside the jurisdiction of this office".*

While this office could not investigate the sale of the policy in 1997/1998, the complaint was investigated to determine if the Provider carried out the terms and conditions of the policy in relation to the administration of the policy and in relation to the review process, particularly in the six-year period prior to date that the complaint was made to this office.

This is a Unit Linked Whole of Life Policy. Benefits are charged for on a yearly basis and the premium rate increases with age. A Fund is built up in the early years but unless the initial premium is substantial the cost of the benefits in later years is greater than the premium and the Fund subsidises the cost of the benefits. In due course there is a need for a review of the policy which can mean an increase in premium or a reduction in the benefits.

Policy Reviews are provided for under Condition 10 of the policy document.

The core issue with this type of Policy is that the premium rate charged for the benefits increases with age (each year) and the amount required to maintain the sum assured increases. The initial premium is not guaranteed to sustain the benefits for the Complainants' entire lives.

The nature of the policy means that the costs associated with the life cover increases over time, as the policyholders' age increases.

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The life cover had to be paid for and the Provider was allowed under the policy to deduct the cost of cover from the policy fund. The policy documentation clearly sets out what charges would be deducted and the need to review the Policy in the future. The Policy provided for the first review to be carried out on the 10th anniversary and subsequently every 5 years. I accept that the Provider carried out the reviews in a timely fashion. The Provider carried out the first review in 2007, the second review in 2012, and the latest review in 2017.

The Policy Review gives an opportunity to realistically assess how the policyholders' needs are being met. Furthermore, it gives the policyholder an up to date picture of the level of cover chosen and provides an indication as to how long the policy fund is likely to sustain that cover. This is particularly important as it allows the Provider to discuss with the policyholder what, if any, action needs to be taken.

The amount of the premium required following a review is a matter of commercial discretion of the Provider's Appointed Actuary. This Office will not interfere with the commercial discretion of the Provider. The premiums charged by the Provider go towards paying for the life cover and other benefits under the policy.

The indexation option is designed to protect the value of the policy benefits (including life cover) and premium against inflation and is a totally separate issue from a Policy Review. Indexation increases do not take into account the increasing cost of life cover, and other benefits, due to increases in age of the lives assured.

The first review was carried out in 2007 and the second in 2012, on both occasions the Provider advised the Complainants that the policy would be further reviewed after 5 more years. It also gave the Complainants the option to increase the premium either to enhance future surrender values or to sustain the present level of life cover for a longer period. The Complainants did not avail of this option.

The Complainants ought therefore have been familiar with the issues involved and ought to have been aware from these earlier reviews that some action was likely to be necessary in the future to sustain the life cover into the future. Some of the Annual Statements that issued after the Policy Review in 2012 should also have clearly alerted the Complainants of the fact that the premium they were paying were not enough to cover the cost of the life cover and other benefits. For example in the 2015 Annual Statement, the cost of benefits was stated to be €1,142.29 and the premium being paid was a lesser sum of €1,053.16.

The Annual Statements from 2015 also clearly set out that:

> *"The value of your policy, if any, will be used, in addition to your premium payments, to fund the cost of providing the protection benefits over time".*

The Provider accepts that the Complainants asked during the complaint process for some additional time to make up their minds in relation to the 2017 review options and that the complaint response letter issued by the Provider did not make reference to that request at the time.

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I accept that it was unreasonable of the Provider not to note this request at the time and not to have offered the additional time in the circumstances of the review communication arriving over the Christmas period. That said, I accept that the Provider's goodwill gesture of €500 is a reasonable payment for this lapse in its customer service. While the Complainants have rejected the €500 goodwill gesture, the Provider has advised that this offer remains open for the Complainants' acceptance.

I also note that the Provider has advised that it can arrange for an Insurance and Investment Manager to meet with the Complainants to discuss more suitable cover should they wish to do so. It is a matter for the Complainants to decide if they wish to avail of these offers.

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

11 November 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.