An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0470
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Mis-selling Dissatisfaction with customer service Failure to provide correct information
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint is brought by the Personal Representatives of the estate of a deceased customer of the Provider (the **Policyholder**) regarding two life plans held by the Policyholder. The Personal Representatives are the Policyholder's daughter (the **First Personal Representative**) and the Policyholder's widower (the **Second Personal Representative**).

The Complainants' Case

The First Personal Representative says that when she was reviewing the Policyholder's policy after the Policyholder's death in **2019**, she discovered that the policy had been mis-sold by the Provider's agent. The First Personal Representative says that the Provider's agent failed to inform the Policyholder of all the options available and stated that if the Policyholder wanted to take a Guaranteed Whole of Life Policy, the Policyholder would have to take it at the present time in **October 2018** and that in order to avail of this product, the Policyholder was required to surrender her old policy and take out a new policy.

The First Personal Representative explains that she made a formal complaint to the Provider and quoted what the Provider's agent had told the Policyholder and First Personal Representative during a meeting on **20 December 2018**. The First Personal Representative advises that the Provider did not uphold the complaint.

In the Final Response letter dated **8 November 2019**, the First Personal Representative says that Provider claimed that its agent:

- explained that the older plan was flexible and could be reduced along with the new Guaranteed Whole of Life Cover being set up providing life cover for €30,000.

- stated that in the meeting with the Policyholder, First Personal Representative and First Personal Representative's husband that the parties reviewed the policies and wanted to continue to the Guaranteed Whole of Life Cover due to cost factors.

The First Personal Representative advises that she has an audio recording of this meeting which disproves what the Provider's agent says took place. On **12 November 2019**, the First Personal Representative says she informed the Provider's Complaints Department of this recording and that she had to wait until **29 November 2019** to hear from the Provider as to whether it would accept a copy of the recording, which it agreed to.

On **17 December 2019**, the First Personal Representative says she received an email from the Provider acknowledging receipt of the recording and that its Complainant Management Team and Legal Department would listen to the recording. The First Personal Representative says she telephoned the Provider on **13 January 2020** for an update and was informed that the recording was sitting with the Legal Department but as far as the Provider was concerned, the case was closed and the Provider was standing by its Final Response letter. The First Personal Representative refers to telephone conversations with the Provider on **20**, **27** and **28 January 2020** and says the Provider was unable to give her an update on matters or provide a timeframe for resolution.

The First Personal Representative submits that she has been more than reasonable with the Provider considering she informed it of the recording on **12 November 2019** and that as of **30 January 2020**, the Provider has not changed its findings.

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In a further submission dated **16 October 2020**, the First Personal Representative states that:

> *"I feel my mother was mis-sold the Guaranteed Whole of Life Policy because* [the Adviser] *did not explain that there were 5 options available to her, the fifth being the option to combine a Guaranteed Whole of Life Policy with her current policy. He clearly states on the audio recording that there were 4 options.*
>
> *He also states that in order to take out the Guaranteed Whole of Life Policy, she must surrender her old policy and take out a new policy. …"*

In resolution of this complaint, the First Personal Representative states:

> *"My late mother wanted the cover of €94,440 which she initially signed up for during our initial meeting with* [the Provider's agent] *in October '18.*
>
> *She could have gotten this by combining 2 policies, instead she was mis-sold a policy for €30,000. I am looking for the difference."*

The Provider's Case

The Provider explains that the Policyholder's next scheduled review in respect of her original plan was due in **2018**. The plan was last reviewed in **2013** and in line with the plan terms and conditions the next plan review was due five years later. Having conducted this review, the Provider says it identified that the plan payment in conjunction with the value that was on the plan at that time was not enough to maintain cover until the next plan review in **2023**. As such, a change needed to be made.

The Provider says it offered the Policyholder a number of options in its correspondence of **5 September 2018** which allowed the Policyholder to maintain the existing reviewable plan in addition to providing a new option which allowed the Policyholder to transfer up to €30,000 from the existing plan to a new plan (without the need for any underwriting) which was not subject to future review. As the new plan (Guaranteed Whole of Life plan) was not subject to future review its payment was fixed. Coincidentally, the Provider says an Annual Benefit Statement issued to the Policyholder in **September 2018** and this also confirmed that the plan was due for its next review at this time.

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In the absence of an option being selected by the Policyholder in response to the letter of **5 September 2018**, the Provider says it sent a remined letter on **1 October 2018**. On **16 October 2018**, the Provider says it received a telephone call from the First Personal Representative. During this call, the Provider says its representative explained the difference between the Policyholder's review correspondence and Annual Benefit Statement (which also contained an annual indexation notice). In addition, the workings of the plan were explained. The Provider says the First Personal Representative focused on both Option B (leave the payment as is and reduce the level of cover on the plan) in addition to the new Guaranteed Whole of Life option. The Provider says it was agreed that the First Personal Representative would contact the Provider's Adviser to discuss.

On **26 October 2018**, the Provider says its Adviser met with the Policyholder and the First Personal Representative to go through the options available and the First Personal Representative's husband was also present. The Provider says its Adviser stated during this meeting that he discussed all options including the option to combine cover on the plan in addition to transferring a portion to the new Guaranteed Whole of Life plan. The Provider says that during the meeting, the Adviser also contacted its Customer Services Team by phone and obtained a number of additional options (to the ones already provided in the letter of **5 September 2018**) for the Policyholder to consider with the First Personal Representative, namely, what cover the Policyholder could get under the plan for €225, €250 and €275 per month.

In the absence of an actual option being chosen and in order to prevent the Policyholder's plan from terminating (as her payment was insufficient to pay for the level of cover on the plan), the Provider says that on **1 November 2018** the plan defaulted in line with Option B (keep the payment unchanged and reduce cover). This happened in line with the plan terms and conditions and the Provider says it wrote to the Policyholder to explain this.

On **5 November 2018**, the Provider says it received a phone call from its Adviser where he enquired if the Policyholder had returned her chosen option yet and it was confirmed to the Adviser that she had not. On **6 November 2018**, the Provider says it received a phone call from the First Personal Representative in which she enquired if the payment of €304.65 as set out under Option A was guaranteed to maintain the cover on the plan (€94,440) until its next review in **2023**. The Provider says it was confirmed that it estimated it would.

The Provider says the Policyholder in conjunction with the First Personal Representative elected to proceed with Option A (increase payment to €304.65 and maintain existing cover of €94,440 until the next review in **2023**) and the chosen option was retuned through the Adviser on **7 November 2018**.

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The Provider says the Policyholder made this decision in conjunction with the First Personal Representative with the Adviser receiving a phone call to inform him of their decision. It was following this call, the Provider says, that the Adviser called to the Policyholder to collect and return the chosen option. The Provider says the Policyholder's instruction to increase payment to €304.65 and maintain cover of €94,440 until her next review in **2023** was applied and the Provider wrote to the Policyholder on **7 November 2018** to confirm this.

On **12 November 2018**, the Provider says it received a phone call from the Policyholder to say that she had made a mistake with her chosen option and that she should not have selected Option A. The First Personal Representative then came on the phone and confirmed that the Policyholder (instead of Option A) now wished to take up Option C (new application for Guaranteed Whole of Life cover). As an option was already chosen, the Provider says it advised that it would need written confirmation from the Policyholder that she wished now to apply for a Guaranteed Whole of Life plan instead of maintaining her cover under Option A on her existing plan. The Provider advised that its Customer Service Representative at this time should have referred the First Personal Representative to the Adviser to arrange the new Guaranteed Whole of Life application instead of asking her to confirm it in writing.

On the same day, the Provider says it received an email from the First Personal Representative confirming that the Policyholder wished to change her existing reviewable cover to the new Guaranteed Whole of Life plan which was non-reviewable and an attached letter from the Policyholder confirmed this.

As it was the Policyholder's intention to replace her existing reviewable plan with a non-reviewable plan, the Provider says it emailed its Adviser on **13 November 2018**. The Provider advises that there were delays with the Adviser getting back to the Policyholder as a result of other work commitments and annual leave so that he could arrange the new Whole of Life application and subsequent cancellation of the existing plan.

The Provider says the First Personal Representative contacted it for an update on the progress of these matters on **29 November 2018**. The Provider says the First Personal Representative contacted it a second time on **29 November 2018** in addition to calls on **30 November 2018** and **3 December 2018**. The Provider says it was during a second call on **3 December 2018** that the First Personal Representative requested for the direct debit on the plan to be suspended allowing for the plan costs to be met from the plan fund until the Whole of Life application had been in place and existing plan would then be cancelled.

The Provider submits it is very clear from the phone conversation that the First Personal Representative had fully reviewed all options presented to the Policyholder and at no point was it said that the Policyholder wanted to maintain a combination of cover through the existing plan and a new Whole of Life product.

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The Provider says a formal complaint was set up at this time as the First Personal Representative was unhappy with the delay in arranging the new application. The Provider says it acknowledged the complaint in writing on **4 December 2018** and an update was issued on **19 December 2018** and **10 January 2019**.

On **20 December 2018**, the Provider says its Adviser met with the Policyholder, the First Personal Representative and her husband in order to arrange the application of the new Whole of Life plan. The Provider states that the Policyholder's request was clear, she wanted her cover going forward to be provided on a non-reviewable basis. This option was not available within the existing plan and in order for the Policyholder's requested need to be met, a new application was required so that the non-reviewable cover could be provided for through a Whole of Life product. It was on this basis, the Provider says, that its Adviser correctly informed the Policyholder, the First Personal Representative and her husband that the existing plan had to be cancelled (as the preferred route of obtaining non-reviewable cover could not be achieved through the existing reviewable plan).

The Provider says there may have been some confusion at this meeting and the Provider says, for any confusion caused, it would like to offer a €1,000 Customer Service Award.

On the basis of the information available to it, the Provider says it does not believe that it was the Policyholder's intention to keep €64,440 on her existing plan which would be subject to review again in **2023** and annual review going forward in addition to transferring €30,000 to a new non-reviewable Whole of Life plan. The Provider has set out the following illustration setting out the costs of going down this route:

Plan Number	Plan Type	Cover	Cost
[Existing plan]	…	€64,440	€166.16*
[Whole of Life plan]	…	€30,000	€197.96**
Total cost per month			**€364.12**

* Subject to review in 2023 and annual review going forward
** Fixed for life

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The Provider refers to the Plan Review Fact Find completed by its Adviser during the meeting on **20 December 2018**. In this document, the Provider says its Adviser recorded the Policyholder's annual income of €12,636 and that she had €94,440 life cover on her existing plan for a monthly payment of €304.65 until its next review on **1 November 2023**. In section 4(d), the Provider says the Adviser did a comparison of the Policyholder's current level of cover versus the maximum €30,000 that she could and wanted to obtain under the non-reviewable Whole of Life option. In the Adviser's freehand notes, the Provider says it is recorded that *"*[The Policyholder] *you have opted for whole of life cover for €30,000. You are aware that this is a lot less than your existing cover of €94,440 …."*

The Provider says the Policyholder subsequently completed the paperwork to transfer €30,000 of her reviewable cover provided under the existing plan to the new non-reviewable Whole of Life plan. The Provider says a copy of the Fact Find was posted to the Policyholder the following day on **21 December 2018**.

On **19 January 2019**, the Provider says it issued a Final Response letter to the First Personal Representative. In this letter, the Provider says:

- It gave a full and detailed explanation of all events surrounding the delay in arranging the Whole of Life application.

- Apologised for the delays experienced and offered a €500 Customer Service Award.

- Provided a savings withdrawal form so that the reviewable plan could be cancelled and its value paid.

On **16 January 2019**, the Provider says it received the Policyholder's written signed acceptance of the Customer Service Award in full and final settlement of the complaint. The Policyholder also provided a cancellation instruction in respect of the original plan.

The Provider says the new Whole of Life plan issued on **17 January 2019** and the value attaching to the original plan at **16 January 2019** was paid and this plan was cancelled in line with the Policyholder's instructions.

The Provider advises that the Policyholder passed away later in **2019** and it paid €30,000 death benefit following receipt of all claim requirements.

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In respect of the meeting which took place on **26 October 2018**, the Provider says its Adviser took the Policyholder, the First Personal Representative and her husband through the options contained in the letter of **5 September 2018**, the option of transferring €30,000 cover from the existing reviewable plan and a new non-reviewable plan, and the option to maintain a combination of the existing plan and a new non-reviewable plan. The Provider says it was agreed at the end of this meeting that the Policyholder and the First Personal Representative would discuss their options and contact the Adviser when they had decided.

The Provider says the Adviser subsequently received a call from the First Personal Representative to confirm that they wanted to proceed with Option A and the Adviser called to the Policyholder to collect this decision from her.

The Provider advises that the Policyholder was in her late sixties when her scheduled plan review was conducted in **2018** and because of her age she was classified as vulnerable. The Provider says the Policyholder made all decisions in respect of her 2018 review in conjunction with her family members namely her daughter (the First Personal Representative) and her daughter's husband. The Provider says that at the meeting on **26 October 2018**, its Adviser went through all options and no decisions were made on this day.

The Provider submits that it is very clear that the First Personal Representative had fully reviewed all communications issued to the Policyholder on the options that were available to the Policyholder and that she was fully *au fait* with these options.

The Complaints for Adjudication

The complaints are that the Provider:

Provided incorrect or inadequate advice regarding of the Policyholder's options;

Mis-sold the Whole of Life plan; and

Provided poor communication and customer service.

Decision

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

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The Personal Representatives were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision, I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 17 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.

Following the issue of my Preliminary Decision, the First Personal Representative made a submission under cover of her e-mail and attachment to this Office dated 29 June 2021, a copy of which was transmitted to the Provider for its consideration.

The Provider advised this Office under cover of its e-mail dated 2 July 2021 that it had no further submission to make.

Having considered the First Personal Representative's additional submission and all submissions and evidence furnished to this Office by both parties, I set out below my final determination.

The Policyholder incepted a reviewable life plan with the Provider around **September 1993**. By letter dated **5 September 2018**, the Provider wrote to the Policyholder advising her that the current premium payments and fund value were no longer enough to sustain the current level of cover under the plan. The letter outlined two options: continue with the existing plan or change to a Guaranteed Whole of Life plan.

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The letter then outlined three further options in respect of continuing with the plan: Option A – Keep the same level of cover (including indexation) and increase payments until **1 November 2023**; Option B – Reduce the level of cover, cancel indexation and keep payments the same until **1 November 2023**; and Option C – Aim to keep the same level of cover for the rest of the Policyholder's life or until the date the benefit ends. In respect of the Guaranteed Whole of Life plan, the letter stated that the Policyholder would need to contact the Adviser or the Provider to change to this new plan and that an application for this plan would have to be made by **1 November 2018**. This letter also contained the contact details for the Adviser to discuss the Policyholder's options and requested that the Policyholder complete and return the enclosed options form.

In terms of selecting the preferred option, the letter advised at the 'Your Options' section, as follows:

> *For each option, we've shown you how the changes will affect your level of cover and monthly payments. Options A and C include your annual indexation increase which protects your benefits from inflation. You may be able to combine some of these options so it is important that you talk to your financial adviser* [the Adviser] *or call us on* [phone number] *to help you choose the type and level of cover that will best suit your needs."*

The Provider also sent the Policyholder an Annual Benefit Statement dated **September 2018**. It appears that the Policyholder did not choose any of the above options and the Provider wrote to her again on **1 October 2018** outlining the various options and requested that she select her preferred option.

The First Personal Representative spoke with one of the Provider's agents (with the consent of the Policyholder) on **16 October 2018** regarding correspondence received from the Provider in **September 2018**. The First Personal Representative noted in respect of Option A that the proposed increase in premium payments was a *massive increase* and queried why this was the case. The Provider's agent proceeded to respond to this query and advised that the Policyholder might wish to consider a different type of cover or move to the Guaranteed Whole of Life plan. The parties then discussed Option B and the Whole of Life plan. The Provider's agent also suggested that the First Personal Representative/the Policyholder speak with the Adviser.

The Provider's agent gave the First Personal Representative the Adviser's contact details. Following this, the First Personal Representative asked if there was anything *in between* the options set out in the Provider's correspondence. The Provider's agent advised that the Adviser *could run a few quotes* for the Policyholder.

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The Adviser met with the Policyholder on **26 October 2018**. It appears that the First Personal Representative and her husband were also present at this meeting. During this meeting, the Adviser telephoned the Provider in the presence of the parties and requested quotes for cover based on proposed monthly payments of €225, €250 and €275 for 5 years. The Provider's agent calculated the relevant life cover quotes at €71,437, €78,087 and €84,448 respectively. The Adviser also requested that it be noted on the file that the Policyholder would be advising the Provider of her preferred option the following week.

The Adviser telephoned the Provider on **5 November 2018** to query whether the Policyholder had forwarded the completed options form. The Provider's agent advised that nothing had been received from the Policyholder in this regard. On **6 November 2018**, the First Personal Representative spoke with one of the Provider's agents querying whether there would be any reviews of the plan before **November 2023** if Option A was chosen. The Provider's agent advised that the plan would not be reviewed for 5 years. The Adviser emailed the Provider on **7 November 2018** advising that the Policyholder wished to choose Option A. It appears that it was around this point that the Adviser furnished the Provider with a copy of an options form signed by the Policyholder dated **25 October 2018**, selecting Option A. The Provider wrote to the Policyholder the same day acknowledging receipt of the selected option.

On **12 November 2018**, the Policyholder telephoned the Provider advising that she wished to make a change to her plan as she made a mistake when she was filling in the options form and wished to change to Option B. The Provider's agent then spoke with the First Personal Representative who stated that she understood there to be two options under Option C, one of which being Guaranteed Whole of Life cover. The Provider's agent advised her of what was required to change options. The First Personal Representative then indicated that the Policyholder wished to choose Option C – Guaranteed Whole of Life cover.

Following this call, the First Personal Representative emailed the Provider attaching written confirmation that the Policyholder wished to change to a Guaranteed Whole of Life plan with no reviews.

The Provider emailed the Adviser on **13 November 2018** requesting that he contact the Policyholder to arrange for the relevant application form to be completed.

On **29 November 2018**, the First Personal Representative spoke with one of the Provider's agents and requested details of the Policyholder's current plan. In response to this, the Provider's agents advised that the Policyholder was on the original reviewable plan and outlined the cover provided by the plan.

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The First Personal Representative advised the Provider's agent that a policy change had been requested earlier in the month. The Provider's agent acknowledged this and advised that it could take some time to go through. The Provider's agent told the First Personal Representative that the policy Adviser was required to be contacted as a new plan was being put in place. The Provider's agent explained that it had asked the Adviser to contact the Policyholder to arrange for the application to be completed. The Provider's agent also explained that even if the application had been received on time, it would not have been received in time to change the direct debit payment due in December from the original plan payment to the new plan payment amount.

The Provider's agent also advised that the new plan would not automatically cancel the original plan because there was an encashment value and proceeded to outline what was required to encash the original plan. The First Personal Representative then stated that none of this was explained by the Adviser.

During a second call on **29 November 2018**, the First Personal Representative had a query regarding the upcoming direct debit payment and also advised that she had spoken to the Adviser who told her that he was busy and from the coming Tuesday would be on annual leave for 10 days and that he did not pick up on the Provider's earlier email. The First Personal Representative explained that the Adviser was going to contact her the next day. In response to a query from the First Personal Representative, the Provider's agent briefly explained how plan payments were treated in terms of being invested in the fund underlying the plan.

The First Personal Representative spoke with the Provider again on **30 November 2018** regarding the request to change to a Whole of Life plan. The First Personal Representative stated that she was not made aware that changing to a Whole of Life plan required the original plan to be cancelled. The First Personal Representative expressed her dissatisfaction with the delays on the part of the Adviser and that this had cost the Policyholder money as she was being billed in respect of the original plan and not the lower amount of the Whole of Life plan. The First Personal Representative also referred to her conversation the previous day with the Provider. The First Personal Representative advised that the Adviser was to contact her that day, but she had not heard from him.

The Provider's agent suggested the possibility of another adviser meeting with the Policyholder but the First Personal Representative did not indicate her agreement to this option and the conversation moved on. The Provider's agent advised that she would get the Adviser's manager or someone from the Adviser's team to contact the Policyholder.

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On **3 December 2018**, the First Personal Representative telephoned the Provider to express her dissatisfaction in respect of the Provider's conduct, the Adviser's conduct and the direct debit that was pending on the Policyholder's bank account. The Provider's agent advised that the direct debit could be suspended but payment would be deducted from the plan value. During the call, the Provider's agent advised that an email was received from the Adviser the previous day where he advised that he would not be in a position to call to the Policyholder for at least two weeks as he was away on leave, that he requested that the premium payments be adjusted to the Whole of Life amount and he would be in contact with the Policyholder on his return. Towards the end of this call, the First Personal Representative stated that it was unfortunate that the Policyholder needed to go through the Adviser to get the change to the Whole of Life plan completed. The Provider's agent said she would check to see if another adviser would be in a position to speak with the parties regarding the plan change. The First Personal Representative explained that she had to leave the call to attend to another matter and that she would call back to give the agent the opportunity check if it was possible for anther adviser to contact the Policyholder.

The First Personal Representative telephoned the Provider again on **3 December 2018** and was advised that an email was sent to the Adviser's Area Manager explaining that the Policyholder was looking for an adviser to deal with the plan change before the Adviser returned from his leave as Policyholder was not prepared to wait until his return. The Provider's agent placed the First Personal Representative on hold and spoke with the Area Manager. Following this, the First Personal Representative was advised that the Area Manager could not get anyone other than the Adviser to call to the Policyholder at that moment in time.

A meeting took place between the Adviser, Policyholder, First Personal Representative and her husband on **20 December 2018**. At this meeting, the Policyholder completed and signed a 'Policy Review Fact find' dated **20 December 2018**. Section 3 of the Fact Find outlined four options to be examined as part of this review, as follows:

> *"**The following are the options to be examined in this review of your current benefits***
>
> - *Keep the same level of cover (including indexation) until the next review date and increase your payment*
>   *€94,440 for €304.65 p/m*
>
> - *Reduce your level of cover and keep the current payment until 01/11/2023 and cancel your indexation increases*
>   *€61,665 for €173.28 p/m*

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- *Aim to keep the same level of cover (including indexation) for the rest of your (life/lives) or until the date the benefit ceases. You plan will continue to be reviewed.*
  €94,440 for €713.47 p/m

- *Change to Guaranteed Whole of Life cover plan with no reviews*
  €30,000 for €189.47 p/m"

At section 4 of the Fact Find, Option D was circled:

*"**D.** Guaranteed Whole of Life cover plan with no reviews*

The proposal is to take out a new guaranteed whole of life plan with the following benefits

	Current Benefit	*Proposed New Benefits*
Life Cover	*€94,440*	*€30,000*
Specified Illness	*€0*	*N/A 0*
Other benefits	*€0*	*N/A 0*
For payment of	*€304.64 per month*	*€189.47 per month*

…"

Beneath this was a text box which appears to have been completed by the Adviser, as follows:

"[Policyholder] *you have opted for Whole of Life cover for €30,000 you are aware that this is a lot less than you existing cover of €94,440. You want your cover to start from 1st Nov 2018 and you also want any premiums over paid since that date refunded. You would also like the value on that date 1st Nov 2018 as an encashment on your policy. We have meet on a number times* (sic) *since Nov 2018."*

At section 6, the following disadvantages of cancelling the existing plan were listed:

"High life cover
Flexible life cover and
Premium"

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The following advantages of the new plan were also listed:

> *"Fixed premium for whole of life*
> *€30,000 life cover"*

In the Provider's Complaint Response, it states that a copy of Fact Find was sent to the Policyholder on **21 December 2018**.

The Policyholder also signed a 'Transfer to Guaranteed Whole of Life Cover Plan' dated **20 December 2018**. Two options were listed on this form. Option 1:

> *"**Replace** you existing plan with the new Guaranteed Whole of Life Cover plan*
>
> *You wish to take out a new Guaranteed Whole of Life Cover plan and fully cancel your existing plan"*

Options 2:

> *"**Set up the new Guaranteed Whole of Life Cover plan* and alter the benefits on your existing plan***
>
> *You wish to take out a new Guaranteed Whole of Life Cover plan and alter the benefits on your existing plan"*

Option 1 was the option that was selected.

The First Personal Representative has provided a recording of the meeting with took place on **20 December 2018**. I have considered the content of this recording. It is not clear at what point in the meeting the recording began.

This is because the recording appears to begin when the First Personal Representative is mid-sentence and taking issue with the Adviser for not reverting to her after **12 November 2018**.

In this recording, the First Personal Representative said that the Adviser did not explain on the last occasion the parties met that in order to take out the Guaranteed Whole of Life plan, the Policyholder was required to surrender the original policy or that the Policyholder could have surrendered the original policy. Later in the conversation, the Adviser explained that in order to take out a new policy, the Policyholder was required to surrender her old policy.

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The First Personal Representative responded by saying that this was not explained by the Adviser previously, to which the Adviser replied that he believed he went through all of the options. The Adviser also made the point that the First Personal Representative would have read the relevant documents which stated that the original policy must be surrendered in order to take out a new policy. Responding to a question from the First Personal Representative, the Adviser explained that if the fund value was depleted that life cover would stay in place and that payments would not change until the next policy review date. The Adviser also explained that a unit linked fund would always be reviewed every year, no matter the value of the fund.

It is also clear from the recording that the Adviser completed the Fact Find and transfer form in the presence of the parties. In terms of the Fact Find, the Adviser recited to the parties, the information he would insert, it appears, at sections 4 and 6, stating *"just so you know what I'm puttin into them when I ask you to sign stuff"*. While the Adviser was doing this, he also remarked that the parties had gone through the different options. I note that the recording furnished by the First Personal Representative does not contain an explanation of the options available to the Policyholder.

Due to the fact that it is unclear whether this recording is a complete recording of the meeting, it may have been the case that options were discussed. However, when the forms were completed, I note that the Adviser gave them to Policyholder to sign but it does not appear that the Policyholder or the First Personal Representative read these forms.

By email dated **16 January 2019**, the First Personal Representative forwarded, amongst other documents, a 'Withdrawal Form' in respect of the Policyholder's reviewable plan which was signed by the Policyholder and dated **16 January 2019**.

Analysis

In the Provider's letter of **5 September 2018**, the Policyholder was advised that her premium payments were no longer sufficient to sustain her chosen level of cover under her current plan.

This letter outlined three options in respect of continuing cover under the current plan and also contained an option to take out a new Whole of Life plan. This letter also contained a statement that a combination of these options could be chosen. This information was repeated in the letter of **1 October 2018**.

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Having considered the evidence, I am satisfied that the Policyholder and the First Personal Representative were aware, or ought to have been aware, of the contents of this letter. Therefore, I am satisfied that if they had read or reviewed these letters, they should, or ought reasonably to have been aware that a combination of the stated options was available to the Policyholder and if the Policyholder wanted a combination of these options, it was open to her or the First Personal Representative to query with the Provider or the Adviser the possible combinations available.

In terms of the surrender of the original plan, it is my view that, reasonably understood, the September and October letters gave the Policyholder the discretion to choose any single option or a combination of options. Accordingly, if the Policyholder wanted only the Whole of Life plan then this would mean that the original plan would have to be cancelled or surrendered – unless the Policyholder wanted to also continue with the original plan.

The letters further explained that if the Policyholder wanted a Whole of Life plan, to contact either the Provider or the Adviser. If the Policyholder or anyone acting on behalf contacted either the Provider or the Adviser regarding a Whole of Life plan, I am satisfied it is at this point that it was reasonable to expect the Provider or the Adviser to explain the surrender process.

The First Personal Representative spoke to one of the Provider's agents on **16 October 2018** regarding the options contained in the September letter. During this conversation, I note that the Provider's agent mentioned that the Policyholder could move to a Whole of Life option. I also note that the First Personal Representative queried whether there was anything available to the Policyholder in between the stated options.

While this may have been an opportunity for the Provider's agent to refer the First Personal Representative to be possibility of combining the options outlined in the September letter and also advise that if a Whole of Life option was chosen that the original policy would have to be surrendered, I do not consider, in the context of this conversation, that the agent's conduct in not explaining these matters was unreasonable.

A meeting took place on **26 October 2018**. In the statement prepared by the Adviser in respect of this meeting, he states that the letter of **1 October 2018** was discussed in full and that *"all options were discussed, including a combination of Whole of Life Cover and reducing the existing Life Cover."* It is the First Personal Representative's position that a combination of options or policy surrender was not discussed.

There does not appear to be any notes or documentation recording what was discussed at this meeting and the Policyholder does not appear to have signed anything at this meeting.

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However, in light of the options contained in the Provider's correspondence and the additional quotations requested by the Adviser, I am satisfied that the options outlined in the October letter were likely to have been discussed at this meeting. Further to this, as the October letter (like the September letter) advised as to the option of selecting a combination of the stated options, it is likely that the possibility of choosing a combination of options may also have been discussed, to some degree.

In his statement, the Adviser has not addressed whether the Policyholder was advised that if a Whole of Life plan was chosen as a standalone option, that the original plan was required to be surrendered. When discussing such an option, I consider it reasonable to expect that such a discussion would include advising a customer that their current plan would not automatically cease and that it was required to be surrendered.

The First Personal Representative has detailed in a post Preliminary Decision submission that:

"*Both letters dated 5th September 2018 and 1st October 2018 outlined options to*

Continue with your existing Lifesaver Account This means you will have to change your payments or level of cover on your plan. Your plan will be reviewed again in 2023 and the cost of your cover may increase again.	**Change to a Guaranteed Whole of Life cover plan with no reviews** This means you can get up to €30,000 life cover (or your current life cover amount if it's less than €30,000) and your payment is guaranteed not to increase for the rest of your life.

Page 2 of the letter states:

"*You **may** be able to combine some of these options so it is important that you talk to your financial advisor,* [redacted] or call us on [redacted] *to help you choose the type and level of cover to best suit your needs." [Could attention please be drawn to the word "may]"*

I followed the instruction of these letters and was provided with the advisor's contact details to arrange a call to my home to discuss ALL options available to us"

[First Personal Representative's emphasis]

/Cont'd…

The First Personal Representative further detailed that:

> ***"At no point did the Adviser tell us there was an option to combine policies – By his own admission, on the recording, in reference to the meeting of the 26th October, at 2mins 03seconds he clearly and distinctly states that he told us there were 4 options.***
>
> ***There were five options, the fifth being the option to combine the guaranteed whole of life policy with her current policy at its current or reduced value.***
>
> ***This is a clear omission of all the facts and options available to us as the consumer and a clear disregard of provision 4.1 of the Consumer Protection Code 2012"***

As detailed previously I have considered the content of this recording. However, I would reiterate that it is not clear at what point in the meeting the recording began.

The recording appears to begin when the First Personal Representative is mid-sentence and taking issue with the Adviser for not reverting to her after **12 November 2018**. The conversation which occurred in the early parts of the recording is adversarial in nature and it is at this point that the Advisor states he "*went through each option*". The First Personal Representative challenged this assertion and states "*No your help desk agent did*", following a short exchange the advisor then states "*there was 4 options* [name redacted]" to which the First Personal Representative responded with "*I know do you know how long I have been on the phone to [Provider] about this*" and proceeded to express her belief that the agent "*didn't do* [his] *job*" and outlined where the parties felt let down by the agent.

I must again state that it is unclear whether this recording is a complete recording of the meeting which occurred, it may have been the case that options were discussed. It does not provide details of what "*4 options*" are or if previous comments were made on this point.

On **12 November 2018**, the First Personal Representative informed one of the Provider's agents that the Policyholder wished to amend her previous option selection from Option A to a Whole of Life plan. It was clear from this conversation that the Policyholder was switching to a Whole of Life plan on a standalone basis and was not doing so in combination with any other options. The Provider's agent advised the First Personal Representative that all that was required was written confirmation from the Policyholder confirming the change. However, as can be seen, this was not the case. The evidence shows that a transfer form was required which was to be completed in conjunction with the Adviser.

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In these circumstances, I believe that the Provider's agent should have advised the First Personal Representative that if the Policyholder was changing to a Whole of Life plan as a replacement for the existing plan then she would need to contact the Adviser, complete the necessary form and decide whether she wished to surrender the existing policy. None of this information seems to have been imparted during this call. Therefore, I am satisfied that the First Personal Representative was not properly advised in respect of changing to a Whole of Life plan during this call. In line with the advice imparted during this call, the First Personal Representative sent confirmation to the Provider that the Policyholder wished to change to a Whole of Life plan under the impression that this was sufficient to effect the change.

While the Provider emailed the Adviser the following day requesting that he arrange for the relevant form to be completed, the First Personal Representative should have been better informed during her call with the Provider. However, this was not the case and it was not until **29 November 2018** that the First Personal Representative was aware of the process required to change to a Whole of Life plan and that the original plan did not automatically cancel when a Whole of Life plan was taken out.

As previously noted, an email was sent to the Adviser on **13 November 2018** requesting that he arrange for the relevant form to be completed for the Whole of Life plan. From the evidence furnished by the Provider, this email does not appear to have been acknowledged or responded to by the Adviser. Although, the First Personal Representative was advised during a telephone conversation on **3 December 2018** that the Adviser had emailed the Provider the previous day to advise that he would not be in a position to meet with the Policyholder for at least two weeks. A copy of this email does not appear to have been furnished by the Provider.

The evidence shows that it was not until **20 December 2018** that the Adviser met with the Policyholder to complete the transfer form. This delay appears to have arisen from two periods of annual leave taken by the Adviser. In the Provider's Final Response letter dated **14 January 2019**, this leave is stated to have been between **13** and **29 November 2018** and *early December 2018*.

It appears that the Adviser may have advised the First Personal Representative that he would call her around **30 November 2018**. However, this call does not appear to have taken place. This was brought to the attention of one of the Provider's agents on **30 November 2018** where the First Personal Representative was advised that either the Adviser's manager or someone on the Adviser's team would contact her. This does not appear to have happened either.

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During the call on **30 November 2018**, the Provider's agent also suggested the possibility of another adviser meeting with the Policyholder but this does not appear to have been accepted, for whatever reason, by the First Personal Representative. However, in conversations which took place on **3 December 2018**, the First Personal Representative was agreeable to another adviser meeting with the Policyholder. As can be seen, the relevant Area Manager was unable to facilitate this, for reasons which are unclear. In the circumstances, as the Provider is likely to have been aware of the Adviser's leave, it is disappointing that it was unable to accommodate the Policyholder by arranging for another adviser to meet with her. This is particularly disappointing given the very clear dissatisfaction expressed by the First Personal Representative at the level of service received from the Adviser.

In respect of the meeting that took place on **20 December 2018**, the Adviser states in his statement that a combination of options were discussed. As noted above, the recording of this meeting may not have captured the whole of the meeting. While I am conscious of this, it is clear from the portion of the meeting captured by the recording that a combination of options was not discussed during that portion of the meeting.

The Adviser does not identify the point in the meeting when a combination of options was discussed. Further to this, the Adviser advised the Policyholder that in order to take out a Whole of Life plan, the original policy had to be surrendered. This is not necessarily consistent with a combination of options being discussed at an earlier point in any unrecorded part of the meeting. There is also no evidence of a combination of options being discussed based on the options recorded on the Fact Find. This would tend to suggest that a combination of options may not have been discussed at the October meeting either.

In my Preliminary Opinion I had detailed that notwithstanding the above, Option 2 of the transfer form clearly states that one of the options open to the Policyholder was to set up a Whole of Life Plan and alter the benefits under the existing plan. While the recording suggests that the Policyholder or the First Personal Representative may not have read this form in any great detail when she was signing it, I am satisfied that information regarding a combination of options was available to the Policyholder. I am also of the view that it is reasonable to expect the Policyholder or the First Personal Representative to have read the documents that were being signed before allowing the Adviser to leave with them.

The First Personal Representative has, in a post Preliminary Decision submission, stated that ***"the adviser did not show the Policyholder or the First Personal Representative page one of the transfer form"*** [Representative's emphasis]. The First Personal Representative further detailed that "*The Adviser, at NO point, showed anybody at the meeting page one of this form, which listed option 2 of setting up New Guaranteed Whole of Life cover and alter the benefits of your existing plan****".***

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The Representative submits that "*we in good faith believed that Provisions 4.1 of the Consumer Protection Code 2012 were being adhered to by the Adviser and that we had all Key Information available and accurate.*

The transfer form was filled in by the advisor and not presented to us. He went through the Policy Review Fact find as he completed it and once we gave him the bank details he proceeded to get 3 signatures in quick succession from the Policyholder who was seated as he was standing next to her showing her where to put the signature".

While I note the statements of the First Personal Representative, it remains my view that it is reasonable to expect the Policyholder or the First Personal Representative to have read the documents that were being signed before allowing the Adviser to leave with them.

Having considered all of the evidence and submissions, I am of the view that the Policyholder and the First Personal Representative were not properly advised regarding the need to cancel/surrender the original policy in the event that the Whole of Life plan was chosen as a standalone option.

Further to this, I am satisfied that a combination of options may not have been discussed at the October or December meetings and I believe such a discussion should have taken place. While there may have been shortcomings in the advice provided to the Policyholder and the First Personal Representative, the evidence suggests that the Policyholder wanted the Whole of Life plan and there is nothing to suggest that this plan was unsuitable for the Policyholder.

It is also reasonable to expect the Policyholder to have been aware of the possibility of choosing a combination of options from the Provider's September and October correspondence and the options contained on the transfer form signed by the Policyholder. Therefore, in the circumstances, I do not believe that the Whole of Life plan was mis-sold.

During the second telephone conversation which took place on **3 December 2018** a formal complaint was logged by the Provider's agent. The Provider wrote to the Policyholder **4 December 2018** acknowledging the complaint. A member of the Provider's Complaints Management Team telephoned the First Personal Representative on **10 December 2018**, to explain the Provider's complaints process and discuss the complaint. The Provider wrote to the Policyholder again on **19 December 2018** advising that it was still investigating the complaint. The First Personal Representative telephoned the Provider in response to this letter on **20 December 2018** to query why the resolution date was extended to **10 January 2019**.

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The Provider's agent explained that the Adviser was away for the first two weeks of December and due to the nature of the complaint, the Provider needed to contact the Adviser and his manager, and that a response was awaited from the Adviser. The Provider's agent also advised that she was waiting for certain details from the Actuarial Department. A further complaint update letter was sent to the Policyholder on **10 January 2019** and a Final Response letter issued on **14 January 2019**.

In respect of the time taken by the Provider to respond to this complaint, I note that section 10.9(d) of the ***Consumer Protection Code 2012*** (the **Code**), requires a regulated entity to attempt to investigate and resolve a complaint within 40 business days and section 10.9(e) requires a regulated entity to inform a customer of the outcome of an investigation within 5 working days of the completion of the investigation. As noted, a complaint was logged on **3 December 2018**. However, a Final Response letter issued in less than 40 business days from the date the complaint was made. Therefore, in light of the fact that the Provider was awaiting certain information from the Adviser and its Actuarial Department and the fact that it issued its Final Response letter within the time prescribed by the Code, I do not consider that the Provider unreasonably delayed in its investigation of and response to this complaint. I am also satisfied that the Provider kept the First Personal Representative updated regarding the complaint.

It appears that a further complaint was made around **1 October 2019**. This was acknowledged by the Provider on **2 October 2019**. A telephone conversation took place on **16 October 2019** where the First Personal Representative explained her complaint to the Provider's agent. This was followed by update letters on **22 October** and **6 November 2019** with a Final Response letter issuing on **8 November 2019**.

In light of the above-mentioned provisions of the Code and the time taken to issue a Final Response letter, I accept that the Provider responded to this complaint within a reasonable period of time and also updated the First Personal Representative regarding the complaint.

The First Personal Representative telephoned the Provider on **12 November 2019** to discuss the November Final Response letter and in the course of the conversation explained that she had a recording of the meeting which took place on **20 December 2018**. The Provider's agent advised that she would have to make enquiries as to whether the Provider could consider the recording and that she would revert to the First Personal Representative. The Provider's agent telephoned the First Personal Representative on **18 November 2019** to advise that a request was made to the Provider's Legal Department as to whether the Provider could consider the recording. This was followed by an email to a similar effect on **19 November 2019** with a further update on **26 November 2019**.

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The Provider wrote to the First Personal Representative on **29 November 2019** requesting that she provide a copy of the recording so that the Provider could listen to it. The Provider's agent telephoned the First Personal Representative on **11 December 2019** to explain that the recording could not be listened to in the format it was sent. The recording appears to have been sent to the Provider again around **17 December 2019**. The First Personal Representative was advised during a telephone conversation on **15 January 2020** that the recording was with the Provider's Legal Department. However, the Provider's position, in any event, was that the complaint was closed. On **11 February 2020**, the Provider wrote to the First Personal Representative to advise that it had listened to the recording but that its position in respect of the complaint remained unchanged.

The First Personal Representative has taken issue with the Provider's conduct in respect of the recording. However, having considered the evidence, I am satisfied that the Provider kept in contact with the First Personal Representative in respect of the recording and I do not accept there were any unreasonable delays on the part of the Provider in terms of deciding to listen to, or in listening to, the recording. Further to this, I accept that the Provider was not required to reopen the complaint or change its decision regarding the complaint in light of the recording.

Goodwill Gesture

In response to the complaint recorded on **3 December 2018**, in the Final Response letter dated **14 January 2019**, the Provider offered a Customer Service Award in the amount of €500 to the Policyholder in respect of the delays associated with arranging the completion of the Whole of Life transfer form. I note that this award was subsequently accepted by the Policyholder.

In its Complaint Response, the Provider states that there may have been some confusion during the meeting which took place on **20 December 2018**. In recognition of this, the Provider says it would like to offer a Customer Service Award in the amount of €1,000.

In light of the fact that an amount of €500 has previously been accepted in respect of certain aspects of the conduct forming part of this complaint, I consider the Customer Service Award of €1,000 offered by the Provider to be a reasonable sum of compensation for the customer service failings on the part of the Provider.

In these circumstances, on the basis that this offer remains available to the Personal Representatives, I do not uphold any aspect of this complaint.

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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

2 December 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.