Decision Ref:	2022-0139
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Mis-selling (insurance) Failure to explain/understand index linking
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants incepted a dual life whole of life insurance policy with the Provider on **1 January 1984**. The First Complainant is now age 83 and the Second Complainant, his wife, is now age 81.

The Complainants were advised on **28 May 2020** and again on **10 August 2020** that this Office could not examine any complaints they had in relation to the sale of the policy in **1983**, as the conduct giving rise to those complaints, falls outside the time limits set out in ***Section 51*** of the ***Financial Services and Pensions Ombudsman Act 2017***. The Complainants were also advised that this Office could not examine any complaints they had in relation to the premium rates that were applied to the policy, as this is at the commercial discretion of the Provider.

This complaint concerns the Provider's administration of the Complainants' whole of life insurance policy from **2002** through to **December 2019**, when the Complainants cancelled their policy.

The Complainants' Case

In **November 2019**, the Complainants' policy was providing life cover in the amount of **€44,403.00** for the First Complainant and **€36,140.00** for the Second Complainant, for a quarterly payment of **€693.32**.

Following a policy review, the Provider wrote to the Complainants on **4 November 2019** to advise that in order to maintain indexation, life cover in the amount of **€46,623.00 (forty-six thousand six hundred and twenty-three Euro)** for the First Complainant and **€37,947.00 (thirty-seven thousand nine hundred and forty-seven Euro)** for the Second Complainant until **1 January 2021**, the quarterly payment would need to increase to **€2,041.42 (two thousand and forty-one Euro and forty-two Cent)**.

The Complainants emailed the Provider on **26 November 2019**, as follows:

> *"… Under what circumstances would this €46,623 and €37,947 be paid out?*
>
> *In other words what is this cover for?*
>
> *Why is the cover amount different and equal for each of us?*
>
> *Why are the payments for this cover going up by 380% from €2.7k p/a to €10.5k p/a?"*

In that regard, the Complainants' Representative says that the Provider should have better informed the Complainants over the years, of the suitability of maintaining their whole of life insurance policy, having regard to the Complainants' specific needs and circumstances. In particular, the Representative says that once the First Complainant retired in **2000**, the policy was no longer appropriate for the Complainants and the Provider ought to have advised them of this.

The Complainants' Representative also questions the adequacy of the information that the Provider supplied to the Complainants on an annual basis, in that she says the annual statements merely stated the amount paid and the premium charged and failed to clearly state the purpose of the policy, the type of cover the policy provided or under what circumstances the policy benefit would be paid out.

In addition, the Complainants' Representative questions why the Provider continued to index-link the policy and says that the annual statements failed to clearly state that the Complainants had the option each year to cancel this indexation.

In her email to this Office on **28 January 2020**, the Complainants' Representative also submits, amongst other things, that:

> *"… My parents did not understand that the purpose of Life Insurance is to protect future income so it is no longer beneficial after retirement. Their mortgage was fully paid when my father retired in 2000 and my parents no longer had young children. They continued to pay into this policy out of fear. They thought it was something they had to pay into for life. My father is 81 and my mother is 79. They are not educated on financial products, nor do they use the internet …*

/Cont'd…

> *If my father died post retirement, my mother would receive a widow's pension and if my mother died, my father would continue to receive his pension so there was no need for Life Insurance ...*
>
> [The Provider] *informed me that the circumstances in which a payment would be paid would occur if one of my parents die. Effectively this means it would be used to pay for funeral expenses …*
>
> *The cover on their Life Insurance was for €44k for my father and €36k for my mother. This is significantly higher than what would be required if the purpose of the policy was to cover funeral expenses …"*

In her email to this Office on **28 May 2020**, the Complainants' Representative further submits that:

> *"…* [The Provider] *knew* [the policy] *was of no benefit to* [the Complainants] *post retirement & didn't advise* [the Complainants] *of same.*
>
> *The complaint in relation to annual statements is:*
>
> [The Provider] *do not state on the face of the statements what the policy plan covers …*
>
> *Every year* [the Provider] *are re-selling this product again and again with a renewal & a new premium amount …*
>
> *For example, the purpose of the plan was not clearly stated on the face of the* [annual] *statements, under what circumstances it would be paid out. When I asked* [the Complainants] *what this plan was for, they couldn't tell me but were scared to cancel it.*
>
> *If it is to pay for funerals, then a justification of the cover amount such as table of average cost of* [funerals]*…If it is to cover future income, then state how much per year, who it would be paid to, how often it would be paid & under what circumstances. Why would someone with grown children, house fully paid and a pension, need to protect future income if they die? …*
>
> *There was nothing written on the* [cover] *letter or annual statement to advise that this policy is no longer suitable for* [the Complainants]*. My parents didn't know this but* [the Provider] *did".*

In addition, in her email to this Office on **13 July 2021**, the Complainants' Representative submits that:

> *"…* [The Provider] *states that my parents benefitted from the policy up until cancellation in 2019. There was no benefit to the plan post retirement as they were paying out funds to* [the Provider] *up until 2019.*

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> [The Provider] *made a point…that my parents could contact them at any time to discuss their plan or obtain financial advice but did not do so. They did not know to seek financial advice. They were sold the plan in the 1980s. It was a whole of life plan that rolled on post retirement. They did not understand the purpose of the plan believing it was something they had to pay for life.*
>
> *… I am saying a whole of life cover plan is unsuitable specifically for my parents at their level of income as it serves no benefit. At their level, the purpose of life cover is to cover mortgage and cost of children should a spouse die before retirement age/children becoming independent adults.*
>
> … [the Provider] *did not address why indexation is applied to a plan which is essentially to cover funeral expenses …"*

The Complainants say that they wrote to the Provider on **1 December 2019** instructing it to cancel their policy, but that they then had to send a further written cancellation instruction on **11 December 2019,** before the Provider cancelled the policy on **13 December 2019**.

The Complainants seek for the Provider to refund all the policy premia that they have paid in respect of their whole of life insurance policy since the First Complainant retired in **2000**.

<u>The Provider's Case</u>

The Provider says that the Complainants incepted a dual life whole of life insurance policy with the Provider on **1 January 1984**, through a tied agent of the Provider. The Provider confirms that all correspondence over the years in respect of this policy was posted directly to the Complainants themselves at their home address.

The Provider says that as the Complainants' policy commenced in **January 1984**, there was no obligation on it from the outset to issue the Complainants with regular statements. The Provider says it did begin sending comprehensive Annual Benefit Statements to the Complainants from **2006** onwards and each of these confirmed the policy fund value at the time the statement was issued, as well as confirming the policy benefits and the outcome of the policy reviews which it continually conducted in the background.

In addition, all Annual Benefit Statements before **2013** also confirmed that the policy fund value should not be viewed as separate savings and that its purpose was to assist in paying for the life cover benefit in the later and more expensive years of the policy.

In **2013**, the Provider amended the information in its Annual Benefit Statements following the Central Bank of Ireland's ***Consumer Protection Code 2012 (as amended)*** to include information on policy charges deducted. The Provider says there was no requirement on it to include this information in annual statements before this time.

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For illustration purposes, the Provider set out an extract from the **2013 Annual Benefit Statement** it issued to the Complainants on **4 November 2013**, demonstrating the comparison between the total payments made over the period, to the charges collected over the same period, as follows:

How you plan value has changed since your last statement

Opening cash in value of your plan at 2 November 2012	€7,417.05

Payments made	
Total payments made up to 2 November 2012	€29,765.86
Payments received since 2 November 2012	€2,026.33
Total payments made up to 4 November 2013	€31,792.19

Charges applied	
Protection benefit charges	€2,149.85
Plan fees	€22.80
Payment charges applied	€139.51

Government charges applied	
Government levies	€20.47

The current value represents an increase in your plan of €964.42 since your last statement.

The Provider says all Annual Benefit Statements over the period **2013** to **2019** contained similar information on the Complainants' policy value at those times, including payments made to the policy over the previous year and charges collected over the same period.

The Provider says that the cost of providing life cover increases with age and with a whole of life policy like the Complainants, it conducts policy reviews at set intervals in line with the applicable **Provisions, Privileges and Conditions Policy Booklet** to ensure that the policy is sufficiently funded through a combination of its regular payments and fund value to meet the expected plan charges between review dates.

For illustration purposes, the Provider set out an extract from the **2013 Annual Benefit Statement** it issued to the Complainants on **4 November 2013** and the **2019 Annual Benefit Statement** it issued to them in **November 2019**, to demonstrate how the cost of providing the life cover benefit over this time was communicated to them.

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The details set out were as follows:

2013 Annual Benefit Statement

Charges applied	
Protection benefit charges	€2,149.85
Plan fees	€22.80
Payment charges applied	€139.51

2019 Annual Benefit Statement

Charges applied	
Protection benefit charges	€5,964.01
Plan fees	€22.80
Payment charges applied	€187.41

In that regard, the Provider says that the cost of providing the Complainants' life cover benefit had increased from **€2,149.85** in **2013** to **€5,964.01** in **2019**.

The Provider notes that Paragraph 2, '**Definitions**', of the applicable **Provisions, Privileges and Conditions Policy Booklet**, a copy of which was furnished to the Complainants when their policy commenced, provides that:

> *"(l) The "Policy Review Date" means the twelfth anniversary of the Date of Commencement of the Assurance and thereafter every sixth anniversary thereof provided that where the older of the Lives Assured has attained age 70 and the Policy has been in force for twelve years the Policy Review Date shall mean every anniversary of the Date of Commencement".*

This provision confirms that the Complainants' policy is subject to review after its first 12 years, every 6 years after that, and annually once the oldest life assured exceeds age 70.

At each review date, the Provider says it reviews the policy in line with Paragraph 16, 'Policy Reviews', of the **Policy Booklet**, as follows:

> *"**Policy Review** – At each Policy Review Date the Company's Actuary will:*
>
> *(a) review the Policy Fee and may adjust it to the level compatible with the scale then being charged by the Company for similar policies or if such policies are no longer being issued by the Company to such level as the Company's Actuary deems appropriate.*

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(b) *determine the maximum Guaranteed Minimum Death Benefit the Company is willing to allow under the Policy until the next following Policy Review Date and in determining the said maximum Guaranteed Minimum Dearth Benefit the Company's Actuary will inter alia take into account the Accumulated Fund on the said Review Date, future options under the Policy, future allocations of Units to the Policy up to the next Review Date assuming all due premiums are paid and then current mortality rates. If on a Policy Review Date the Guaranteed Minimum Death Benefit under the policy exceeds the permitted maximum as determined by the Company's Actuary then the Guaranteed Minimum Death Benefit under the Policy will be reduced to the said maximum or at the option of the Proposers the amount of premium payable in the future will be increased to such amount as the Company's Actuary shall determine".*

As the Complainant's policy commenced in **January 1984**, the Provider notes that the first scheduled policy review became due in **1996**, with the next review due 6 years later in **2002**. The Provider says that while the Complainants' policy would have passed both of those reviews, in that no change to the premium was required, it did not communicate the outcomes of these two policy reviews to the Complainants.

The Provider apologises for not communicating the outcomes of the **1996** and the **2002** policy reviews to the Complainants but stresses that there was no financial consequence for its communications not being sent at those times.

In addition, the Provider confirms that it conducted an internal review on the Complainants' policy in **1999** and this estimated that their payment in conjunction with the policy fund value would maintain the policy until **2015**, which it says demonstrates that the Complainants' policy would have passed its reviews in both **1996** and **2002**.

The Provider says it continually conducts regular policy reviews in the background and from **2006** it began to include the outcomes of these reviews in all of the Annual Benefit Statements it issued to the Complainants.

The third scheduled review of the Complainants' policy was due in **2008**, 6 years from **2002**, and at this time the Provider says it confirmed in the **2008 Annual Benefit Statement** it issued to the Complainants in **November 2008** that it estimated that their policy payment in conjunction with the policy fund value would maintain the policy for at least the next ten years, as follows:

> *"**Plan Review***
> *Assuming a future fund growth rate of 4.80% and our charges for benefits do not change, we estimate your payments will maintain your benefits for at least the next ten years".*

The Provider notes that similar review communications were included in the Annual Benefit Statements that it issued to the Complainants in **2009**, **2010**, **2011** and **2012**.

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The Provider says that in **2013**, it amended the format of the Annual Benefit Statement in line with changes in the ***Consumer Protection Code 2012 (as amended)*** at that time so that from **2013** onwards, it began to include a summary of how the policy value had changed since the last annual statement and provide a breakdown of all payments made to the policy over the period and the policy charges deducted over the same period. In addition, the Annual Benefit Statements from this time onward provided further information to the Complainants on the increasing cost of maintaining the life cover benefit.

The fourth scheduled review of the Complainants' policy was due in **2014**, 6 years from the **2008 r**eview, and at this time the Provider says it confirmed in the **2014 Annual Benefit Statement** it issued to the Complainants in **November 2008** that it estimated that their policy payment in conjunction with the policy fund value would maintain the policy for the next year, as follows:

> *"**Plan Review***
> *A review of your plan payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time. This assumes a future fund growth rate of 4.30% and our charges for benefits do not change. Your next plan review will be on 1 January 2016 when we will again check that the payments to your plan are sufficient to cover the cost of your benefits".*

As the First Complainant was then over the age of 70, the Provider notes that policy reviews would thereafter take place annually, in line with the policy terms and conditions.

The Provider says that the Complainants' policy passed its reviews in **2015**, **2016**, **2017** and **2018** and that this was confirmed in each of the respective Annual Benefit Statements.

Following the policy review in **2018**, the Provider wrote to the Complainants on **2 November 2018** offering them the option to transfer up to a maximum of **€30,000 (thirty thousand Euro)** life cover from their existing policy to a new non-reviewable guaranteed whole of life plan, without the need for any underwriting, where the payment on the new policy would not be subject to regular review and was fixed for life and advised:

> *"If you have any questions or you'd like to talk about your cover, please talk to your financial adviser* [named redacted]*. You can also contact our customer service team by email at* [email address redacted] *or call us on* [telephone number redacted]*".*

The Provider notes that the Complainants did not request any financial advice from the Provider following this letter.

At the time of the policy review in **2019**, the Complainants' policy was providing them with life cover in respect of the First Complainant in the amount of **€44,403.00 (forty-four thousand four hundred and three Euro)** and **€36,140.00 (thirty-six thousand one hundred and forty Euro)** in respect of the Second Complainant, for a quarterly payment of **€693.32 (six hundred and ninety-three Euro and thirty-two Cent)**.

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As this policy review identified that the payment in conjunction with the policy fund value was no longer sufficient to maintain the policy until its next review and as such a change was required, the Provider wrote to the Complainants on **4 November 2019** with options to continue policy cover, including maintaining the indexed level of life cover for a higher quarterly payment or reducing the level of life cover and cancelling the indexation while maintaining the quarterly payment.

In addition, this letter also offered the alternative option which allowed the Complainants to transfer up to a maximum of **€30,000 (thirty thousand Euro)** life cover from their existing policy to a new non-reviewable guaranteed whole of life plan without the need for any underwriting, where the payment on the new policy would not be subject to regular review and was fixed for life.

The Provider notes that this letter of **4 November 2019** advised:

> *"**Tell us what you'd like to do**…*
>
> *You may want to get advice from your financial adviser,* [named redacted] *or call us on* [telephone number redacted]. *They can help you see what level of cover you need and what option will suit you best. There may be other options available to you which your adviser can talk you through ….*
>
> *… If you have any questions please talk to your financial adviser,* [named redacted]. *You can contact our customer services team by email at* [email address redacted] *or call us on* [telephone number redacted]".

The Provider notes that the Complainants did not request any financial advice from the Provider following this, or any of their scheduled policy reviews.

In the absence of a response, the Provider sent a reminder letter to the Complainants on **1 December 2019**.

The Provider says it received an email from the Second Complainant on **1 December 2019** in which she set out details of her complaint and asked as to what the process was for cancelling the policy. The Provider emailed the Second Complainant on **2 December 2019** to advise that her email had been passed to its Complaints Management Team, who issued a formal complaint acknowledgement letter to the Complainants on **3 December 2019**.

The Provider says that following two unsuccessful attempts to speak with the Complainants on **9 December** and **10 December 2019** regarding the email of **1 December 2019**, it spoke with the Complainants' Representative on **11 December 2019**. During this telephone call, the Representative clarified the details of the Complainants' complaint. The Agent referenced the Second Complainant's enquiry in her email of 1st December as to what was needed to cancel the policy and confirmed to the Representative that if the Complainants did wish to cancel the policy, the Provider required a written instruction signed by both in addition to a copy of identification and proof of address.

The Provider says that, in addition, the Agent also confirmed that if the Complainants cancelled the policy, they would receive back the policy fund value of the day the Provider received all the valid cancellation requirements.

The Provider received an email later that same day, **11 December 2019**, with the valid cancellation requirements and it cancelled the Complainants' policy on **12 December 2019** with a correct effective date of **11 December 2019**. The Provider issued the Complainants with a cheque in the amount of **€1,839.61 (one thousand eight hundred and thirty-nine Euro and sixty-one Cent)** on **13 December 2019**, representing the full value of the policy on **11 December 2019**.

The Provider is satisfied that it did not delay in cancelling the Complainants' policy.

The Provider notes that the Complainants paid for the policy since its inception, through payroll deduction. Following the policy cancellation, the Provider says it received 3 further contributions in respect of the cancelled policy from the payroll administrator, and that it refunded:

- **€213.32** to the Complainants by cheque on **17 December 2019**,
- **€213.32** by cheque on **6 January 2020** and
- **€224.00** by cheque on **25 February 2020**.

In that regard, the Provider says it retained no monies after the policy cancellation and the 3 sums received from the Complainants' payroll administrator were immediately refunded to the Complainants, by way of cheque.

In relation to the indexation of the Complainants' policy, the Provider says that the indexation benefit is automatically applied to the policy unless cancelled by the policyholders, in line with Paragraph 13, 'Variation in Guaranteed Minimum Death Benefit', subsection (b), 'Automatic Increase', of the applicable **Provisions, Privileges and Conditions Policy Booklet**:

> *"**Automatic Increase** - Unless the Proposers decline such increase then on the third anniversary of the Date of Commencement of the Assurance and thereafter on every third anniversary thereof prior to the attainment by the older of the Lives Assured of age 60 whilst premiums continue to be payable and are paid under the Policy the Guaranteed Minimum Death Benefit will automatically be increased without any further evidence of health. The increased Guaranteed Minimum Death Benefit shall be equal to the Guaranteed Minimum Death Benefit prior to such amendment increased by a percentage equal to the percentage increase in the Consumer Price Index between he last quarterly Consumer Price Index published before notification by the Company to the Proposers of the increase and the last published Consumer Price Index extant three years previously.*

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On such increase the amount of premium currently payable shall be increased by a similar proportion to the increase in the Guaranteed Minimum Death Benefit subject to a minimum in such premium of IR £6 per month or its equivalent or such other minimum as the Actuary shall decide".

The Provider says that in **1985**, to enhance the customer experience so that the indexation benefit was of more relevance, it moved from a three-year indexation arrangement as provided for by Para. 13(b) to an annual one, and that the age limit at which indexation would automatically cancel was also removed at this time. The Provider says this change was made in the context of the prevailing conditions which was an environment of high inflation, in that it was felt that it was more appropriate to protect customers' benefits against the effects of inflation on an annual basis as opposed to every three years.

The Provider says that this change to the indexation arrangement was communicated to the Complainants through an annual indexation offer letter which gave them the option of not progressing with the annual increase, if this was what they wished. The Provider has not retained copies of all annual indexation notices issued over the life of the Complainants' policy. The Provider notes that from **2006** onwards, it started to include an annual indexation notice as part of the Complainants' Annual Benefit Statement. The Provider notes that at no time did the Complainants request for the indexation benefit to be cancelled and therefore it continued to apply and continued to protect their life cover benefit against the effects of inflation, right up until they cancelled their plan.

In that regard, the Provider says that indexation is a valuable benefit which protects the real value of the life cover over time, against the effects of inflation. The Provider notes that the Complainants could have cancelled this indexation benefit at any time, if they wished to do so. In addition, the Provider says that the Annual Benefit Statements issued to the Complainants from **2006** onwards provided them with their annual indexation notice and confirmed what they needed to do, if they wished to cancel this indexation benefit. As no cancellation instruction was ever received, the indexation benefit continued to apply and the life cover remained protected against the effects of inflation.

To demonstrate the indexation notice, the Provider set out the following extract from the cover letter accompanying the **2019 Annual Benefit Statement**:

"When you started this plan you chose to increase payments and benefits every year. This is called Indexation. By increasing the payments, you are helping to protect the benefits of your plan over the long term. The attached benefit statement shows the increase in your quarterly payments from €693.32 per quarter to €727.99, from 01 January 2020. This includes a government levy of 1.00%. We have set out a breakdown of your payment and your revised benefits over the page.

If you decide not to choose to increase this year please write to us within 10 days of receiving this letter. We will need both of your signatures to process your request".

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The Provider says that if the Complainants had any other queries relating to the indexation benefit including how to cancel it, they could have contacted its Customer Services Team, the telephone number of which was detailed in the correspondence.

In response to the Complainants' Representative's comments that the Complainants' policy was no longer appropriate, following the First Complainant's retirement, the Provider says it cannot agree with this very broad and general statement, as all its customers' needs and requirements are different, depending on their own individual set of circumstances and while some customers may not have a need for whole of life cover after retirement, a large number of people do.

The Provider says that if the Complainants did not require the level of life cover benefit being provided by their policy after the First Complainant's retirement, they could have spoken with a financial adviser and/or cancelled the policy. The Complainants did not do this and so they benefitted from the life cover being provided by the policy, right up until they cancelled the policy in **December 2019**, in that the policy would have paid out the life cover in the event of the death of one or both lives assured.

The Provider stresses that at all times it was the responsibility of the Complainants to inform the Provider if they required any financial advice or a meeting with a Provider Financial Adviser, so that the relevant appointment could be arranged, and the facility availed of. The Provider refers to the cover page on each of the Annual Benefit Statements it issued to the Complainants from **2006** onwards where it reminded them that the Provider offers a free no obligation annual financial review and it provided the contact telephone number for them to make the necessary appointment with a financial adviser if they required such an appointment.

The Provider says that no appointment requests were ever sought by the Complainants in respect of the policy. In addition, the Provider says it was also open to the Complainants to have sought advice from an independent intermediary at any time.

In conclusion, the Provider says that for not communicating the outcomes of the **1996** and **2002** policy reviews to the Complainants, notwithstanding that it reiterates that there was no financial consequence for its communications not being sent at those times, the Provider would like to offer the Complainants a customer service payment in the amount of **€2,000.00 (two thousand Euro)**.

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The Complaint for Adjudication

The complaint is that the Provider maladministered the Complainants' life insurance policy throughout the period **2002** to **2019** by:

1. failing to advise the Complainants over the years as to the suitability of the policy to their changing needs;

2. continuing to apply indexation on the policy and failing to clearly advise the Complainants that they could cancel this facility at any time; and

3. failing to cancel the policy as and when the Complainants first requested its cancellation on **1 December 2019**.

Decision

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

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

A Preliminary Decision was issued to the parties on **28 February 2022**, 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. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

In relation to the first element of this complaint, that the Provider maladministered the Complainants' life insurance policy throughout the period **2002** to **2019,** by failing to advise them over the years as to the suitability of the life insurance policy to their changing needs, I note that in her email to this Office on **28 January 2020**, the Complainants' Representative says that *"my parents did not understand that the purpose of Life Insurance is to protect future income so it is no longer beneficial after retirement".*

The Representative also said that the level of life cover being provided by the Complainants' policy was *"significantly higher than what would be required if the purpose of the policy was to cover funeral expenses"*. She further submits that in the event of the death of the other, each of the Complainants had their respective pensions to rely upon.

I do not accept the Complainants' Representative assumption that the purpose of life cover, after the policyholder retires or reaches a certain age, is simply to meet funeral expenses. It may be that some policyholders have funeral expenses in mind, but people take out and maintain life cover of varying amounts, for a variety of personal and financial reasons and in that regard, I am satisfied that it is a matter for each policyholder to ensure that the level of life cover that they are paying for, continues to meet their individual needs, and they are free to reduce or indeed cancel the life cover at any time, if they so wish. Ultimately the purpose of life cover, is to provide for a cash benefit, in the event of the death of the insured. There are many reasons why life cover is incepted, and I note that in this instance, the policy was purchased by the Complainants in 1984, almost 40 years ago, for whatever reasons they had in mind at that time. Their premium payments over those many years, ensured that the cover continued in place, though happily no death benefit claim became necessary during that period.

I am conscious that in her submission following the Preliminary Decision of this Office, the Complainants' Representative also observed that:

> *"Please explain to me how this is not mis-selling in the context of Income Protection Insurance which was sold to banking customers when they applied for a new credit card in the early 2000s. It was found that this was mis-selling as it was something customers didn't need."*

As previously outlined above, it falls outside the jurisdiction of this Office to investigate any complaint regarding the sale of the policy in late **1983**, as the conduct giving rise to those complaints, falls outside the time limits set out in ***Section 51*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

I note from the evidence before me that the Provider made it clear in the annual statements it sent to the Complainants from **2006** onwards that the Complainants could contact the Provider if they needed advice regarding their life insurance policy.

I note that in the submission made by the Complainants' Representative since the Preliminary Decision was issued by this Office, it is suggested that the Provider, and other providers of policies of this nature, should be required to display:

> *"the average cost of funerals in the clients county and the amount this leaves per child or whoever is to inherit this pay out."*

I do not accept that it would be practical to require a financial service provider to display such information, or indeed that it would even be possible for a provider to be aware of the inheritance plans of its customers.

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I note that the **2006 Annual Benefit Statement** the Provider sent to the Complainants in **November 2006** stated, among other things, that:

> *"… If you would like some help reviewing your financial needs, please call* [telephone number redacted] *to set up an appointment with your financial adviser. The financial review takes just one hour, is completely free and there is no obligation ….*
>
> *If you have any questions or need more information, please call our customer service team on* [telephone number redacted] *…"*

I note that similar statements appeared in each annual statement up to and including the **2019 Annual Benefit Statement** the Provider sent to the Complainants in **November 2019** which stated that:

> *"… If you would like some help, please call* [telephone number redacted] *to set up an appointment with your financial adviser. The financial review service takes just one hour. We provide this service to help you to plan for your financial needs. There is no charge for the service and you do not have to buy. We will send you a detailed report of your review within one week.*
>
> *If you have any questions or if we can help in any way please contact your financial adviser or call us on* [telephone number redacted] *…"*

I am satisfied that it was a matter for the Complainants to determine the level of life cover they wanted to maintain throughout the term of their policy, and that it was open to them to discuss this at any time with a Provider Financial Adviser for free if they so wished, and that the Provider reminded them of this option, on an annual basis. The Complainants themselves were best placed to understand their requirements, and indeed if the policy was held for the purpose of meeting future funeral costs, this is an issue they could have explored to establish the costs of any funeral plans they had in mind.

It is important to note that the Complainants' policy continued to provide them with valuable cover throughout the period **2002** to **2019**, in that in the event of a valid claim or claims (the policy was underwritten on a dual life basis), the policy would have paid out the appropriate life cover benefit as detailed in the annual statement preceding any such claim.

I am therefore of the opinion that, given the evidence made available by the parties, there is no reasonable basis upon which it would be appropriate to uphold this element of the Complainants' complaint.

In relation to the second element of this complaint, that the Provider maladministered the Complainants' life insurance policy throughout the period **2002** to **2019** by continuing to apply indexation on the policy and failed to clearly advise the Complainants that they could cancel this facility at any time, I note from the evidence before me that the Provider made it clear in the annual statements it sent to the Complainants from **2006** onwards, that indexation applied to their policy and that they were free to cancel this option.

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For example, the **2006 Annual Benefit Statement** the Provider sent to the Complainants in **November 2006** stated, among other things, that:

> *"… When you took out this plan, you chose to increase payments and benefits every year. This is called indexation. By increasing the payments, you are helping to protect the benefits of your plan against inflation …*
>
> *If you decide to choose indexation this year please write to us within 10 days of receiving this letter. We will need both your signatures to process your request …*
>
> *If you have any questions or need more information, please call our customer service team on* [telephone number redacted] *…"*

I note that similar statements appeared in each annual statement up to and including the **2019 Annual Benefit Statement** the Provider sent to the Complainants in **November 2019** which stated that:

> *"… When you started this plan, you chose to increase payments and benefits every year. This is called indexing. By increasing the payments, you are helping to protect the benefits of your plan over the long term …*
>
> *If you decide not to choose to increase thus year please write to us within 10 days of receiving this letter. We will need both of your signatures to process your request.*
>
> *If you would like some help, please call* [telephone number redacted] *to set up an appointment with your financial adviser. The financial review service takes just one hour. We provide this service to help you to plan for your financial needs. There is no charge for the service and you do not have to buy. We will send you a detailed report of your review within one week.*
>
> *If you have any questions or if we can help in any way please contact your financial adviser or call us on* [telephone number redacted] *…"*

I note that in **2002**, **2003**, **2004** and **2005**, the Provider says it issued the Complainants with an annual indexation offer letter which presented them with the option of not progressing with the annual increase if this was what they wished.

I am satisfied from the evidence before me that throughout the period **2002** to **2019**, the Provider made it clear to the Complainants on an annual basis that indexation continued to apply to their life insurance policy and advised them how they could cancel this option if they wanted to.

I am therefore of the opinion that, given the evidence made available by the parities, there is no reasonable basis upon which it would be appropriate to uphold this element of the Complainants' complaint.

/Cont'd…

The Complainants' Representative has asked:

> *"Can the Ombudsman recommend that it become a requirement to explain to customers why indexation is applied in relation to current and projected rates of inflation and the purpose of the plan cover?"*

I would ask the Provider to consider the way in which it might implement that suggestion, perhaps by making additional information available to its policyholders annually, but I do not consider it appropriate to make a direction in that respect in this matter, particularly as the Complainants no longer hold a policy with the Provider.

In relation to the third element of this complaint, that the Provider failed to cancel the Complainants' life insurance policy as and when the Complainants first requested its cancellation on **1 December 2019**, I note from the evidence before me that the Second Complainant emailed the Provider on **1 December 2019** and asked, among other things, that:

> *"… What is the process of cancelling this cover & how much can we recoup of the funds we paid into this cover over the past 20 years? …"*

This was not a request to cancel the policy. Instead, in my opinion, it was a query as to the cancellation process.

I note that following a telephone call between the Complainants and the Provider on **11 December 2019**, the Complainants emailed the Provider later that same day, as follows:

> *"Further to our call this afternoon, please find attached written instruction to cancel* [the Complainants'' policy] *with proof of address and ID".*

I am therefore satisfied that it was on **11 December 2019** when the Complainants first formally requested for their policy to be cancelled and supplied the Provider with the necessary cancellation requirements to action that request.

I note the Provider cancelled the Complainants' policy on **12 December 2019** with a correct effective date of **11 December 2019**. As a result, I do not consider that the Provider delayed in any way, in actioning the Complainants' request to cancel their life insurance policy.

I am therefore of the opinion that, given the evidence made available by the parities, there is no reasonable basis upon which it would be appropriate to uphold this element of the Complainants' complaint.

Having regard to all of the above, the evidence does not support the Complainants' complaint that the Provider maladministered the Complainants' life insurance policy throughout the period **2002** to **2019**.

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I note that in the course of the Provider reviewing the background to this matter, in the preparation of its response to this complaint, it formed the opinion that as a result of not communicating the outcome of the 1996 and 2002 policy reviews to the Complainants, the Provider ought to make a compensatory payment to the Complainants by way of redress, notwithstanding the limited impact that the Provider's failure had on the Complainants.

In my opinion, this is a reasonable approach for the Provider to take and I am satisfied that it will be a matter for the Complainants to make direct contact with the Provider if they wish to accept this compensatory gesture of €2,000. In that event, they should make contact expeditiously, as the provider cannot be expected to hold that compensatory offer open to the Complainants indefinitely. I do not however consider it appropriate to make a direction to the Provider in that regard, as suggested by the Complainants' Representative, because I have found no evidence of wrongdoing by the Provider, to form the basis of upholding the 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.

MARYROSE MCGOVERN
Financial Services and Pensions Ombudsman (Acting)

22 April 2022

PUBLICATION

Complaints about the conduct of financial service providers

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.

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Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension 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.