An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0154
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Maladministration (life) Delayed or inadequate communication
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a whole of life assurance policy that the Complainants hold with the Provider.

The Complainants' Case

The Complainants incepted a whole of life insurance policy with a third-party provider in **1991**, the ownership of which was subsequently transferred to the Provider. They submit that it was their understanding that the sum assured of **€623,732** (six hundred and twenty-three thousand, seven hundred and thirty-two Euro) was guaranteed under the policy and would remain unchanged. They state that, since **1991**, they have paid in excess of €87,000 (eighty-seven thousand Euro) to maintain the policy cover.

They state that they became aware that there may be a serious issue with their policy when they received a communication from the Provider dated **4 December 2019** which informed them that the current premium payments and any fund built up on the plan, were no longer enough to maintain the current level of cover under the plan. The letter stated that to continue with their level of cover, the monthly premiums would need to increase from €250 (two hundred and fifty Euro) to €7,592.06 (seven thousand, five hundred and ninety-two Euro and six Cent). They assert that this increase is unjustifiable, unreasonable and unaffordable.

The Complainants state that, due to the substantially increasing level of cost applied to the plan, they were aware that its value had reduced to a critically low level and may become worthless in the near future.

They state that in **December 2019** they were offered by the Provider to convert the policy to a Guaranteed Whole of Life Cover Plan with an assured amount of €30,000 (thirty thousand Euro) with a monthly premium of €211 (two hundred Euro) which they state would become worthless after ten years as they would have paid more into the policy than they could ever have claimed and it would have resulted in them losing the money which they had paid in premiums since the inception of the policy. They also state that this change would mean that the policy would lose its tax-exempt status which was an important factor in choosing the policy.

They submit that they made an official complaint regarding the plan review dated **December 2019** and that the provider failed to deal with the complaint in any meaningful way. The Complainants state that they directed their representative to review the plan, who then contacted the Provider on **3 April 2020** and was provided with the plan's yearly statements from **2006** to **2019**. Included within these documents was a plan review dated **December 2018** which they state they never received at the time. They further submit that no plan review had been carried out by the Provider prior to **2018** and that the Provider failed to inform them in a timely manner that the fund value and premium payments were insufficient to maintain the plan into the future. They contend that the Provider maladministered the cash fund, letting it run down significantly over recent years, and that this has had a significant impact on the value of the plan.

The Complainants state that the options within the plan review sent to them in **December 2019** were due to expire on **20 February 2020** and that this was insufficient time for them to make an informed decision and that when their representative contacted the Provider on **15 April 2020** enquiring as to whether those options remained available, they were sent revised options on **14 May 2020**. These options were to continue paying the current premium up until **20 February 2021** with a life cover totalling €114,298 (one hundred and fourteen thousand, two hundred and ninety-eight Euro). This was a significant decrease from the similar option offered to them in **December 2019** which had the same premium under **20 February 2021** but with a life cover of €182,707 (one hundred and eighty-two thousand, seven hundred and seven Euro). The Complainants state that they find it difficult to understand why this adjustment had been made.

They submit that if they had been made aware at an earlier date, that their cash fund was being depleted to pay for the costs of their cover, they would have been in a better position to decide whether to cash in what was left of their fund, to purchase cover elsewhere. This is now not possible due to their age and health status.

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The Provider's Case

The Provider accepts that the Complainants would have needed to increase their monthly payments from €250.71 (two hundred and fifty Euro and seventy-one Cent) to maintain their level of cover. In late 2019, to maintain that cover until the next review, the premium needed to increase to €2,360.05 (two thousand, three hundred and sixty Euro and five Cent) per month or €7,592.06 (seven thousand, five hundred and ninety-two Euro and six Cent) per month for the rest of their lives. The Provider states that the Inheritance Tax Plan chosen by the Complainants was originally granted by Company A in **1991** before ultimately, through a series of mergers, it has been administered by the Provider since **1999**.

The Provider states that the plan was at all times administered by the Provider "*exactly in line with their original terms and conditions which issued to them at the outset of their plan*". It states that the plan is a *"unit linked protection plan designed to pay out a lump sum on death. While it does accumulate a value it is not an investment product and should not be viewed as such."*

The Provider states that the plan functioned in the following manner; every time a payment was received "*units"* were purchased in the plan fund and then charges, including the *"monthly life cover cost"* and *"plan fee"* were cancelled from the same fund. The remaining units made up the value of the plan which built up over time. The monthly life cover cost depends on a number of factors including "*the plan's fund value, ages of the lives covered, level of cover on the plan and current mortality rates"*.

The Provider states that the cost of life cover increases with age and so the deductions would increase to reflect this. The Provider states that there is no relationship between the payments made by the Complainants and the benefit which would be paid out on death, and that the death benefit would be paid at any point during the plan, upon the death of the last survivor.

The Provider further states that it began providing **Annual Benefit Statements** from **2006** onwards which it was not obliged to do in the early years of its administration of the plan. The Provider states that the practice of the initial fund provider Company A *"when the value of the plan fund reduced… to nil… was to cancel the plan"*. The practice of the Provider when dealing with a plan with a value reducing to nil, is to instead conduct a review and offer options for continued cover and that such reviews are conducted *"after the first ten years, every five years after that and annually from age 70 onwards"*.

The Provider states that it took the decision to offer former customers of Company A, such a review when it estimated that their fund value was reducing to nil.

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The Provider states that during a review it examines factors such as *"the ages of the lives covered at the time of the review, the fund value on the plan at the time of the review, mortality rates at the time of the review and the level of cover being provided by the plan at the time of the review."* From this the Provider says it estimates whether the current payments along with the value in the plan, is sufficient to maintain cover provided until the next review. If it is not sufficient, it calculates what changes need to be made to the monthly payment to keep the same level of cover, along with providing other options.

The Provider states that such a review was conducted in **December 2018** and at that time, it determined that no changes were required. A further review was then carried out in **December 2019** which established that the current payment, in conjunction with the fund value remaining, was no longer sufficient to maintain the cover and so a number of options were provided to the Complainants as an alternative to cancellation. The Provider states that as no option was chosen, revised options were provided in **May 2020** and it explains that at that point, the fact both Complainants were older, and the remaining fund value was less than it had been, impacted upon the new options provided.

The Provider states that the plan costs first exceeded the regular payment in **February 2009** and, at this stage, the excess fund value began to supplement the regular premium payment to maintain the plan. The Provider states that this was what the built-up value was *"always intended to do"*.

The Provider states that it was evident to the Complainants from their **2013** annual statement, that their plan costs exceeded their monthly payments, and it was in **2019** that the Provider identified that the payments, along with accrued value on the plan, would no longer maintain their cover, going forward.

The Provider accepts that no reviews were communicated to the Complainants before **2019** but it states that none were needed as the fund value in addition to the regular premium payment was always sufficient to meet the plan costs prior to **2019**.

The Provider refutes any allegations of maladministration and states that the plan was:

> *"always administered in line with its original Terms and Conditions which issued to them at the outset of their plan and their plan always operated exactly how it was designed and intended to operate."*

The Provider has made an offer within its response of €**3,000** as a 'Customer Service Award' in relation to poor communication with regard to plan reviews. This offer was rejected by the Complainants.

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The Complaints for Adjudication

The first complaint is that the Provider maladministered the Complainants' life assurance policy. The Complainants say in that respect that the Provider failed to inform them within a timely manner that their premiums were insufficient to cover the cost of the benefits under the plan.

The second complaint is that the Provider failed to deal with the Complainants' complaint in any meaningful manner.

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

I note that, more than 30 years ago, on **20 February 1991**, the Complainants incepted a '**Flexible Last Survivor Plan'** with Company A. The following extracts of the original policy conditions are relevant to this complaint:

> ***Allocation of Units and Unit Prices***
>
> *…*

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16. *Allocations will be made in respect of each Life Premium payable under this policy to units of one or more of the funds to which the Company then permits the benefits of this policy to be linked. The amount so allocated will be divided between the aforementioned funds in such proportions as are determined by the Grantee(s) and the said amount will be allocated to units of these funds at their offer prices on the valuation day next following the Life Premium due date, or the date of receipt by the Company of such Life Premium, if later.*

…

20. *(i) If the number of units attaching to the policy is less than the number of units to be met by a deduction from units attaching to the policy, a negative balance of units will be attaching to the policy after the said deduction is made. The number of units attaching to the policy after the said deduction is made shall equal the number of units attaching to the policy before the said deduction is made less the number of units to be deducted.*

(ii) If at any time after the second anniversary of the Date of Policy the number of units attaching to the policy is negative, then the Company shall have the right to cancel the policy without value and all liability of the Company under the policy shall immediately cease.

…

[My emphasis]

Death Benefit Charges and Policy Changes

26. *A charge shall be made for the Death Benefit once in each calendar month, at a time determined by the Company, by deduction from the units allocated to the policy.*

The amount of the charge is obtained by applying the relevant life assurance rate to the excess, if any, of the sum assured over the cash value of the policy.

The relevant life assurance rate will be determined with reference to:

(i) The mortality rate appropriate to each of the Lives Assured, having regard, in the case of each Life Assured, to the sex of such Life Assured and whether or not non-smoker mortality rates apply to such assured, and, where such life assured was not accepted at standard rates, the increase or increases applied to standard mortality rates in respect of such Life Assured, and

(ii) The attained ages at the Date of Policy of each of the Lives Assured and the duration elapsed since the Date of Policy.

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If any Life Assured was not accepted at standard mortality rates, then the mortality rates in respect of such Life Assured will be increased by such proportion and by such amount as are specified in Schedule 1.
The mortality rates and life assurance rates adopted for the purposes of this condition will be determined from time to time by the Company acting on the advice of the Actuary.

27. *A policy fee shall be charged each month by deduction from the units allocated to the policy. The amount of the policy fee will be determined from time to time by the Company.*

I note that the **Annual Benefits Statements** sent from the Provider to the Complainants from **December 2006** onwards contained the following relevant information:

December 2006
*"**Current value of your fund** **€66,470.13***
If your plan does not have a separate savings element we may show your protection plan to have built up a value. We will use this value to fund your protection benefits in the more expensive later years of your plan. Please do not think of this as extra savings. If your plan does have a separate savings element the value above includes your protection and savings values.

[My emphasis]

Plan Review
Assuming a future fund growth 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. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time."

The wording changed in **2009** to the following:

December 2009
*"**Current value of your fund at 3 December 2009** **€51,094.66***
This is a protection plan, so the value is not extra savings. This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan.

[My emphasis]

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Plan Review
Assuming a future fund growth of 4.80% and our charges for benefits do not change, we estimate your payments will maintain your benefits until 20 January 2017. We will then review your plan to make sure that your payments and any value built-up in the plan are enough to support the benefits applying at that time."

The wording again changed in **2011** to the following:

December 2011
"Current value of your fund at 3 December 2011 €50,162.30

This is a protection plan, so the value is not extra savings. This value will be used, in addition to your regular payment, to fund your protection benefits in the late, more expensive years of your plan.

Plan Review
Assuming a future fund growth of 4.80% and our charges for benefits do not change, we estimate your payments will maintain your benefits until 20 December 2018.To avoid your plan ceasing at that time we will at the previous plan anniversary advise what increased payment you need to make to cover the cost of your benefits at that time.

[My emphasis]

If you prefer, you can extend the period of cover by increasing your payment now. For example, we estimate that to sustain Benefits until 20 December 2024, you would need to increase your current payment to €1398.15. If you would like to do this, please contact us or your financial advisor."

I note that the format of these letters changed in **2013** with the Provider providing far more information on the plan than had been provided during previous years:

December 2013

"Plan Review

Assuming a future growth rate of 4.30% and our charges for benefits do not change, we estimate your payments with the support of the unit account will maintain your benefits until 20 October 2019.To avoid your plan ceasing at that time we will at the previous plan anniversary advise what increased payment you need to make to cover the cost of your benefits at that time.

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If you prefer, you can extend the period of cover by increasing your payment now. For example, we estimate that to sustain Benefits until 20 October 2025, you would need to increase your current payment to €1,556.35. If you would like to do this, please contact us or your financial advisor.

…

Total fund value at 4 December 2013	*€58,380.32*
…	
Opening cash in value of your plan at 5 December 2012	*€53,824.49*
…	
Payments received since 5 December 2012	*€2,978.43*
…	
Charges applied	
Protection benefit charges	*€7,079.33*
Plan fees	*€75.45*
Payment charges applied	*€49.59*

…

The current value represents an increase in your plan of €4,555.83 since your last statement"

I note that the formatting of these letters then remained largely the same from that time onwards and the following information extracted from those letters is relevant to this complaint:

Year	**Current Cash Value**	**Protection Benefit Charges**
2014	€61,211.61	€8,387.02
2015	€61,595.03	€9,866.13
2016	€53,579.36	€11,775.95
2017	€46,512.47	€13,923.25
2018	€33,666.63	€16,538.01
2019	€19,026.08	€19,657.09

I note that in the statements from **2015** onwards, the 'Plan Review' section changed from the above to the following:

*"**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 2.15% and our charges for benefits do not change. We will continue to check your payment each year to ensure you payments are sufficient."

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A letter dated **July 2018** was sent to the Complainants from the Provider titled "*Understanding your reviewable protection plan"* which provided a hypothetical example to show the "*Journey of a reviewable protection plan"* which included the following details:

> *"The cost of providing cover is lower when you are younger and increases as you get older. The cover is for the whole of your life. This means it doesn't have an end date. The plan is checked regularly to make sure that the monthly payment and any value that may have built up is enough to pay for the cost of the life insurance. This regular check is called a policy/plan review."*

The first **Plan Review Letter** was sent to the Complainants dated **5 December 2018** which sets out the following:

> *"We've carried out your latest review and the good news is that your current payments and the fund built up on your plan are enough to cover the cost of your benefits at this time.*
> *…*
> ***The cost of your cover will increase in the future***
>
> *The cost of providing cover increases as you get older. So although you do not need to make any changes to your plan now, it is likely that the cost of your cover will increase significantly in the future. This means you will need to increase your payments or reduce your level of cover.*

A table was then provided to set out what was required to *"maintain your current level of cover into the future"*

Your current monthly payment	**Estimated payment to maintain your cover to 2023**	**Estimated payment to maintain your cover to 2028**	**Estimated payment to maintain your cover for the rest of your life**
€250.71	€2,058.01	€3,246.29	€7,389.22

The next **Plan Review Letter** sent on **4 December 2019** sets out:

> *"We've carried out your latest review and your current payments and any fund value you've built up are no longer enough to keep your current level of cover"*

A number of options were then provided for the Complainants. These were:

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- Keep the same level of cover of €623,732 and increase their payments until **20 February 2021** at a monthly cost of €1,980.92.

- Reduce their level of cover to €182,707 and keep their monthly payments of €250.71 the same until **20 February 2021.**

- Aim to keep the same level of cover for the rest of their lives for an estimated monthly payment of €7,592.06 (seven thousand, five hundred and ninety-two Euro and six Cent).

- Change to a new Guaranteed Whole of Life Cover 10 year plan, with no reviews, for €211.15 per month for a level of cover amounting to €30,000 (thirty thousand Euro).

No option was chosen by the Complainants and a further **Plan Review Letter** was sent on **14 May 2020** which provided the following options:

- Keep the same level of cover of €623,732.00 and increase their payments until **20 February 2021** at a monthly cost of €2,360.05 (two thousand three hundred and sixty Euro and five Cent).

- Reduce their level of cover to €114,298 and keep their monthly payments of €250.71 the same until **20 February 2021.**

- Aim to keep the same level of cover for the rest of their lives for an estimated monthly payment of €7,592.06.

- Change to a Guaranteed Whole of Life Cover 10 year plan with no reviews for €211.15 per month for a level of cover amounting to €30,000 (thirty thousand Euro).

The First Complainant contacted the Provider by telephone on **30 December 2019** and the following conversation took place:

Agent: *[reading from **4 December 2019** letter] if you wanted to stay with your current monthly payments of €250 a month it would reduce the life cover down, that's quite significant actually*

First Complainant: *Absolutely unbelievably significantly*

Agent: *Yeah*

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First Complainant: which was not what I was sold in 1991

Agent: And when you first took this out were you under the impression that this would have continued on at this level of cover for the whole time.

First Complainant: Yeah

…

First Complainant: I've been living here on the understanding that when we both pass away that this €623,000 would pass on to our children and its obviously not going to be the case.

Agent: Yeah, unless the premiums increased

First Complainant: So, I believe I have been sold something which isn't

Agent: Which isn't what they said it was

First Complainant: Which isn't what they said it was

The First Complainant was then called back, by the Provider, on **6 January 2020** and the Complainants confirmed that they were unhappy with the **4 December 2019** review. The Provider's Agent then proceeded to explain the history of the policy and that its terms did not include the potential for reviews, but that the Provider was offering them options instead of cancelling the plan completely. The Agent then explained that the cost of life cover increases over time, and was in excess of the premiums being paid and the following relevant extracts are transcribed below:

First Complainant: That wasn't explained to me when I took out the cover, when I took out the cover with [Broker] I was given this particular amount a month around €250 or whatever and that on the expiration date it would be on or around €600,000. Now I was never told that I mean for instance to bring it up to what your asking me to pay approximately €24,000

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Agent: *I do understand that the increase is quite significant and I do apologise for that unfortunately for that level of life cover that increase would be needed I am afraid*

First Complainant: *But why wasn't it explained to me when I took out the policy*

Agent: *The policy itself was sold to you by an independent broker so unfortunately* [Provider] *I wouldn't be able to comment on how that was sold to you… but it would have been in your terms and conditions that the cost of cover is dependent on your current age current mortality rates and that would be deducted from the fund value.*

…

First Complainant: *I feel I've been conned*

Agent: *What I will be doing here I will be sending you a formal response letter setting out everything we have been discussed and if you do remain unhappy at that time you do have the option of referring the matter to the Financial Ombudsman.*

A response letter was then sent on **9 January 2020** which sets out that:

"I note from your telephone conversation with our Customer Service Tam on 30 December 2019 and also our telephone conversation on 6 January 2020 that it was your understanding that your level of life cover would remain the same. You also stated that you were unhappy with the sale of your plan"

I am mindful that the policy that the Complainants incepted in **1991,** is a unit linked life assurance policy, which has the benefit of being a "whole of life" policy, as long as the premiums continue to be paid and those premiums can support the level of policy benefits. The Complainants' reasoning for taking out this policy was to provide for a lump sum upon their death, to address inheritance tax.

The benefit of a unit linked protection plan is that the policyholder can pay a premium in the earlier years which more than covers the cost of the life cover and the excess remains invested in the designated fund. This fund builds value over time to supplement the premium paid in future years, when the cost of life cover has increased, allowing the policy benefits to be maintained. However, although the cash value in this instance, was accessible to the Complainants, these policies are not intended to be savings plans. The cost of providing the life cover increases as the assured gets older and the purpose of the built-up

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cash fund is to supplement the premiums paid, once those premiums alone can no longer meet the cost of cover.

I am satisfied that the Complainants' policy operated in line with the terms and conditions of the policy, which were in force from **1991** and which formed the basis of the contractual arrangement.

The Complainants state that the Provider maladministered the fund, in that the value of the fund, was allowed to run down significantly, over the last few years. The Provider refutes any allegations of maladministration. I accept that the plan was administered, as it was designed to be and as was set out within the **1991** terms and conditions. A cash value was built up over the years of the policy and was invested and at the point when the premiums no longer covered the monthly costs, from **February 2009** onwards, that fund then supplemented the premiums, to meet the cost of an additional 10 years of cover. As can be seen from the Annual Benefits Statements the decline in the cash value was not due to any decline in the value of the investment; it declined because it was being used to pay the increasing cost of cover, as the Complainants got older. I am not satisfied therefore that there was any maladministration of the fund.

It is clear from the submissions of the parties and from the documentary evidence that the Plan Review dated **4 December 2019** is what alerted the Complainants to the fact that maintaining their then current level of cover would require a substantial increase in their monthly payments. This was 10 years after the premiums on their own, began to no longer meet the cost of providing the cover, and needed to be supplemented by the value accumulated in the fund.

The Provider is correct that under the original terms and conditions, there was no contractual obligation upon it to offer a plan review to the Complainants. The Provider however is obligated, regardless of contract, to comply with the **Consumer Protection Code 2012** (CPC) and in particular provisions 4.1 and 4.2:

> *"PROVISION OF INFORMATION*
> *GENERAL REQUIREMENTS*
>
> *4.1 A regulated entity must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English. Key information must be brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.*
>
> *4.2 A regulated entity must supply information to a consumer on a timely basis. In doing so, the regulated entity must have regard to the following:*

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a) the urgency of the situation; and

b) the time necessary for the consumer to absorb and react to the information provided.

I note that following the commencement of the CPC provisions, the Provider sent the Complainants annual Benefit Statements from 2013 onwards, which noted that the premiums were insufficient to maintain the policy benefits. In addition, the 2013 and 2014 statements made clear that the payment of premium at the then current level would support the policy benefits until a date which was specified within the communication.

It is clear from the Complainants' position that they do not disagree that the policy operates in the way which is set out within the policy terms and conditions. Rather, their difficulty and the issue that gives rise to their complaint is the fact that they believe that this was not adequately explained to them at the time when they incepted the policy in 1991. Because of the time limits for making complaints to this Office, any complaint regarding the suggested mis-selling of this policy to the Complainants in 1991, falls outside the jurisdiction of this Office.

The complaint against the Provider is that it has maladministered the policy but in fact, it is clear to me from the evidence that the policy has been administered in a manner anticipated by the policy provisions. I note that when the built-up value of the plan reduces to nil, it is open to the Provider to simply cancel the policy with no options offered to the Complainants. Rather than doing so, the Provider has offered to review the premium or, alternatively, it is willing to make available a term policy for a period of 10 years at an affordable premium for the Complainants to pay for life benefit of €30,000. In my opinion, this is a reasonable approach for the Provider to take and these options are potentially beneficial to the Complainants if they consider one or other to be suitable.

Insofar as the original policy is concerned however, I am satisfied that it fell to the Provider to calculate the premium payable, based on the mortality rates applicable as the Complainants grew older and in the absence of payment from the premium combined with the units available from the built-up fund, the Provider was entitled to cancel the policy with no further cover then available to the Complainants.

Although the Complainants say that the Provider failed to inform them in a timely manner that their premiums were insufficient to cover the cost of the benefits under the plan, I am satisfied that considerable information was made available to the Complainants from 2009 onwards, making clear that the built-up value in the fund would be used, in addition to the regular premium payment, in order to fund the cost of the protection benefits in "*the late, more expensive years of your plan*".

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I am also satisfied that following the commencement of CPC 2012, the Provider amended the information available to provide information in a way which was clearer than before, though the Provider acknowledges that its plan review communications could have been better again and taking account of this issue, the Provider has offered the Complainants a compensatory figure of **€3,000** by way of apology.

I note that the Complainants also say that the Provider failed to deal with the complaint in a meaningful manner. The internal complaint was raised through two phone calls with the First Complainant and the Provider, extracts of which are transcribed above. At this stage, the complaint being raised was that the Complainants had been mis-sold the policy and that they were told at the time, in 1991, that their premiums would not increase. The Provider responded to the complaint on **9 January 2020** and the response letter was six pages in length and in my opinion, provided a detailed explanation of how the policy was operating and the function of the **Plan Review Letter** sent on the **4 December 2019,** while correctly identifying that the policy had been sold by an independent broker, and so the Provider could not comment upon what was said to the Complainants at the time. I believe that this response was detailed and clear in responding to what the complaint was at the time. Once the Complainants instructed a representative, their complaints developed to include the above issues and there was further communication between the parties at that point.

Having considered the evidence available at length, I take the view that there has been no wrongdoing by the Provider concerning its administration of the policy. Although the Provider acknowledges that some of its communications could have been clearer, I am satisfied that the compensatory measure of €3,000 is adequate to address that issue and it will be a matter for the Complainants to make direct contact with the Provider if they wish to accept that compensatory gesture. Accordingly, on the basis of the evidence before me, I do not consider it appropriate to uphold this complaint.

Conclusion

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

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

MARYROSE MCGOVERN
Financial Services and Pensions Ombudsman (Acting)

6 May 2022

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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.

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.