An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0190
Sector:	Insurance
Product / Service:	Unit Linked Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a Unit Linked Life Assurance Policy that the Complainants hold with the Provider.

The Complainants' Case

The Complainants incepted a Unit Linked Life Assurance Policy with the Provider on **1 October 1988**. The Complainants previously brought a complaint to the Financial Services Ombudsman in relation to this policy, which was adjudicated upon in **April 2010**. The Complainants have life cover of **€49,566** (Forty-nine thousand, five hundred and sixty-six Euro) for the First Complainant and **€33,045** (Thirty-three thousand, and forty-five Euro) for the Second Complainant.

The Complainants state that they received a policy review letter on **1st September 2020** which sought to *"impose a 20% rate increase"* increasing their monthly premium from €159.32 (one hundred and fifty-nine Euro and thirty-two Cent) to €181.38 (one hundred and eighty-one Euro and thirty-eight Cent). The Complainants state that they had an intermediary contact the Provider on their behalf in **October 2020** querying the increase in cover and instructing the Provider to *"hold renewal terms/decision"* until their complaint before the Financial Services and Pensions Ombudsman was resolved. They state that in contravention of those instructions they were informed that the indexation on the policy was cancelled by the Provider.

The Complainants complain of *"excessive reviews"* since **2014** and that a 20% increase is not *"fair now or ever"*. They further question why their cover decreased from *"upwards of"* €90,000 (ninety thousand Euro) to the current levels and state that the policy changed to a *"lifesaver account"*. The Complainants state that they took this policy out to protect against one of them passing away and the other being *"left with half the income but the same outgoings and living expenses"* and that they *"took this policy out in good faith, trusting [the Provider]"*.

The Provider's Case

The Provider states that the policy held by the Complainants was a *"reviewable whole of life protection plan"* and that it was subject to regular premium review in line with paragraph 2 (0) of the plan's terms and conditions. The Providers states that the plan was subject to review after its first ten years, every five years after that and annually from age seventy onwards. The Provider asserts that all reviews which occurred between **2014-2020** were *"correctly conducted and communicated to [the Complainants]"*. The Provider states that the review feature of the plan relates to the fact that the *"cost of maintaining life cover increases as one gets older"*.

The Provider states that the Complainants' plan payment and benefit indexed each year until **2020** when it was cancelled following the **2020** plan review with their plan *"default to Option B"*. The Provide states that it communicated to the Complainants on **5 August 2020** that from **1 October 2020** their current payment would no longer be sufficient to maintain the plan and its benefits, and they were provided with a number of options.

The Provider states that it was made clear in this letter that if no option was chosen the plan would default to 'Option B' to prevent the plan from terminating. Under 'Option B' *"the payment on the plan remains the same, the indexation benefit is cancelled and the cover on the plan is reduced to a level that can be maintained by the existing payment until the plan becomes due for its next review"*. The Provide states that a reminder letter was sent on **1 September 2020** and when no option was chosen by the Complainants the plan defaulted to 'Option B' on **1 October 2020** and the Provider wrote to the Complainants to confirm this.

The Provider states that the indexation did not come off the account in a *"timely manner"* and the account was incorrectly charged €167, instead of €159.32. The Provider states that it received correspondence from the Complainants' independent financial intermediary about this on **7 October 2021** and the Provider corrected the error and wrote to the Complainants on **22 October 2020** to confirm the cancellation of the indexation, and credited the account €7.97 (seven Euro and ninety-seven Cent). The Provider apologises for this error, and it has offered a 'Customer Service Award' of €250 (two hundred and fifty Euro) in its formal response to this investigation, which was rejected by the Complainants.

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The Provider states that there has been no change to the product name of the Complainants' policy nor have there been any changes to the terms and conditions of the plan. The Provider states that at no point did it inform the Complainants that the **2020** review was *"on hold"*; it states that it offered the Complainants the option of *"deferring"* the review as part of its COVID-19 Pandemic support but that the Complainants *"did not avail of this"*

The Provider states that the plan the Complainants are on provides for regular reviews and that reviews will occur on an annual basis because they are over the age of seventy. The Provider states that it offered the Complainants in its **2018** review, the option of transferring up to €30,000 (thirty thousand Euro) of life cover to a 'Guaranteed Whole of Life Plan' which is not subject to review.

In relation to the premiums paid by the Complainants the Provider states that the amount paid is significantly lower than that which would be owed under the plan's original contract rates. The Provider states that it altered the payment structure as a result of the earlier complaint and that this change is highly beneficial to the Complainants. The Provider states, by way of example, that the Complainants paid €157.74 (one hundred and fifty-seven Euro and seventy-four Cent) for their cover in **June 2021** and that under the rates contained within their original terms and conditions they would have owed €306.04 (three hundred and six Euro and four Cent). The Provider states that the Complainants will continue to benefit from these *"more favourable rates"* for as long as the plan is in force.

The Complaint for Adjudication

The complaint is that the Provider maladministered the Complainants' policy during **2014-2020**.

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.

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A Preliminary Decision was issued to the parties on **27 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. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Complainants took out a '[name redacted] Account' with the Provider on **1 October 1988**. The following extracts of the original policy conditions are relevant to this complaint:

> *Paragraph 2 – DEFINITIONS*
>
> *…*
>
> *(o) The "Policy Review Date" means the tenth anniversary of the Date of Commencement of the Assurance and thereafter each fifth anniversary thereof provided always that where the Life Assured or the older of the Lives Assured has attained age 70 and the Policy shall have been in force for not less than ten years the Policy Review Date shall mean each anniversary of the Date of Commencement of the Assurance."*
>
> *…*
>
> *Paragraph 4 – AUTOMATIC INCREASE IN PREMIUMS & GUARANTEED MINIMUM DEATH BENEFIT*
>
> *On the first anniversary of the Date of Commencement of the Assurance and on each subsequent anniversary thereof the then current premium payable under the Policy shall be increased by the yearly rate of increase in the Consumer Price Index for the preceding year subject to a minimum increase of 5% per annum WHEREUPON the then current levels of Guaranteed Minimum Death Benefits and Ancillary Benefits shall automatically be increased in the same proportion without evidence of health of the Lives Assured.*
>
> *PROVIDED THAT*
>
> *(i) If the Proposers decline any such increase in Premium no further such increases will be given unless the [Provider] shall otherwise decide*
>
> *(iii) If the increase in Premium is not received by the [Provider] within the Period of Grace [as hereinafter defined] the Proposers shall be deemed to have declined the increase in Premium and the terms of proviso (i) shall apply;*

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…

*Paragraph 20 – **POLICY REVIEW***

At each Policy Review date the [Provider'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 to such level as the [Provider's] Actuary deems appropriate.

(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 Death Benefit the [Provider's} Actuary will inter alia have regard to the Accumulated Fund on the said Review Date future options and Premiums under the Policy 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 [Provider's] Actuary then the Guaranteed Minimum Death Benefit under the Policy will be reduced to the said maximum or at the option of the Proposer(s) the amount of the premium payable in future will be increased to such amount as the Company's Actuary shall determine.

(c) Review the limits and charges specified in paragraph 3, 16, and 19 and adjust any he deems necessary

AND

(d) Review the rates of premium payable for Ancillary Benefits

I note that the Complainants received annual statements from the Provider every **August**. Relevant extracts from the most recent statement are below and are largely the same as sent previously:

August 2020

"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 you plan over the long term. The attached benefit statement shows the increase in you monthly payments from €159.32 to €167.29, from 01 October 2020. This includes a government levy of 1.00%. We have set out a breakdown of your payment amount 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.

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…

Your benefits automatically increasing from 1 October 2020

	[First Named Complainant]		*[Second Named Complainant]*	
Benefit	***Current***	***Increased***	***Current***	***Increased***
Life Cover	*€52,797.00*	*€55,437.00*	*€35,199.00*	*€36,959.00*

…

Plan Review

As your plan is a reviewable protection plan this means we regularly check that the amount you pay and your fund value are enough to maintain your cover. This review is separate to any indexation increase offered on your plan. We will write to you separately about your plan review.

…

Your current cash in value at 05 August 2020

Total fund value at 5 August 2020	*€0.00*

The Complainants policy was reviewed on **2 August 2012, 2 August 2018, 2 August 2019,** and **2 August 2020**. The letters of **2018, 2019,** and **2020** are largely the same, as below:

Your protection plan needs to change – here's what you need to do

We're writing to you about your [Name] *Account. As your* [Name] *Account is a reviewable protection plan this means we regularly check that the amount you pay monthly and any fund built up on your plan is enough to maintain your cover. The cost of providing cover increases as you get older.*

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.

…

Option A – Keep the same level of cover (including indexation) and increase your payments until 1 October 2019

…

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Option B – Reduce your level of cover, cancel your indexation and keep your payments the same until 1 October 2019

With option B we will cancel your indexation which protects your benefits from inflation. We cancel this because your payments automatically increase with indexation and you want your payments to stay the same until your next review date. ….

If you don't reply to this letter, we'll automatically keep your monthly payments the same, but your level of cover will reduce as shown in Option B. This change will happen from 1 October 2018

I note that the **2018** review included the following as a third option:

Change to Guaranteed Whole of Life cover plan with no reviews

This means you can move up to a maximum of €30,000 life cover only or your current life cover amount if less than €30,000 to a new plan. With this new plan you won't need to provide any medical details and your payments will be fixed for the rest of your life.

[My underlining for emphasis]

The third option offered in the **2019** and **2020** letters differ from the above:

Change to a Life Long Insurance plan with no reviews

This means you can cancel your existing plan and move to a new guaranteed whole of life plan. With this new plan you can choose a maximum of the life cover amount shown below. This is your current life cover amount less your fund value. You won't need to provide any medical details and your plan will not be reviewed again for the rest of your life. As you have inflation protection on your current plan this will be included in this new plan until age 75. You can choose to remove inflation protection from the new plan. You can't change your benefit amount with this plan after it starts. This option only applies to life cover, you can't move other benefits into this plan.

[My underlining for emphasis]

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The **2020** review also included the following:

> ***COVID-19 Customer Support – Offer to Defer Your Plan Review for 12 Months***
>
> ***Your plan review letter shows the options normally available to you. However, due to the impacts of COVID-19, you may not be able to meet your financial adviser to discuss these, or your personal circumstances may have changed. So we are giving you an additional option – to defer your review for 12 months.***

The letter then proceeded to explain how this deferral would work and included a response form to request the deferral.

Analysis

The table below sets out the premiums paid and the level of cover for the Complainants over the relevant period:

Year	Premium	First Complainant	Second Complainant
2014	€96.43	€41,369	€27,580
2015	€191.25	€43,437	€28,959
2016	€196.31	€45,609	€30,407
2017	€111.63	€47,889	€31,927
2018	€139.35	€50,283	€33,523
2019	€159.32	€52,797	€35,199
2020	€159.32	€49,566	€33,045

I note that the policy that the Complainants incepted in **1988** 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 can support the cost of the cover. Under the policy's terms and conditions, the policy was to be reviewed ten years after inception, every five years thereafter, until one of the Complainants reached the age of seventy when the policy would be reviewed every year from then on.

Separately, the policy was also an 'indexed' policy, in that both the premium level and the death benefit, increased by at least 5% every year unless the Complainants stated that they no longer wanted it to be indexed. These policies aim to build up a fund over the early years of the policy when the policyholder is younger, and that fund subsequently supplements the premiums paid during the later years, when the cost of life cover increases.

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The cash value in this policy has been at nil for a significant time, as a result of a decision taken by the Provider to amend the charging structure from the original contract rates to what it refers to as 'term rates.' This action was taken following a previous error which was the subject of the earlier complaint in relation to this policy. I am satisfied that this change to the rates was favourable to the Complainants as they have since been paying close to half of what they would have been obliged to pay, under the original contract.

At the time when the Complainants made their earlier complaint to the Financial Services Ombudsman, the Legally Binding Finding of the Financial Services Ombudsman which issued partly substantiated their complaint and made a direction for compensation by way of uplift to the unit value of the Complainants' policy. It is important to note that this earlier Finding noted that:

> "*The Complainants will however need to make a decision as to whether to agree to an increased premium level or whether alternatively, to reduce the current level of benefit in place, in return for a lower premium than now required.*"

This earlier Legally Binding Finding of the Financial Services Ombudsman offered a commentary to the parties regarding the manner in which the policy works and the options which fell for consideration by the Complainants in terms of their ongoing cover under the policy, a feature of which is the periodic review of the premium level to be paid.

The Complainants complain of excessive reviews since **2014** and that the increases to their premiums were unfair. The first such review which occurred within the time period relevant to this complaint was in **August 2018**. The increases on the Complainants' monthly premiums from **2014** to **2018**, however, were not as a result of any policy reviews but rather they arose as a result of the policy being indexed in line with Paragraph 4 of the terms and conditions. I am satisfied that it was made clear to the Complainants that they could choose not to increase their premiums in line with the indexation by writing to the Provider, but they did not do so. Accordingly, I am not satisfied that there was any maladministration of the policy between **2014** and **2018**, as the indexation increases were in accordance with the terms and conditions, communicated to the Complainants, and they were informed that they could cancel these increases if they wished.

I note that from **2018** onwards, the policy was subject to annual reviews due to one or both of the Complainants having attained the age of seventy. I note that this is in accordance with the terms and conditions of the policy and is a result of the cost of providing more expensive cover as the Complainants get older. As set out above, I am satisfied that the monthly premiums paid by the Complainants are significantly lower than they would be under the original terms of the contract.

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I find no fault in the Provider increasing the premium every year to reflect the cost of providing cover to the Complainants, having also increased due to their getting older. The Provider did not however, inform the Complainants of the reason why their policy was now being the subject of reviews, every year. Though I accept that it was set out in the original terms and conditions of the policy, these were agreed more than thirty years ago. It has clearly caused the Complainants considerable distress for annual reviews to occur without warning. In my opinion, this could easily have been avoided, had the Provider set out clearly, in **2018**, the reason why there would now be reviews every year, instead of every five years (as had occurred previously). I am satisfied that this is important information which should have been properly conveyed to the Complainants.

I note that the Complainants have been benefiting from a significantly discounted rate for the level of cover which they enjoy, and will continue to do so for the remainder of the policy. I am also conscious that the Provider has made an option available to the Complainants since 2018 to enable them to move away from their current policy, and to elect to transfer to cover which can be incepted for them without any medical details being sought, and on the basis that the premium payment agreed will be fixed for the rest of their lives.

As the Complainants are now in their mid-seventies, this is an option which I suggest they should give significant consideration to, with the benefit of independent financial advice. I note indeed that since the preliminary decision of this Office was issued, the Complainants have indicated a desire to explore this further with the Provider, but they are looking to secure more favourable rates. I would urge the parties to continue discussing options for cover for the Complainants, as I am conscious of their ages, and it would be useful to strike a new arrangement as soon as possible, if terms can be agreed. This is a matter which the parties can address by communicating directly with each other.

In the meantime, I note the current option of a payment of €250 which the Provider has indicated remains available to the Complainants in respect of the error as a result of which the cancellation of indexation was not immediately implemented. It will be a matter for the Complainants to decide whether or not they wish to accept that compensatory measure.

Insofar as the complaint of maladministration in the period from 2014 to 2020 is concerned however, I take the view that there is no evidence of substantive wrongdoing by the Provider and in those circumstances, I do not consider it appropriate to uphold 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.

MARYROSE MCGOVERN
Financial Services and Pensions Ombudsman (Acting)

7 June 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.

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.