An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0253
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Fees & charges applied Results of policy review/failure to notify of policy reviews Premium rate increases
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a whole life policy, where the Complainant asserts the Provider amended the way in which the indexation is calculated.

The Complainant's Case

The Complainant asserts that when his whole life policy was set up with the Provider in **1996**, he was led to believe that the "*increase in the premium was at the same rate as the increase in the sum assured, for the automatic increase facility*."

The complaint further asserts that the terms and conditions of the policy state that the "*automatic increase facility is increased at 7.5% or [the UK's Weekly Average Earnings Index], whichever is the greater and throughout the entire history of the plan, still at 7.5%*."

The Complainant advises that in the Provider's scheduled review letter of **10 June 2016**, it stated that his "*next review is not until 1 June 2021."* The Complainant further advises that he fully understands the review process, as set out in the Provider's "*Regular Premium Review*" brochure, however, he contends that this is contradictory to the Provider's letter dated **11 April 2017**, which stated that it "improved" the method used to calculate premiums, for the sum assured increase.

The Complainant advises that the Provider informed him that his original contract was not amended, however, it had changed the way in which the indexation is calculated. The Complainant asserts that the Provider has denied this is an amendment, as it improves the plan for the Provider but not client. The Complainant asserts that he was "*misled by the literature"* and never expected the premium to rise above the rate of sum assured, on annual automatic increase. The Complainant also contends that the Provider did not notify him about the changes to the method used to calculate premiums and the dates on which it carried out policy reviews.

The Complainant advises that this is opposed to the review increases, which he did expect. The Complainant wants the Provider to refund his premiums and to stop the unscheduled reviews. The Complainant also states that if the Provider intends "*to change the terms and conditions of the contract I applied for and signed, it can be cancelled*".

The Provider's Case

The Provider submits that the insurance plan was distributed through independent financial advisors and in this case the Complainant was the initial adviser on the plan. The plan is a regular premium unit linked life insurance and critical illness contract. The Provider states the plan was issued in the single name of the Complainant on a single life basis or if earlier, upon admittance of a critical illness claim.

The plan commenced on **14 May 1996** with the monthly premium of £88.66 (eighty-eight pounds, sixty six pence). This sustained an initial "Accelerated Critical Illness" sum of £80,000 (eighty thousand pounds).

The Provider states that the policy was set up on a maximum cover basis, meaning the cover provided the highest amount of cover for the lowest possible premium. On a monthly basis the bulk of the monthly premium is used to meet the charges to be taken that month. As a result, there is a much lower proportion of the monthly premium to be allocated to the underlying fund, than would be the case with the standard cover basis plan. As this plan was taken out on the maximum cover basis, the Provider expected the fund value after 10 years to be zero, as shown in the illustration which was provided with the policy document. The Provider asserts that the Complainant availed of the automatic sum assured increase option. Under this option, a policyholder is entitled to automatically increase the sum assured by the greater of 7.5% or the prevailing rate of increase in the UK average earning index without medical evidence.

The plan was reviewable on the tenth anniversary and every five years thereafter, to assess whether the premium being paid at the time of the review would be enough to maintain the level of cover chosen for a further five years. The Provider states that its actuary calculated the required increase in premium for this additional cover. The Provider submits that it stated in each of its review letters addressed to the clients, when the next review would take place.

/Cont'd…

The Provider also says that details of the additional cover and premium were communicated to the Complainant by way of an annual premium and benefit statement, which was sent out "*several months prior to the increase*".

The Provider asserts that it did not need to alter the terms and conditions in respect to the Automatic Increase Facility, because the Provider was not altering anything in relation to the way it provided the option to the client on an annual basis. The option would still be offered to the client each year and the client could decide to remove the indexation altogether from the plan.

In particular, the Provider refers to a letter to the Complainant dated **11 April 2017** which enclosed an Annual Premium and Benefit Statement. This letter stated as follows:

> "*We would like to bring to your attention that we have improved the method used to calculate the premium for your sum assured increase. The calculation of your indexation premium uses the actual attributes of your Plan, excluding any build up fund. Previously a set of approximations were used to calculate the indexation premium required. This change may have resulted in the premium required for your increased sum assured being higher or lower than we previously quoted*."

It states that the Complainant had the option to decline the annual increase on a permanent basis, and on **1 September 2018** the plan lapsed due to nonpayment of premiums resulting in the life cover and critical illness cover being lost.

In an email dated **24 May 2018**, the Provider stated that the Complainant's original contract had not been amended and the automatic increase of 7.5% annually is based on the sum assured increasing by this percent and the premium increase is calculated separately.

The Provider states in this email that it had amended the way in which the indexation is calculated to ensure that the Complainant's plan was fully funded, to ensure that the value of his plan did not reduce to zero before the next review was carried out on his plan.

The email also stated that the bond was a unit linked product and so no guarantees have ever been provided in relation to the growth rate that would be achieved. The premium that is calculated on a yearly basis, along with 7.5% increase to the sum assured, is calculated to ensure that the revised premium is sufficient to cover the charges deductible on the bond monthly.

The Provider submits that the plan would accumulate debt if the value reduced to zero and it is in the customer's interest for premiums to be sustainable. The higher increases in **2017** and **2018** made it less likely that the value would fall to zero and start accumulating debt (which would then have caused a large premium increase at the next five-year review because the review premium would need to pay off the debt, in addition to covering future charges).

/Cont'd…

In his final response letter dated **7 June 2018** the Provider stated that:

> "*The application form confirmed that under the terms of the Automatic Increase Facility the Sum Assured would increase on each Plan anniversary with a corresponding increase in the level of premium payments*."

The Provider further states that the illustration which the Complainant received with the policy schedule, also stated that the premium would increase annually by the amount required to support the increase in benefits, as a result of the "*Automatic Increase Facility*". The "illustration" that was provided with the policy stated:

> "*The premium will increase annually by the amount required to support the increase in benefits as a result of the Automatic Increase Facility. This facility may be cancelled by the Planholder during the term of the plan*."

The Provider submits that premium levels are not guaranteed and in line with the product rules (Terms and Conditions) regular reviews are carried out to check the funding position. The Provider submits that the policy at page 19 stated that:

> "*The appropriate rate shall be determined as follows:*
>
> *- Where the Schedule states that the "Automatic Increase Facility - 7.5% or AEI" applies to the Policy, the appropriate rate is the greater of 7.5% and the percentage by which the published National Average Earnings Index of the United Kingdom has risen in the previous 12 month period. (To permit adequate notice of increase to be given, this 12 month period may conclude no more than 3 months prior to the effective date of the increase.)"*

The Provider also states that under the policy at page 4, "Index":

> "*shall mean the Consumer Price Index as published by the Government of Ireland or if, in the opinion of the Actuary, this index shall cease to be appropriate for the purposes of the Policy, such other index or measure as they Actuary shall decide, at his absolute discretion, not excluding for this purpose an index calculated by the actuary*."

The Provider submits that the level of premium increases each year, were calculated based on an approximation and the various factors affecting this were:

- The current premium
- the indexation rate chosen - 7.5% for this plan
- the number of years the plan is in force
- various other factors including the Product, the Benefit type, the Level of Cover, Average age (min and max) and Death basis.

/Cont'd…

The Provider further submits that these approximations were based on expected future growth rates, which were "*considerably higher than its current expectations*". The Provider advises that it changed the way it calculated the required indexation premium increase, and that the new method is based on cash flow projections, using the growth rates of the funds which the Complainant's plan is invested in. The Provider states that regular reviews are carried out to check the funding position of the plan.

The Provider said it is satisfied that the automatic increases applied to the Complainant's plan were correct and in line with the policy conditions.

The Complaint for Adjudication

The complaint is that the Provider, as from **June 2017**, wrongfully changed the method it used to calculate indexation of premiums and the dates on which it carried out policy reviews.

Jurisdictional Consideration

At the time when this complaint was made to this Office, it was noted that the policy provisions set out as follows: -

> "*Law of Policy*
>
> *The policy shall be governed by and construed in accordance with the laws of England. The contracting parties agree that the Courts of England shall have exclusive jurisdiction to settle any disputes which arise out of or in connection with the terms and conditions of the policy."*

For the purpose of this complaint investigation, both the Complainant and the Provider agreed to the investigation and adjudication of this complaint by the Financial Services and Pensions Ombudsman, pursuant to the laws of Ireland.

Whilst the parties noted that the underlying governing law of the contract would remain English law, both consented to permitting this Office to formally investigate this complaint pursuant to the laws of Ireland, and in due course to issue a legally binding decision. Both confirmed their understanding that the decision issued would be binding on both parties, subject only to a statutory appeal by either party to the High Court in Ireland, within 35 days of the said legally binding decision.

/Cont'd…

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was 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 **24 May 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 a particular paragraph within the preliminary decision of this Office created confusion, because of certain typographical errors by this Office in the figures quoted. In addition, the Provider has acknowledged an error in a small portion of its response to this Office. As these particular details are considered to have no direct bearing on the substantive issue for consideration in this complaint, they have been removed from this Decision.

I note that the relevant section of the policy document is entitled

> "**APPENDIX - AUTOMATIC INCREASE FACILITY**"

and states:

> "*If the schedule shall state that the Automatic Increase Facility applies to the Policy and subject to the provisions of the following paragraph, the Company shall, on each Renewal Date, increase all categories of Sums Assured provided by the Policy by the appropriate rate. The increase in Sums Assured shall be made without any requirement to provide evidence of continued good health or any other evidence of continued insurability.*

/Cont'd…

The appropriate rate shall be determined as follows:

- *Where the Schedule states that the "Automatic Increase Facility - 7.5% or AEI" applies to the Policy, the appropriate rate is the greater of 7.5% and the percentage by which the published National Average Earnings Index of the United Kingdom has risen in the previous 12-month period. (To permit adequate notice of increase to be given, this 12-month period may conclude no more than 3 months prior to the effective date of the increase.)*

- *Where the Schedule states that "the "Automatic Increase Facility – 5%" Applies to the policy, the appropriate rate is the 5%.*

Where no category of Sum Assured applies to the Policy, the Premium shall be increased by the appropriate rate

Following notification of a claim for Stand Alone Critical Illness Benefit or Accelerated Critical Illness Benefit, neither the Sum Assured nor the Premium shall be increased.

Following notification of a claim for Waiver of Premium Benefit, the Premium shall be increased by the appropriate rate along with the increase in the Sum Assured which the increase in Premium is sufficient (sic) *support on the basis on which the Policy was originally established.*

Where the policy has been written on a Progressive Standard Cover Basis the provisions of this Appendix shall become effective from the fifth Renewal Date of the Policy.

During the Period that the Automatic Increase Facility applies to and is effective under the Policy, an increase in the Administration Fee specified in 4.2 above shall be suspended.

The Policyholder may, at any time, elect that the automatic increase facility be withdrawn from the policy, in which case:-

(a) The amount of the Administration Fee shall be restored to the level applicable had the Automatic Increase Facility never applied to the Policy and
(b) subject to Section 7 above – Plan Review, and increases in Premium arising as a result of establishing the Policy on a Progressive Standard Basis, the Policy shall continue at the level of premium and level(s) of Sum Assured then in force.

Providing that neither a Stand Alone Critical Illness Benefit Sum Assured nor an Accelerated Critical Illness Benefit Sum assured applies to the policy, the Policyholder may elect to reinstate the Automatic Increase Facility without evidence of continued good health."

[My underlining on the preceding page, and above, for emphasis]

/Cont'd…

At section 1.2 of the policy under "***Definitions***", it states:

> ""*Review Date" shall mean the date the Actuary undertakes a review of the policy for the purposes of determining whether premiums payable under the policy and/or the units allocated to the policy are sufficient to cover future charges. The First Review Date shall be the 10th Renewal Date and thereafter each fifth Renewal Date, any date on which the Company amends any scale of charges applying to the Policy, or any other date which the Company determines appropriate for the Actuary to undertake a review*."

I note accordingly that after the tenth year, a review could happen at any of:

i. each fifth Renewal Date;
ii. any date on which the Company amended any scale of charges applying to the policy;
iii. **or** any other date which the Company determined appropriate for the actuary to undertake a review

I note that the policy definitions stated that the Renewal Date:

> "*shall mean any anniversary of the Premium Commencement Date*"

The **Plan Review** is set out at Clauses 7.1 - 7.3 and prescribes as follows: -

> *"7.1* ***Date of Review***
>
> *The Policy shall be reviewed by the Actuary on each Review Date.*
>
> *7.2* ***Reduction of Sum(s) Assured***
>
> *In undertaking his Review, the Actuary, on whatever assumption he shall determine regarding the growth (if any) of the value of Regular Premium Units and regarding the future level of charges under the Policy, shall decide whether Regular Premiums payable up to the next Review Date (or during such longer period as he may determine), together with the Regular Premium Units then allocated to the Policy, shall be sufficient to cover these charges during that period. If they shall be insufficient to cover these charges, the Sum(s) Assured provided by the Policy shall be reduced to such amounts that, on these assumptions, they shall be sufficient.*
>
> *The results of each Review shall be sent to the Policyholder as soon as practicable thereafter.*

/Cont'd…

7.3 ***Continuation of Sum(s) Assured***

If, in terms of 7.2 above, the Sum(s) Assured are to be reduced, the Policyholder shall have the option, within 3 months of the reduction, of restoring the Sum(s) Assured to the previous amount, without any evidence of continued good health or any other evidence of continued insurability, but subject to such revised Regular Premium as the Company shall determine."

It is worth noting that the provisions of the Plan Conditions which address the issue of a Policy Review, address a periodic review process which is entirely different from the very separate issue of indexation (referred to within the Policy Provisions as the "Automatic Increase Facility".

POLICY REVIEWS

In the letter of **10 June 2016**, the Provider states that "*the review indicates that your premium no longer supports your chosen level of cover until the next review date your next review date will be on 01 June 2021*". The letter also states the following:

"*The result is based on certain assumptions made for the review that we have set out in the accompanying document. These assumptions may or may not be achieved, but we believe that they are an appropriate basis on which to conduct reviews.*

The original purpose of the Plan was to provide your chosen level of cover for 10 years. We are providing options to you, based on your current review assumptions, to help you continue your level of cover until your next review date. Please note that if you choose to take action to make your Plan sustainable and these assumptions are not met, it is likely that you will need to take further action at a future review date to maintain your chosen level of cover.

Why are premiums no longer at a sufficient level to provide cover?

When you purchased your [policy name redacted] *Plan, Your premium was calculated to support your chosen level of cover for 10 years. Your plan has now been reviewed to assess whether your current premium will support your cover until your next review date, on the current review assumptions.*

When cover is taken out or reviewed, the premium depends on your age at that time. Premiums increase as your Plan ages and this review has taken this into account.

What about the future?

Future conditions may improve or decline and this will continue to affect the value of your Plan and therefore the ability of future premiums to support your chosen level of cover. To help you monitor the progress of your plan we will send you a yearly statement indicating the value of your plan.

/Cont'd…

> *In addition, we will continue to review your plan at least every five years, at which point we would write to you again, with appropriate options if required. Your next review will be on 1 June 2021"*

The letter put forward two options for the Complainant. The first was to increase the monthly regular premium to £712.52 (seven hundred and twelve pounds, fifty-two pence) or to reduce the level of the critical illness benefit to £87,727. In the event, the Complainant selected the option to reduce the cover level. The letter said that the Provider would automatically reduce the level of cover, six weeks after sending the letter, if it did not get notification of the Complainant's preferred option.

I note that similarly, 10 years earlier, the Provider had previously sent a letter in **June 2006**, where it carried out its ten-year review under the policy and, in response, the Complainant had selected the option to reduce the level of benefit amount covered.

AUTOMATIC INCREASE FACILITY (INDEXATION)

I note that in a letter of **11 April 2016**, to the Complainant, the Provider stated the following:

> "*We would like to take this opportunity to remind you of some of the important features of Your Plan:*
> *…*
>
> *Your Plan Includes the provision to help protect the value of your benefits by automatically increasing your sum assured by the greater of 7.5% and the current rate of increase in the UK Weekly Average Earnings Index each year without medical evidence*."
>
> [My underlining for emphasis]

This letter made no reference to the level of premium payable or any ensuing increase, as a result of indexation. It is this issue of indexation which has given rise to this complaint. The issue arose in 2018 when the Complainant received his annual Notification of Increase in Premium.

On **17 April 2018**, the Complainant spoke to a Provider's agent by telephone. During this conversation, the Complainant stated that the Sum Assured increased by 7.5%, but the premium had increased by more than 7.5%, and he was enquiring about the reason for this.

The Provider's agent stated that the premiums "*go up by what is required to sustain the new sum assured*" and now each policy goes up on a case-by-case basis and so the premium will be increased to cover this.

The Complainant stated that the original contract states that this increase can only be done by a review under the policy, initially after ten years, and then after five-year reviews.

/Cont'd…

The Complainant referred to the letter of **10 June 2016**, which states that:

> "*… the review indicates that your premium no longer supports your chosen level of cover until the next review date your next review date will be on 01 June 2021*"

The Complainant stated that there had been an amendment to his original contract. The Provider's agent stated that there was no amendment to the policy and referred to the Provider's letter of **11 April 2017**. The Complainant added that, although he wanted the matter investigated, he did not want it registered as a complaint. The letter of **11 April 2017** sent to the Complainant the previous year, had stated:

> "*We would like to bring to your attention that we have improved the method used to calculate the premium for your Sum Assured increase. The calculation of your indexation premium uses the actual attributes of your plan, excluding any build up fund. Previously a set of approximations were used to calculate the indexation premium required. This change may have resulted in the premium required for your increased Sum Assured being higher or lower than we previously quoted ….*"

On **26 April 2018**, the Complainant spoke again to a Provider's agent by telephone. During this conversation, the Complainant stated that the Sum Assured increase under the policy was for 7.5%, but he noticed that the premium had been going up "*by way over than that*". He also stated that he received correspondence from the Provider to the effect that the premium goes up every year, and the Complainant stated this was not in his policy. The Provider's agent stated during this call that the premium itself is not always 7.5% and is "*not always proportionate*" and "*can be more money*" to make sure the policy gets enough money to cover the cost of the cover. She also stated that this was done during the indexation.

The Complainant stated that "*all of what she just said is not in question at all*" and "*completely agree with you***".** The Complainant stated that the position which the Provider's staff member had just outlined represented an amendment to the contract, which was exactly what he was taking issue with. The Provider's agent then stated that she did not have the correct contract to hand and so advised that the Complainant email the relevant contract to the Provider, as a scanned copy, so it could deal with the matter.

I note that on **30 May 2018**, the Complainant spoke to a Provider's agent by telephone. During this conversation, the Complainant stated again that his contract had been amended and that under the policy conditions, the appropriate rate for the premium increase is the same as the sum assured increase, therefore, if it is 7.5% increase in the sum assured, then the premium increase should be for this amount. He further stated that the Provider had now changed the terms of the policy, so that a premium increase by review took place "*every year, after the ten-year review was done*". During this call, the Provider's agent stated that she would transfer the call to the complaints department. The Complainant also stated that there was an urgency, as there would be an increase in premium due to be applied shortly.

/Cont'd…

Analysis

The issue raised by the Complainant is the fact that the indexation increase, of 7.5% to the amount assured, has not been matched by an equivalent premium increase of 7.5% and rather, the premium increase has grown by more than 7.5% in order to support the 7.5% indexed increase in the sum assured.

The Complainant has expressed the very firm view that the Provider was not entitled to increase the premium over and above the 7.5% agreed for indexation, without undertaking a formal policy review in accordance with the provisions of Clauses 7.1 – 7.3 pf the policy. I note that within the Provider's Final Response Letter which it issued to the Complainant on 7 June 2018, the Provider referenced the Complainant's application for the policy in **May 1996** and advised, amongst other things, that: -

> "*The application form confirmed that under the terms of the Automatic Increase Facility, the Sum Assured would increase on each plan anniversary with a corresponding increase in the level of premium payments.*
>
> *The illustration which you would have received with the policy schedules also confirms that the premium will increase annually by the amount required to support the increase in benefits as a result of the Automatic Increase Facility.*
> *…*
>
> *The policy conditions booklet confirms that under the Automatic Increase Facility on each renewal date we will increase all categories of Sums Assured by the appropriate rate; they do not confirm that the premium will increase by the same rate. A copy of the policy conditions is enclosed for your reference.*
>
> *You can choose to remove the indexation option from your plan…"*

I note indeed that the policy "***Key Features***" four-page document, included in the evidence made available to this Office, includes a page of "***Your questions answered***" including the following information: -

> "*Will My Benefits Always Be The Same?*
>
> *Included in your plan is the Automatic Increase Facility under which benefits and premiums are increased without medical evidence each year…*
> *Premiums will rise by an amount sufficient to sustain the cover on the basis on which your plan was established*
> *Each year you will be offered the right to forego that year's increase…"*

I am conscious that within the policy provisions there is no suggestion that at the time of the sum insured increasing by 7.5% (or by 5% if that was the rate selected) the premium would be increased "*by an amount sufficient to sustain the cover*". Rather, the policy provisions themselves, which address the Automatic Increase Facility (set out at Page 19 of the policy) refer only to increases in the premium "*by the appropriate rate*".

/Cont'd…

In circumstances where "*the appropriate rate*" refers to the 7.5% or the 5% selected, one can well understand why the Complainant took the view that, in the event of the Sum Assured increasing by the amount of 7.5%, the premium increase to support this, would be the same percentage.

Certainly, in my opinion, the policy provisions under the heading "***Appendix – Automatic Increase Facility***" create that very impression and I accept the Complainant's position in that regard.

The provisions within the policy which give discretion to the Actuary regarding the premium to be calculated, are those provisions which address the "*Plan Review*" under Clauses 7.1 – 7.3. No similar discretion is notable from the policy provisions governing the Automatic Increase Facility.

I note that following the application by the Complainant for cover, a policy "*illustration*" referred to by the Provider, was issued dated **27 March 1996**, many weeks before the policy came to be issued on **14 May 1996**. I note in that regard that included with the details under the heading "***HOW MUCH WOULD IT COST?",*** the Provider confirmed the initial Annual Premium, the initial Sum Assured, the Life Assured Basis and the cover type, together with the following information: -

"

- *The premium is payable until throughout life or until diagnosis of a critical illness.*
- *The above premium provides the following benefits:*
  - *Life Assurance*
  - *Critical Illness*
- *The premium will increase annually by the amount required to support the increase in benefits as a result of the Automatic Increase Facility. This facility may be cancelled by the Planholder during the term of the plan.*

…."

I accept that this "*illustration*" made available to the Complainant at the time when he was considering his proposal for the cover in question, made clear that the premium would increase annually by "*the amount required"* to support the increase in benefits as a result of the Automatic Increase Facility. One can well understand however, how, in circumstances where a policyholder was entitled to elect between an Increase Facility of 5% or 7.5%, the "*amount required*" would be understood to refer to that percentage itself.

It is disappointing that the policy provisions did not in fact call out any entitlement by the Provider to support an annual indexation of 7.5% to the Sum Assured, by increasing the premium by a percentage which could be less or more than the percentage in question, if that is what the intention was.

/Cont'd…

In those circumstances, I accept that the Complainant raised a very valid argument regarding the Provider's entitlement, at the time of indexation, to increase the premium beyond the percentage of 7.5%, in the absence of an express entitlement by the Provider to do so, pursuant to the Terms and Conditions of the contract which had been agreed (other than in the context of a plan review) given indeed that the "*illustration*" did not form part of the contract.

I am conscious that the revision of the premium to be paid in the context of indexation could have ultimately benefitted a policyholder such as the Complainant, by spreading the increase in the cost, over the period leading up to the next formal plan review, but I take the view that in the context of the actual policy provisions, the Provider was not entitled to apply a premium increase other than at "*the appropriate rate*".

It is important to bear in mind that this policy was entered into by the parties in **1996,** approximately 26 years ago, and the regulatory environment at that time was very different from the current environment in which financial service providers are required to make information available. In the context however of the particular policy provisions agreed between the parties, in my opinion the Provider's action in applying a premium increase at a level which went beyond the indexation increase of 7.5% was unfair to the Complainant and was unreasonable within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

I note that since this complaint was made, the policy has in fact been terminated, and therefore there is no life cover in place any longer, pursuant to this policy. I am also conscious that, in 2018, when this issue was raised by the Complainant, arising from his dissatisfaction with the increase in the premium, it was open to him to simply decline indexation at that time, pending the outcome of the investigation of his complaint by this Office.

Accordingly, whilst I accept the Complainant's contention that the Provider sought to increase the policy premium by a figure which was not permitted by the policy provisions in the absence of a policy review, I take the view that in marking that finding, it is appropriate to recognise that the parties are no longer contractually bound to each other.

I note that when the indexation of 7.5% was applied in **June 2017**, a premium increase of 7.5% would have amounted to approximately **£33.50** per month. In fact, however, the monthly premium increased by **£58.69** representing an extra increase of almost double what it ought to have been, which the Complainant is unlikely to have been expecting.

Thereafter, in 2018, in the context of the Complainant's grievance, I note that only three premiums were paid before the policy was terminated in **August 2018**. In all those circumstances, I take the view that it will be appropriate to mark my decision in this matter, by directing the Provider to make a compensatory payment to the Complainant, as specified below. I also recommend to the Provider that it re-consider its approach to the calculation of premium in the context of the provisions of the indexation provisions of the policy, to avoid the type of issue which has given rise to this complaint.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld, on the grounds prescribed in ***Section 60(2)(b).***

- Pursuant to ***Section 60(4)(d) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider make a compensatory payment to the Complainant in the sum of **£750 (seven hundred and fifty pounds Sterling)** to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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)

29 July 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.

/Cont'd…

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.