An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0268
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Mis-selling Delayed or inadequate communication Fees & charges applied Failure to provide product/service information Results of policy review/failure to notify of policy reviews Premium rate increases
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint concerns a "***Living insurance Plan***" life insurance and investment policy, ("the policy") which the Complainants have with the Provider.

The Complainants' Case

The policy commenced on **1 May 1989**, initially with Provider A, which became Provider B, and which in turn was subsequently acquired by the respondent Provider in **1999.** A representative was formally authorised on behalf of the Complainants in **August 2018.**

The complaint was initially referred to this Office in **July 2019**. The complaint was the subject of a jurisdictional assessment, and it was determined that the following two elements of the complaint made, could progress to investigation. The conduct complained of is that the Provider failed to comply with the policy terms and conditions in that it:

A. wrongfully continued to collect premiums after the 25-year policy term had ended in **2014**
B. wrongfully applied fees and charges from **2002** to **2019.**

The Complainants summarised their complaint as follows:

> "*on reviewing the Policy and its over inflation price rises we became aware that … [w]e had believed that the policy was for 25 years but discovered we had now been paying premiums for 30+ years…That the charges (we believe there are three different ones) were never explained fully to us and that these charges have been used to divert premiums away from the investment fund overtime to a disproportionate degree*".

The Complainants state that they incepted this policy in **1989**. It was taken out to provide life cover, but they submit that they believed there to be a savings element to the policy also.

The first element of the complaint relates to a funding period. The Complainants submit that they believed there to be a fixed funding period of 25 years, meaning that premiums would cease in **2014**. In a communication with the Provider dated **30 April 2019**, the Complainants submit they believed that the policy was sold on a fixed funding term basis of 25 years, and they estimated therefore that the funding term should have ended on 1 **May 2014**.

It is the Complainants' contention that the fixed funding period of 25 years is "*clearly stated"* in the revised first schedule relevant to the policy, dated **14 November 1994** and paragraph 8 of the policy's second schedule.

The second element of the complaint is that the Provider wrongfully applied fees and charges in the period from **2002** to **2019.** The Complainants contend that the three different charges were never fully explained to them and that the charges have been used, to divert premiums away from the investment fund over time, to a disproportionate degree. The Complainants submit that the charges have resulted in the investment element of the policy being valued at "*a paltry*" **€500** (five hundred euro) after 30 years.

In a letter dated **30 April 2019**, the Complainants further set out that they were seeking clarification regarding the difference between a policy charge and a management fee. The Complainants also contend that the Provider's letter dated **24 September 2018**:

> "*omits the management fee cost p.a. It also admits the remaining part of the premium which remains to be invested in the 'CAPP' at which would be used to buy units in the fund. This again would be helpful if you could provide."*

In this letter, the representative also states that it is regrettable that the policy document supplied by the Provider, does not contain a copy of Schedule One. The representative also sought details of the ten-year policy review.

The representative enclosed a revised first schedule dated **14 November 1994** which they say demonstrates that the funding term is for 25 years, from the date of commencement on **1 May 1989**.

The Complainants also assert that:

> "*the insurer has carte blanche ability to increase premiums to whatever they wish which results in a higher dropout rate of those prepared to pay the increasing monthly premiums therefore reducing the number of final payments made on such policies and could perhaps be classed as a money making racket*."

/Cont'd…

The Complainants contend that there are two possible resolutions to the complaints:

1. They would accept a cessation of premiums with life cover elements remaining in place and refund of monies paid after the 25 years of the term of the policy expired on 1 May 2014; or
2. The Complainants' policy be deemed null and void, in light of the Provider's conduct and that all premiums paid plus interest, be returned to the policyholders.

The Provider's Case

In a letter issued by the Provider dated **24 September 2018**, the Provider references a telephone call where it is understood that this query was initially raised. The Provider outlines the policy operation as follows:

> "*When a premium is paid, 100% of this is credited to the Policy's Investment Account. The cost of production benefits together with the management charges and policy fee, are then deducted from the policy Investment Account each month. When the cost of the sums insured together with the policy charges is less than the premium being paid, the balance of the premium remains in the Investment Account to enable the policy to accrue value*".

The letter further outlines the fee structure as follows:

> *"[The Provider's] investment expenses relating to fund management are recouped by means of 0.75% per annum management charge to Initial Units and Accumulator Units. [The Provider] recover the initial expenses and charges involved in setting up a new Policy by investing the first two years premiums (together with the first two years of any subsequent increase in premium) in the Initial Units and these bear an additional management charge of 4.00% per annum, over the funding term of the Policy. The funding term on this policy is 25 years as noted on the First Schedule*."

The Complainant submits that there is no specified fixed term in the policy document and, rather, there is a "*funding term*" of 25 years which relates to the period during which the Provider deducts a higher management charge.

The Provider states that the revised first schedule of the policy document clearly states that premiums are payable for life "*during the lifetime of the last survivor of the Lives insured*". The Provider asserts that the funding term is set out at part 8 of the second schedule of the policy document. In this letter, the Provider further states that, following the cessation of the fixed funding period, the investment is subject only to a management charge of 0.75%. The letter also states that the Complainant's third-party representative advised during a previous phone conversation that the Complainants were provided with illustrative values at the policy inception. The Provider stated that it did not have a copy of these illustrative values on file, but that illustrative values are not guaranteed and are based on specific criteria such as a specific dividend return, a specific level of premium and a specific level of cover.

/Cont'd…

After the Complainants sent a letter querying the **24 September 2018** Provider's letter, the Provider sent a Final Response Letter on **31 May 2019** stating that the management charges levied within the fund, are reflected in the unit price and this is not a monetary amount and therefore it is unable to provide the correct charges relating to the policy for the management fee.

The letter also made reference to the review of the policy. The Provider says that the review was expected to be carried out at the 10-year anniversary of the policy in **1999**, however, due to a change in computer systems the review did not take place until **2004**.

The Provider states that the purpose of a policy review is to ensure that the policy can continue to provide life cover at a certain level, until such time as a policyholder cancels the policy or a claim is made against it. As a policyholder gets older, the cost of cover increases, therefore in order to continue the policy with the same level of cover, the premium must also increase. It states that this age-related increase in the cost of insurance cover, is an inherent factor of life cover benefit, and is not a penalty being applied by the Provider.

It states the following regarding the annual policy review:

> *"… the total premium payable on the policy is recalculated by the Company's Appointed Actuary taking into account the life cover, the value of the investment account, if any, the ages of the lives insured and an assumed future rate of return. The total premium payable is recalculated by taking the following steps:*
>
> *Firstly we look at the current premium together with the investment element of the policy, if any, and then calculate how long, such level of premium will maintain the current protection benefits (i.e. number of years). (We refer to this length of time as the 'cover term').*
>
> *Next we calculate the premium required to extend this cover by one year or to a maximum of three.*
>
> *A client may decide not to accept the increased premium following a review. However, if declined, the length of time (i.e. number of years) that the protection benefits can be maintained will be reduced and, in some cases, this necessitates a reduction in the level of benefits."*

In respect of the first schedule, this letter from the Provider states that a copy was not held on file and that the first schedule provided by the Complainant's third-party representative, appears to have been provided following the partial encashment in **November 1994**, and that a copy of this revised Schedule was not held on file.

The Provider states that annual statements have been issued every year since **2012** in accordance with the Consumer Protection Code 2012 (CPC 2012) and every statement since **2014,** has set out the positive charges and premiums paid over the previous year. It submits that the statements make clear that the cost of benefits, exceeded the premiums paid.

/Cont'd…

The Complaint for Adjudication

The first element of the complaint is that the Provider wrongfully continued to collect premiums on this life assurance and investment Policy, after the *"25-year period"* ended in **2014**.

The second element of the complaint is that the Provider wrongfully applied fees and charges to the life assurance and investment Policy in the period from **2002** to **2019**.

Decision

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

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

A Preliminary Decision was issued to the parties on **13 July 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 policy was incepted on **12 April 1989** to commence on **1 May 1989** and the capital sum payable on death for the First Complainant was £50,000, and £30,000 for the Second Complainant. The total monthly premium was £25.93 from **1 May 1989**.

In **November 1994**, I note correspondence which concerned the Complainants seeking a part encashment from the policy. In a letter dated **7 November 1994** the insurer stated that it required the policy document from the Complainants and that if the document had been lost or mislaid, that a lost policy declaration form would need to be completed.

/Cont'd…

Although there is no evidence that such a lost policy declaration form was signed in 1994, it seems that subsequently, another such document was signed and dated **13 December 2000** by the Complainants. This was following a similar part encashment application, when the insurer stated that the first schedule of the policy documentation provided by the Complainants, was missing. This indicates that the Complainants were unable to locate the first schedule to the **1989** policy document, and that accordingly, they followed what is the industry standard practice in such circumstances, of completing a lost policy declaration, so that the encashment could progress.

The Complainants have since provided a revised first schedule to the Provider on **2 May 2019**. The schedule had a date of issue of **14 November 1994,** and which appears to have been completed by the insurer following the previous partial encashment in **1994.** This revised first schedule states as follows:

"

First Life Sum Insured	**£53608**
Second Life Sum Insured	**£32400**
Date of Commencement	**1/05/89**
Premium Due	**£25.93**
Payable	**Monthly by Direct Debit from the last anniversary date and during the lifetime of the last survivor of the Lives Insured.**
Policy Fee	**£2.09**
Funding Term	**25 years from date of Commencement**

"

In the absence of the original first schedule as agreed in **1989,** I am satisfied that this revised first schedule properly reflects the funding term of 25 years, a fact that does not seem to be in dispute between the parties.

I note that in **November 2016**, the second Complainant wrote to the Provider, stating that the Complainants could not afford anymore increases in the monthly payments on their policy. She stated that they had been paying since **1989** and asked was there any way she could rescind, surrender or sell the policy and just take out a policy that would cover her "*death*" payments.

I note that the Provider responded stating that the Complainants would require to pay premium increases in **2017,** in order to maintain the then current benefits under the policy. Because the Provider advised that the benefits would remain the same until **2017,** without premium increase, the second Complainant elected to decline the increase in premium, until 2017.

/Cont'd…

The second schedule of the policy document states that the policy account consists of two parts, a Contributions Against Premium Payments (CAPP) account and a Unit account. At paragraph 8 of the second schedule, it clearly states:

> "*The Company shall debit the CAPP Account, with the Regular Management Charge calculated at the rate of three quarters percent per annum. <u>For a period equal to the Funding Term of 25 years (or such other Funding Term specified in the First Schedule), the Company shall each year debit the Initial Part of the CAPP Account with a further Regular Management Charge of four percent per annum</u>. for this purpose, the Initial Part of the CAPP Accounts shall be that part which is attributable to the first two years CAPP Premiums together with CAPP portion of the first two years of any increase in premiums under the Fifth Schedule together with the dividends added thereto.*
>
> *On the effective date of any increase in premium the Company shall also debit the Initial Part of the investment account with the charge calculated at 4% of the increase multiplied by the number of years since the date of commencement or by the Funding Term if less"*
>
> [my underlining added for emphasis]

In its final response letter dated **24 September 2018**, the Provider stated that:

> "*Based on the policy funding term of 25 years the policy holds units in Initial units for the first 25 years of the policy. After that, all holdings in the initial units are transferred to Accumulator units and pay lower management charge as described above. As the policy commenced on 01/05/1989 this 25 years ceased at 01/05/2014. At that time, all holdings in the Initial units were transferred to Accumulator units and the policy is now subject to the lower management charge of 0.75% only."*

The fifth schedule of the policy document also covers increase in premium, which states:

> "*The Total Premium shall be increased in the same proportion as any increase in the Sum(s) Insured under this Schedule. However, the Company may, at its discretion, increase the Total Premium by a greater amount to be calculated by the Actuary on the basis of applying to the increase in Sum(s) Insured the rate of premium which in his opinion is appropriate to a new policy, having regard to the age of the Life or Lives Insured at the anniversary date and the ratio between Sum(s) insured and Total Premium under the policy immediately prior to the said increase*."

In this regard, the Provider has submitted letters that it sent annually to the Complainants since **2004,** setting out the total premium and also the premium increase required to maintain the level of protection under the policy. I am also satisfied that the Provider has complied with Provisions 4.1 and 4.2 of the Consumer Protection Code 2012 (CPC 2012) in that it issued annual statements to the Complainants since 2014, which included details of the premiums paid, the policy charges and the value of the fund. For example, the letter dated **19 April 2015**, expressly outlined the cost of the policy charges, the current premium and current value of the fund, as of **April 2015**.

/Cont'd…

The Provider has also submitted a schedule of the cost of cover for the policy, which includes the policy fee and management charges.

Accordingly, I am satisfied that the Provider is entitled to apply fees for expenses relating to fund management, which are recovered by means of 0.75% per annum management charge to Initial Units and Accumulator Units. Under the second schedule, the Provider is entitled to debit the Initial Part of the CAPP Account with a further "*Regular Management Charge"* of four percent per annum. This policy provision is not, as recently suggested by the Complainants, "*a flimsy reference to the period of costs*". Rather it is a central provisions of the contractual arrangements which were agreed between the parties many years ago.

After the 25 years have elapsed, the management fee reduces to 0.75%. Therefore, on the basis of the evidence available, I am satisfied that the 25 years refers to the period during which the higher management charges are deducted, and I do not accept the Complainants' argument that the end of the 25-year period, was the endpoint for the premiums to be paid.

I note from the revised first schedule, that the premium will be payable "*monthly by Direct Debit from the last anniversary date and during the lifetime of the last survivor of the Lives Insured*". Therefore, I am satisfied that the premium remains payable even after the 25 years of the funding term has expired.

The Complainants have indicated their disappointment that the preliminary decision of this Office did not:

> *"advise/instruct insurers to be very clear on this point going forward to ensure the public are made very aware of what they are being sold. In our view a very unfair policy."*

It is worth noting in that regard, that without any comment of that nature from this Office, the regulatory obligations on insurers are now vastly more substantial, than they were in 1989, or in the early 1990s, long before the Central Bank of Ireland as the regulator, implemented regulatory codes to be complied with by relevant financial service providers. This Office expects every financial service provider to comply with such regulatory obligations, but such obligations do not apply retrospectively.

Whilst the Complainants have, since the preliminary decision of this Office, again raised the issue of mis-selling of the policy at the time when this cover was sold, as previously explained to the Complainants it is only the conduct of a financial service provider after 1 January 2022, which falls within the jurisdiction of this office, owing to the provisions of ***s51*** of the ***Financial Services and Pensions Ombudsman Act 2017***.

Accordingly, based on the evidence available, I do not consider that it would be reasonable to uphold either element of the Complainants' complaint against the Provider.

/Cont'd…

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)

16 August 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.