An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0152
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Results of policy review/failure to notify of policy reviews
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a joint life insurance policy taken out by the Complainants on **28 February 1992** with an initial provider. The initial provider was subsequently acquired by the Provider about which this complaint is made.

The complaint is that the Provider did not correctly administer the policy, particularly in relation to the review process of the policy and this resulted in a substantial increase in the premium payments, to come into effect on **28 February 2017**.

The Complainants' Case

The Complainants state that they took out a joint life policy on **28 February 1992** and that this policy was subject to a premium review on the tenth anniversary of the inception of the policy and every fifth anniversary thereafter, until the fifth anniversary preceding the older of the Complainants' 60th birthday, when reviews would then occur yearly.

The Complainants chose a voluntary inflation protection option as part of their policy. This voluntary option protected the benefits from the effects of inflation over the long term and increased the Complainants' premium by 5 percent per annum. This inflation protection option was in place until **11 July 2012** when the Complainants cancelled it.

Reviews of the policy took place as scheduled in **2002** and **2007**. The Complainants submit that the Provider conducted a scheduled review in **March 2012** also. The Complainants have furnished a letter dated **18 January 2012** from the Provider, which advises that the inflation protection option on the plan will increase the Complainants' premiums by 5% from 29 **February 2012**.

The Complainants say that on **2 February 2016** the Provider wrote to them indicating that the monthly premium paid by the Complainants in respect of their life insurance policy was anticipated to increase from a payment of €87.15 per month to a payment of €405.63 per month, with the increase in premium payment to come into effect on **28 February 2017**. The Provider advised the Complainants of two options available to them at this stage. One option was to increase the monthly premium to €405.63 per month and the other was to maintain their premium payment at the existing level and correspondingly reduce their policy coverage from €206,821 on each life to €55,731.00. On **8 November 2016** an option to apply to switch to an alternative plan with the Provider was also given to the Complainants and details of two such plans were provided by the Provider to the Complainants.

The Complainants claim that this rise in the price of their premium was exorbitant (amounting to a price increase of almost 465%) and would mean that they are not in a position to continue maintaining the life insurance policy.

The Complainants state that they would like the policy cover and the premium to stay at the level it is at. The Complainants state that they have been loyal customers with the Provider and the previous provider of the policy since 1992 and that they cannot afford to pay the increased premium price which the Provider wants them to pay in order to maintain their existing cover.

The Complainants furnished an additional statement to this Office on **26 June 2017** which states that they currently have no life insurance policy as a result of being priced out of their premium payments with the Provider and this has caused an immense amount of upset to them. They have described this experience as an unexpected and defeating blow.

The Complainants confirm that they were offered €250 from the Provider as an apology for the inconvenience caused which they did not accept on principle.

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

The Provider says that it is important to understand the workings of the policy held by the Complainant. The Provider states the Complainant's policy is a unit linked protection plan designed to provide increased flexibility to customers, particularly in relation to the ability to vary the level of protection benefits on their plan. Each time a payment is received on the plan, the Provider purchases units in a fund. The cost of providing benefits and maintaining the plan is then debited from the fund.

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The Provider submits that the monthly payments made by the Complainants are not designed to solely cover the cost of providing benefits. The payment is used to purchase units in a fund which are then surrendered to cover the costs of providing the benefits, in accordance with the terms and conditions of the plan.

The Provider says that the cost of the insurance increases with age, so in the early years the monthly payment exceeds the cost of the benefits and the fund value builds up. In the later years the cost exceeds the payment, and more units are being surrendered from the fund than are being purchased by the monthly payment.

The aim with the monthly payment as set at the commencement of the plan is that it is estimated to remain static for as long as possible, while the cost of maintaining the benefits is deducted from the fund. It is estimated at the outset how long the payment can remain at its initial level without an increase being required, while reviews are still carried out in accordance with the terms and conditions of the plan.

Paragraph 15 of the Complainants' terms and conditions provide for their plan to be reviewed on its tenth anniversary and thereafter every 5 years (and when the older of the Complainants reaches age 60 the reviews will be carried out on an annual basis). As the plan started in **1992**, the first review due on the plan was in **2002**, then every five years in **2007**, **2012**, **2017** etc., until the older of the Complainants reaches the age of 60.

The plan was reviewed on **20 May 2002** and the Complainants were advised that the current payment at that time was estimated to maintain the cover on their plan until its next review date, assuming a 5% net growth of the fund.

In **2004** the Complainants contacted the Provider to enquire how long it was estimated that their current payments at that time would maintain the benefits on their plan, as well as enquiring as to how much of a payment was needed if they increased their cover to €190,000. The Provider wrote to the Complainants on **23 July 2004** advising that their current payment was estimated to maintain their cover for the next five years based on 5% growth rate. The Provider also advised that should the Complainants wish to increase their cover to €190,000 the estimated payment per month would be €81.13 per month.

The Complainants plan was reviewed again on **24 September 2007** and the Provider advised that the plan had passed its review and it estimated that the Complainants' payments were sufficient to maintain their cover until the next review date in **March 2012**.

The Provider notes that the plan was due to be reviewed in **2012**. In a letter from the Provider to this office dated **27 April 2018** the Provider notes that it has no record of the scheduled review being conducted in 2012 and therefore must assume that this review was missed.

As a result of the missed review, the Provider states that it was surrendering more units from the Complainants' fund that it could purchase. The Provider states that if it had reviewed the plan in **2012** the Complainants would have had the option of either increasing their payments or reducing their benefits at that time, however as this was not done, the

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unit holding on the Complainants' plan was impacted. As this was an error on the part of the Provider it amended the unit holding by adding €4,840.34 to the plan on **31 December 2015** and a further addition of **€212.83** on **19 January 2016** to ensure that the missed review in **2012** did not affect the Complainants' plan and the payment that was required when the plan was reviewed in **2017**.

The Provider also agreed to maintain the Complainants' current monthly payment and current life cover until the next review on **28 February 2017** and agreed to cover the shortfall of providing the cover until that date.

The Provider notified the Complainants by letter dated **2 February 2016** that the monthly payments in respect of the plan were to increase to €405.63 from **28 February 2017**. In this notification letter**,** the Provider apologised for the oversight in missing the scheduled review of the plan in 2012 and offered the Complainants €250 for the inconvenience caused.

The Provider refers to the 5% indexation option that the Complainants added to their plan at commencement and says this was a voluntary option which was utilised to protect the benefits from the effects of inflation over the long term and is different from the Plan Review, which looks at the present value of the fund and the cost of maintaining same.

The Provider says that while it understands that no customer welcomes the need for either an increase in their premium payments or a decrease in their protection benefits, it is satisfied that the changes that are needed to cover the rising cost of providing benefits to the Complainants are a fair reflection of the increased risk borne by the Provider to provide the Complainants with their benefits.

The Complaints for Adjudication

The primary complaint for adjudication is that the Provider incorrectly conducted the review process of the policy, in that a review scheduled review was not conducted in 2012 although this was not communicated to the Complainant's and a further review was conducted in February 2016, resulting in a substantial increase to the Complainant's premium, from €87.15 monthly to €405.63 a month, which they complain is exorbitant.

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.

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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 9 April 2019, 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 submissions from the parties, I set out below my final determination.

A policy review gives the Provider an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, a policy review should give the Provider the information to provide the Complainants with an up to date picture of the level of cover chosen and provide an indication as to how long the premium and policy fund is likely to sustain that cover. Such reviews are important as they allow the Provider to discuss with the Complainants what, if any, action needs to be taken. This is highly important for the Complainants and policyholders in general.

The Provider indicates that it did not carry out the contractually required review in **2012**. I note that while the Complainant's indicate that the policy was reviewed in 2012, the letter dated **18 January 2012** from the Provider to the Complainants states that the 5% increase to be applied from **29 February 2012** was due to the inflation protection option which was chosen as part of the Complainants' policy, it does not indicate that this increase arises from a scheduled review. By not undertaking the review of the policy over this period, the Complainants were denied an opportunity to decide what action they wished to take regarding the policy. It could, for example, be the case that:

(i) The Complainants may have wished to exit the policy, after discovering how the policy was to operate in the future. It is one thing to set out in the policy document how something is going to be done, but not knowing the full implications, including the financial implications of a review process is another matter.

(ii) The Complainants may also have wished to take the fund value that was available at the relevant **2012** review date. This opportunity has been lost due to the lack of communication from the Provider, in a timely manner, of the missed review.

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The consequence of the Complainants not having their plan reviewed when it should be reviewed means the loss to them of an early insight into the operation and effect of such a review on their policy. In this complaint, I find that the Provider should have reviewed the policy at the appropriate and contractual review date in **2012** and also should have communicated the failure to carry out the scheduled review earlier than it did. It was not until 4 years after the missed **2012** review that the Complainants became aware that the review had been missed.

While I accept that the value of the fund could rise or fall and it was not a guaranteed value, I do consider it reasonable that a Provider communicates at the earliest opportunity, typically at the review stage, that the premium being paid is no longer sufficient on its own to cover the cost of providing the policy benefits.

I believe that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is for the purpose of life insurance.

The evidence shows that the Provider missed a review of the policy in **2012**, failed to communicate for a period of 4 years that this review had been missed and failed to correctly communicate that the premium being paid was not sufficient on its own to support the cost of the policy benefits (the fund was supplementing the cost of cover in addition to the Provider making up the shortfall).

I accept that the documentation sent to the Complainants in respect of their policy did not set any expectation that the protection benefits and premium would remain at the same level throughout the lifetime of the policy.

Having reviewed the express wording of the policy terms and conditions, I accept that the Complainants were on notice from the time of the commencement of the policy that the policy was to be reviewed on its tenth anniversary and thereafter every 5 years (and in the situation where the older of the Complainants reached age 60, on an annual basis) and that the Provider could assess if the level of cover could be maintained at the existing premium until the next scheduled review or whether it was necessary to increase the premium to maintain the level of benefit.

With regard to the provision of information to a consumer, the Consumer Protection Codes state that a regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key terms are all brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information. I find that there was a continuing failure by the Provider from **2012** up to **2 February 2016** to correctly inform the Complainants about how the policy had been administered relative to the review provided for in the policy document and to follow up over those years with regard to the level of cover the Complainants wished to have in place.

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While I find, as outlined above, that there were lapses by the Provider in regard to the administration of this policy, I do not find that these lapses warrant a direction for the Provider to maintain the benefits as they were and at their existing lower cost. Overall, I find that the issues here are ones requiring better administration and greater and better communication from the Provider for the identified lapses. Therefore, I find that a substantial compensatory payment is merited in this complaint. This compensatory payment is to be in addition to the Provider's concessionary measures.

The concessionary measure applied by the Provider for its errors was to amend the unit holdings by adding units to the value of €4,840.34 on **31 December 2015** and a further addition of €212.83 on **19 January 2016**. The Provider also agreed to maintain the current payment and current cover for the Complainants until **28 February 2017**. The Provider also agreed not to seek to recover any previous shortfall. The Provider states that the total write off of charges amounted to €6,566.48 since **2012**.

I note that the Complainants have informed this Office in their letter of **26 June 2017** that they currently do not have life insurance cover a result of being priced out of their premium payments with the Provider. I accept that this has caused an immense amount of upset to them. I also note that the Complainants state that they are now suffering from a number of health issues which were not in existence at the inception of their policy with the Provider. While the Provider has advised the Complainants of alternative policies that it has available, I note that they have not yet decided what to do regarding alternative life cover. In this regard, it is reasonable to expect that finding a new policy of insurance at a rate which is affordable for the Complainants could prove difficult for them, given that any new policy would take into account the Complainants ages and any existing health issues.

I do not believe that the €250 offered to the Complainants as an apology was sufficient compensation and I note that the Complainants declined to accept this offer.

Having regard to the particular circumstances of this complaint, in particular the failings on the part of the Provider that have been noted above, I partially uphold this complaint and direct the Provider to make a compensatory payment of €15,000 (fifteen thousand euro) to the Complainants.

Conclusion

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

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €15,000 (fifteen thousand euro), to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider.

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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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

8 May 2019

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.