DRN-4127104

The complaint

Mr D complains about a reviewable whole of life (RWOL) policy he holds with Phoenix Life CA Limited t/a Sun Life Financial of Canada (SLFOC). He's unhappy with the outcome of a policy review held in 2020 which said that changes needed to be made to either the policy's premiums or sum assured and thinks the policy was mis-sold to him.

What happened

Mr D took out the policy in 1985 for the purpose of providing protection for his family. It had a sum assured of £60,000 for monthly premiums of £20.40. It was reviewable after the first ten years and then every five years thereafter until Mr D reached the age of 65 when reviews would be held annually.

The policy passed all its reviews until 2015 when it failed, and the sum assured was reduced to £57,000. It then failed the 2020 review and SLFOC wrote to Mr D and said that if he wanted to maintain the sum assured, he'd have to increase his monthly premiums to £124.14 or the sum assured would fall to £11,400.

Mr D complained to SLFOC and said, in summary, that he was unhappy with the outcome of the review. He felt it was contrary to what he was told when he took the policy out and therefore thought it had been mis-sold.

SLFOC looked into his concerns but didn't uphold the complaint. They noted that at the time of the sale there was no requirement to record discussions about alternative products, so they were unable to substantiate any claims regarding the advantages of taking out a different product. However, they thought that the policy was appropriate for Mr D and therefore didn't think their advisor had failed in his duties.

Mr D didn't accept their findings and asked for our help. The complaint was considered by one of our investigators who didn't think it should be upheld. The investigator explained that there was limited evidence available from the time of the sale, but in his opinion, the sale met the requirements of the regulations that applied at the time.

However, the investigator didn't think that SLFOC's review communications had met the standards set by the regulator. He thought that it was likely that by 2010, the costs of the policy had overtaken the premiums being paid which would have impacted the long-term sustainability of the policy. Because of this, SLFOC needed to provide Mr D with information about the future costs of the policy and the premiums that might be needed to avoid significant changes in the future. But, in his opinion, even if SLFOC had provided Mr D with this information, he didn't think it would have made Mr D take a different course of action.

Mr D didn't agree with the investigator. He noted that the review communications weren't at the heart of his complaint and his concerns mainly related to the sale of the policy. He set out his recollections of what he was told at the time he took out the policy.

SLFOC's advisor had offered him two products – term assurance or whole of life assurance. The advisor had explained the difference between both products i.e. fixed term was cheaper

but would eventually expire leaving you without cover in later life at a time when taking out a new policy would be expensive. Whole of life cover didn't have this drawback and would pay out on death regardless of how long that took, but at a higher cost than term cover. He'd also said that this policy had the added benefit of flexibility because there was the option to convert some of its value to an investment product in the future.

He asked the investigator to consider the likelihood of him taking out the policy if the advisor had made him aware of the potential for significant changes in the future to either the sum assured or premiums. He also thought that SLFOC should have made him aware of this, regardless of the regulatory requirements that applied at the time.

SLFOC also didn't accept the investigators findings, mainly because they thought their communications were clear, fair and not misleading and gave a clear and consistent indication of how long the current premium was likely to maintain the current level of cover. They thought their letters had contained a clear warning that it was likely that the policy would need to change in the future in order to maintain the same level of cover and they'd provided an option to help Mr D mitigate this risk.

The investigator wasn't persuaded to change his opinion, so the complaint was passed to me to decide. I recently issued a provisional decision where I said:

"I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I don't think this complaint should be upheld and I will now explain why.

Was the policy mis-sold?

I appreciate Mr D's comments regarding what he should have been told at the time he was sold the policy. But I must consider his complaint against the rules and regulations that were in place at the time. With that in mind I'll summarise the rules that were in place in 1985.

The Financial Services Act 1986 which regulated investment advice, didn't come into play until 1988. So, in 1985 there was no requirement for advisors to consider if a recommendation was suitable for a consumer's circumstances. Instead, they had to ensure that they advised with reasonable care and skill, disclosed relevant material information and didn't give any negligent misstatements.

I've considered what Mr D has said about what he was told at the time he took out the policy and reviewed the limited documentation available from the time of the sale. Mr D has explained that at the time he took out the policy he was looking to provide protection for his family as his wife was expecting their first child. With this in mind, I think that a recommendation to take out life insurance was reasonable.

The advisor also appears to have discussed possible alternative policies such as term assurance before Mr D made the decision to proceed with the RWOL policy. Cost appears to have been factor in Mr D's considerations. He's explained that the cost of policy was a significant monthly outlay at the time. And while a term assurance policy was cheaper, he didn't want to take the risk of having to take out a much more expensive policy (due to his age) when the term policy would have expired.

The other option would have been to take out a non-reviewable whole of life policy. But this would have been even more expensive than a RWOL policy. Given what Mr D's said about the premiums on the RWOL policy being a significant outlay, it doesn't seem likely to me that he would have opted for a more expensive policy, even if it wasn't reviewable.

The key issue here, in my opinion, is if Mr D was made aware of the potential for changes in the future. As I've previously noted, there is a lack of available evidence from the time of the sale. And while I note Mr D's recollections of what he was told at the time, I must take into account that the sale took place 20 years ago and memories will fade over time. Because of this, I think it's reasonable to factor in any documentary evidence that is available.

I've seen a copy of the terms and conditions document he would have been given at the time. It explains that the policy is subject to reviews and if necessary then changes could be made to either the premiums or sum assured. I can't see that any guarantees were given regarding the sum assured and premiums never changing.

I appreciate any documentation Mr D received doesn't explain the scale of changes that might be required, but I don't think this would have been evident at the time of the sale. It might not have been the most suitable product for him given the potential for changes over time compared with a non-reviewable policy, but the lower cost of a reviewable policy compared to a non-reviewable policy must be taken into account and in any event there was no requirement to recommend the most suitable product. From what I've seen, on balance, I think the policy was appropriate for Mr D's circumstances at the time given his desire for family protection and I don't think it was mis-sold.

However, SLFOC had certain requirements relating to their ongoing administration of the policy. I've considered if they treated Mr D fairly by providing enough information to enable him to make an informed decision about the policy.

In considering what is fair and reasonable in all the circumstances of this complaint, I am required to take into account relevant law and regulations, regulators' rules, guidance and standards, codes of practice; and what I consider to have been good industry practice at the relevant time. Having taken all these elements into account, I've set out below what I consider to be the key factors:

Relevant considerations

I think the FCA's Principles for Businesses ("the Principles") are relevant to this complaint. They are set out in the FCA's Handbook as "a general statement of the fundamental obligations of firms under the regulatory system" (PRIN 1.1.2G). Particularly relevant are Principles 6 and 7 which say:

- *Principle 6 – "A firm must pay due regard to the interests of its customers and treat them fairly."*

- *Principle 7 – "A firm must pay due regard to the information needs of its clients, and communicate information to them in a way which is clear, fair and not misleading."*

Principle 6 and 7 have applied unchanged since 1 December 2001.

The Conduct of Business Sourcebook (COBS) sets out further relevant regulatory obligations. I consider the most relevant obligations here are:

- *COBS 2.1.1R (1) – "A firm must act honestly, fairly and professionally in accordance with the best interests of its client (the client's best interests rule)."*

- *COBS 4.2.1R (1) – "A firm must ensure that a communication or a financial promotion is fair, clear and not misleading."*

These obligations were in place at the time of each of the relevant policy reviews I have set

out in the background section above and since 1 November 2007 when COBS came into force.

FG 16/8 Fair treatment of long-standing customers in the life insurance sector

In 2016, the FCA published a guidance note – "FG 16/8 Fair treatment of long-standing customers in the life insurance sector" – which I think is also a relevant consideration. It was published in December 2016, following a Thematic Review and a period of consultation. The guidance was provided in four high level outcomes (with fourteen sub-outcomes). The four high level outcomes were:

1. *The firm's strategy and governance framework results in the fair treatment of closed-book customers.*

2. *The firm's closed-book customers receive clear and timely communications about policy features at regular intervals and at key points in the product life cycle to enable them to make informed decisions.*

3. *The firm gives adequate consideration to, and takes proper account of, fund performance and policy values in a way that ensures it treats its closed-book customers fairly and proportionately.*

4. *The firm's closed-book customers are able to move from products that are no longer meeting their needs in a fair and reasonable manner.*

Also of particular importance is the note's clarification that:

1.14 The requirements on firms have not changed; they reflect the Principles and certain other rules. Some of the detailed expectations have also previously been set out in:

- *formal guidance in the form of Responsibilities of Providers and Distributors for the Fair Treatment of Customers (RPPD) Regulatory Guide*

- *other communications such as a previous With-Profits Regime Review Report and various Treating Customers Fairly (TCF) communications as referred to in Chapter 2 of TR16/2; and*

- *senior management speeches*

The relevant sections of the finalised guidance, in my opinion, are:

Outcome 1: The firm's strategy and governance framework results in the fair treatment of closed-book customers.

Sub-outcome 1.2: The firm checks, through periodic product reviews, that closed-book products remain fit for purpose and continue to meet the general needs of the target audience for whom they were designed.

Finalised Guidance: Our expectations

As stated in the RPPD, and in line with Principle 6, we expect firms to review a product periodically to check whether it continues to meet the general needs of the target audience for whom it was designed at the point of sale or after any subsequent changes are communicated between the firm and customers. To do this, firms that have closed-book customers should have well-defined and effective processes to ensure that products

continue to meet customers' reasonable expectations. Firms should also have in place adequate risk management systems to ensure that they can identify where poor outcomes may be occurring, and take appropriate action.…

Firms should ensure that closed-book products are delivering fair outcomes for customers. Although we recognise that T&Cs should be taken into account when reviewing a product, this should not detract from the need to focus on achieving fair outcomes for customers. Firms will be aware that some products were manufactured and sold in a different era – where, for example, economic conditions may have been fundamentally different. The risk that the passage of time could adversely impact on the outcome the customer receives is something that firms should be aware of, and their processes should take this into consideration.…

We expect firms to consider whether a product continues to provide a fair outcome to the customer. This may include assessing whether customers have received the investment return that they could reasonably expect, or whether product charges consistently outweigh the performance being produced.

When considering outcomes that closed-book customers may be experiencing, the firm should take into consideration all the relevant factors that could affect the product's performance. For example, value for money, and product performance (including the impact of charges, contractual obligations, communications to customers and complaints data) are all likely to be relevant factors to assess. However, this is by no means an exhaustive or definitive list. Firms should be able to articulate clearly the criteria that they assess products against and be able to explain what a fair outcome should be for each product (or group of products). This should take into account what a reasonable customer expectation should be, based on what the customer is likely to have understood by the information given to them at point of sale.

Where firms identify issues, they should take appropriate and timely action to address them in line with the fair treatment of affected customers….

Outcome 2: The firm's closed-book customers receive clear and timely communications about policy features at regular intervals and at key points in the product life cycle that enable them to make informed decisions.

Sub-outcome 2.1: Regular communications to customers provide them with sufficient information to make informed decisions.

Finalised Guidance: Our expectations

We expect firms to ensure that they meet the information needs of all their customers, including closed-book customers, on an ongoing basis.

Principle 7 of our Principles for Businesses requires firms to have due regard to the information needs of their customers. As such, firms should have appropriate mechanisms in place to assess these information needs and ensure their communications meet these needs. To do this, firms should provide their closed-book customers with regular communications regarding their policies. We would expect this communication to be issued at least annually, unless the firm is able to justify how it is otherwise meeting the information needs of its customers.

In line with Principle 7, firms should also ensure the content of these regular communications is consistent with their customers' information needs. In their communications, firms should include, for example, sufficient and clearly explained details regarding the performance of

the product, its value, and the impact of fees and charges.

Principle 7 also requires communications to be fair, clear and not misleading.

Therefore, reflecting the nature of the policy sold, firms should consider including the following in the communication (as relevant or appropriate to customers' information needs):

- *The current value of the policy. The policy value may be different, due to charges or policy conditions, from the transfer or surrender value. Where this is the case, firms should provide both the current and the surrender value of the policy. For whole-of-life policies with cash-in-value, we expect this to be included as the current value. For conventional with-profits policies, the current value may be challenging to calculate; in such cases, firms should explain the impact of any likely terminal bonus on the current value and any reductions in asset share that will reduce the current value on surrender.*

- *The value at the previous communication date and the value of any premiums paid in over that period. This facilitates a broad comparison of the performance of the policy with reference to the current year's value.*

- *For unit-linked (non-profit) policies, charges incurred over the period in monetary figures. This includes setting out, in addition to the aggregate charge, a breakdown of the major components and the charge to the customer for benefits such as life cover and guarantees.*

- *For unitised and conventional with-profit policies, an explanation of the charges being deducted – for example, the guarantees that incur a charge and policy fees – and an indicative level of charge (in monetary terms) applicable to the policy.*

- *Where customers have specific options and benefits associated with a policy – for example, life cover or a guaranteed minimum death benefit – a reminder of this should be in regular communications.*

Sub-outcomes 2.2 and 2.3: Communications to customers at the time of key policy events are clear, accurate and enable them to make informed decisions; and communications with customers make them aware of guarantees or options (whether time-critical or not).

Finalised Guidance: Our expectations

Principle 7 of our Principles for Businesses requires firms to have due regard to the information needs of their customers and communicate in a way which is clear, fair and not misleading.

In line with this, we expect firms to ensure that closed-book customers are fully informed of the various options, features and guarantees that form part of their policies – both on an ongoing basis and in the lead up to policy events. Firms should undertake an assessment of the products' benefits and determine how to ensure customers are kept informed.

In line with our requirement that firms' communications should be clear, fair and not misleading, we expect firms to be specific when setting out guarantees or benefits that are available to closed-book customers and avoid language that is ambiguous. For example, it would not be appropriate simply to provide statements such as 'you may have life cover as part of your policy'. Instead, firms should state the level of cover provided as a monetary amount. Furthermore, firms should also not 'cherry pick' which benefits are to be disclosed.

The needs of customers vary, and benefits that are not of significance to one customer may be valuable to others.

In communications with customers regarding a policy event, firms should highlight the benefits (plus any associated costs) that are likely to be impacted by the event in a sufficiently prominent and specific manner.

Additionally, to be clear, fair and not misleading, we expect any communication surrounding a key event to:

- *set out clearly all options available to the customer in a balanced manner including the risks, costs and potential benefits of each option*
- *set out clearly any charges that may apply (exit and/or paid-up charges should, where possible, be presented as monetary figures so that the impact is clear)*
- *provide sufficient notice to customers and provide clear time lines for when a decision is needed*
- *highlight where there may be a need for the customer to seek advice; and*
- *provide alternative options to incurring a paid-up/exit charge (for example, indicate if a customer could delay surrendering a policy so that a charge would not apply or would not apply at that time)*

…

Firms should carefully consider the layout and structure of event-driven communications to ensure that information is easily accessible and key information is sufficiently prominent. Consumer testing is one approach to assessing the quality of communications; proactively engaging with consumers both during the initial development of communications and afterwards will help ensure all communications remain fit for purpose. Firms should also take both the quality and contents of event-driven communications into consideration in the course of product reviews.

I think it's important to reiterate that even though the Finalised Guidance was published in December 2016, the examples of good practice it gave were based on actions the FCA reasonably expected from firms before that time based on rules and Principles that were in existence throughout the period in question.

FG 16/18 contains explicit statements regarding this point:

- *Feedback statement 2.9 – "Our existing rules and Handbook guidance, together with this guidance, are sufficient for firms to understand our requirements in this area and to make any changes necessary to comply with our expectations. The guidance simply adds an extra level of detail about our expectations to improve customer outcomes. These are not new expectations and are reasonably predictable from the Principles and relevant rules."*

- *Feedback statement 2.99 – "The guidance is not intended to create any new requirements but to remind firms of our expectations in relation to existing requirements contained in COBS rules and elsewhere."*

Taking both of these statements into account, I think it is reasonable to use FG 16/18 as not

only a relevant consideration, but also as what the FCA would consider to be good industry practice. With this in mind, I've thought about Mr D's complaint against SLFOC.

I will firstly recap how RWOL policies generally work in practice. At the outset, when charges are relatively low, the difference between the premiums being paid and the charges results in an investment pot being built up. As the life assured gets older, the cost of providing cover increases and can exceed the premiums being paid in, but this can be offset by selling the accrued funds, or the return from the investment pot.

Businesses will undertake reviews to ensure that the policy can continue to provide the chosen level of cover. They will look at a number of different factors such as the size of the investment pot, current mortality rates and investment performance. If they decide the policy isn't sustainable at its current premium, the consumer will usually be offered the option of reducing the sum assured or increasing the premium.

The reason behind Mr D's complaint was the outcome of the 2020 policy review where significant changes to the policy were required. The changes were required because SLFOC's projections showed that the cover would only last for another year before the benefits ran out and the policy ended. This was clearly a poor outcome for Mr D, and I've considered previous communications he received to see if he was provided with sufficient information to be able to make an informed decision about the policy.

I've also taken into account the cost of providing cover versus the premiums Mr D was paying. The table below shows how the cost of cover has increased over time:

Policy year ending	***Total Life cover costs***
24 December 1998	*£28.52*
24 December 1999	*£69.44*
27 December 2000	*£85.18*
27 December 2001	*£149.40*
27 December 2002	*£166.29*
24 December 2003	*£184.40*
24 December 2004	*£204.28*
23 December 2005	*£225.14*
27 December 2006	*£248.97*
27 December 2007	*£275.56*
24 December 2008	*£308.91*
24 December 2009	*£347.18*
24 December 2010	*£385.52*
23 December 2011	*£429.57*
27 December 2012	*£478.77*
27 December 2013	*£531.89*
24 December 2014	*£592.14*
24 December 2015	*£654.40*
23 December 2016	*£694.15*
27 December 2017	*£772.47*
27 December 2018	*£862.45*
27 December 2019	*£965.51*
24 December 2020	*£1,003.07*
24 December 2021	*£234.32*

24 December 2022	*£278.51*
28 December 2023	*£283.32*
28 November 2024	*£285.78*

Mr D was paying annual premiums of £244.80 which meant that the cost of providing cover had exceeded the premiums being paid by the policy year ending 27 December 2006. This was an important tipping point in the lifetime of the policy. From this point onwards the investment pot that had built up would be used to offset the cost of cover. As the cost of cover would increase over time there was the possibility that the pot would become completely depleted.

However, the impact can be lessened by making changes earlier to the policy. The earlier premiums can be increased, the better the chance the investment fund will have to continue to build up and grow over time. This means the policy will have a better chance of avoiding significant premium increases or reductions in the level of cover.

If consumers are put in an informed position early on, then they can decide to either make the necessary changes to a policy, or not to continue with it if it isn't cost effective or doesn't meet its original purpose. The later these decisions are left, the more difficult it will be for consumers to have reasonable options to mitigate substantial changes.

SLFOC were in a position where they had information about the policy that Mr D didn't, such as the level of future mortality costs. The impact of these costs on the long-term sustainability of the policy was a factor that could lead to a poor outcome for Mr D if action wasn't taken. Therefore, I think the tipping point was where SLFOC needed to provide him with clear, fair and not misleading information about the policy's long-term sustainability, given that it was meant to last for life.

In order to put Mr D in an informed position, SLFOC needed to share the information I've set out below with him:

- *A clear outline of the existing cover – including the sum assured, premiums and current surrender value.*
- *The policy costs (including administration and mortality charges).*
- *A clear explanation that the costs were no longer being met by premiums and that units in the investment fund needed to be sold.*
- *A clear explanation of roughly how long the policy was likely to be sustainable on its existing terms.*
- *Estimates of what the policy might cost at the point when the policy was likely to cease to be sustainable on its existing terms in order to give Mr D information that would allow him to fully appreciate the risks and consequences of not taking any action.*
- *A clear explanation of the poor outcomes he might face at the point the policy became unsustainable on its existing terms. This should include a clear outline of the levels by which premiums would need to increase (or the sum assured would need to decrease) in order to maintain the policy at that point (reasonable approximations or illustrative examples would suffice).*

- *A clear explanation of the options available to him that were aimed at mitigating that outcome, together with the costs and benefits of each option (including increases in premium levels, decreases in the sum assured or surrender of the policy).*

I think SLFOC should fairly and reasonably have provided Mr D with a clear outline of his options as I've set out, within 12 months after the date at which the tipping point was reached, so by the end of 2007. At that time, the policy was being reviewed every five years, but Mr D was receiving annual statements which would have provided SLFOC with the opportunity to deliver the information I set out above.

I've considered their communications with Mr D. Some information as being provided, such as how long the policy was expected to last. But I can't see that he was ever made aware of the costs of the policy and an explanation that they were higher than the premiums being paid. Therefore, I'm not satisfied that Mr D was given all the information he needed to make an informed decision about what steps he wanted or needed to take to make the policy sustainable for life.

What would Mr D have done differently?

I've considered what, if anything, Mr D would have done differently if he'd been provided with all the information I've set out above after the tipping point was reached. It's important to note that some information was provided in the review letters he received, specifically a forecast of how long the policy was projected to last.

The 2005 review letter said:

How do we perform the review?

In reviewing your policy we take many things into account: your current age, your policy's benefits, its current value, the rate at which it may grow in future and any charges we expect to make.

We've assumed future investment growth of 6.00% a year (before charges) - lower than we anticipated when we initially calculated your premium. The industry regulator sets growth rates that we use for projections and they reflect the market conditions at the time.

More detailed information is included in the enclosed leaflet "Your policy review".

So what does this mean for you?

Subject to the above, we are pleased to advise you that with the above assumptions, no premium increase should be needed to maintain the same level of benefits for a further period of at least five years.

Based on our current assumptions your benefits are actually projected to last for sixteen years.

If you would like a quotation to upgrade your protection so that your policy benefits are projected to run for the whole of your life, then please call us……

The 2010 review letter delivered a similar message and said that the benefits were projected to last for nine years. The 2015 review letter said that the premium wasn't enough to maintain the current level of benefits. It also warned that it was likely that premiums would increase in the future by a significant amount.

The original purpose of the policy – providing protection for Mr D's family – still remains and is evidenced by Mr D choosing to keep the policy in place despite the failed reviews in 2020 and 2021. However, despite the warnings and projections that Mr D received, he didn't take any action to ensure the long-term sustainability of the policy. So, I'm not persuaded that even if SLFOC had provided him with all the information I previously set out, he would have taken a different course of action such as surrendering the policy or taking any other steps to make it sustainable for life.

Taking all this into account, I don't think I can fairly uphold this complaint."

Responses to my provisional decision

SLFOC didn't provide any further submissions. Mr D didn't accept my findings and made the following points, in summary:

- He was surprised that this issue hadn't received more publicity and investigation.

- I should consider how the reviews were explained to him at the time he took the policy out. The salesman had told him about reviews but only in the context of them giving him the option in the future to consider increasing the level of cover. The salesman also didn't make him aware of non-reviewable policies.

- A reviewable policy simply wasn't a suitable product for him, given his risk-averse nature. This could be evidenced by his refusal to take out an endowment mortgage despite being encouraged to so by several mortgage brokers because of the risk that there might be a shortfall in the funds needed to pay off the mortgage.

- He noted the regulatory requirements from 1985 and was surprised that there no records of what he was told at the time of the sale or that he wasn't asked to sign an acknowledgement that he had been advised of the potential risks inherent in this type of policy.

- His comments about the cost of the whole life cover being considerably higher than term cover shouldn't be taken to mean that that the whole life cover was barely affordable or the maximum he could afford, but to make the point that the fact that they were so much more expensive gave him reassurance that what he was being offered wasn't too good to be true.

- The provisional decision referred to the investigator's view that despite the limited evidence available from the time of sale, it had met the requirements of the regulations that applied at the time. This didn't give the impression that the outcome was logical or based on fact.

- The provisional decision also referred to a question he'd asked the investigator about the likelihood of taking out the policy if there had been full disclosure of the potential for significant changes in the future to either the sum assured or the premiums. This question hadn't been answered and needed to be addressed.

- I'd made my decision based on his lack of action despite the warnings that had been provided. However, the reality was that it wasn't a slowly developing situation, it escalated quickly and went from him believing that he had significant life cover to a situation where there was a seven-fold increase in premiums or five-fold decrease in the sum assured with the potential for further changes in the future. It was difficult to choose the least negative option and he'd continued to pay his premiums in order to keep the policy live while the complaint process was ongoing.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I'm still not persuaded that this complaint should be upheld and I will now explain why. I'd firstly like to thank Mr D for his testimony, and I'd like to reassure him that I've carefully thought about the points he's raised. I take his point that he potentially would have taken a non-reviewable policy over a reviewable one, but this doesn't necessarily mean that he was mis-sold the policy that he took out.

I must stress that regulations were very different before the implementation of the Financial Services Act 1986. To recap the rules at the time, there wasn't a requirement to assess the suitability of the product being sold or the risk level of the customer. Instead, an adviser had to ensure that they advised with reasonable care and skill, disclosed relevant material information and didn't give any negligent misstatements. It is very important to not look to retrospectively apply the modern standards of suitability to the advice Mr D received in 1985 to take out the policy.

It is with this in mind that I've considered if the policy was broadly appropriate for Mr D. There was a need for the policy as he was seeking cover for family protection as his wife was expecting their first child, so it doesn't seem inappropriate on that basis. I appreciate the points he's raised about the costs of the policy and being able to afford a more expensive policy, but a non-reviewable policy would have been considerably more expensive, and I think this would have factored into his considerations at the time given that his wife was expecting and household expenditure would undoubtedly increase.

As I noted in my provisional decision, it's important to consider any documentary evidence available from the time to see if any misstatements were given. The terms and conditions document Mr D received explained that the policy was subject to reviews. And if it was considered necessary, then the sum assured could be reduced or the premiums could be increased. I think this sets out how the policy works so I can't say that there were any misstatements or that Mr D was given any guarantees that the policy wouldn't change over time.

I fully appreciate that the adviser may not have told Mr D about the potential for significant changes in the future. But the scale of any changes wouldn't have been apparent to the advisor at the time as it was dependent on investment performance. I think all he could have done was to let Mr D know the policy was reviewable and there could be changes. As this information was contained in the terms and conditions, I don't think I can fairly say that relevant material information wasn't disclosed. And having reconsidered all the available evidence, on balance, I don't think the policy was mis-sold as it was a reasonable fit for Mr D's circumstances at the time.

I've also considered the points Mr D has raised about his lack of action after being made aware that the policy wasn't sustainable. I appreciate that the changes proposed in the 2021 were significant, but the evidence I've seen shows that while SLFOC didn't provide all the information they should have done, they did let Mr D know that the policy wasn't sustainable for life.

- The 1995 review letter said that the policy would last for another 27 years.
- The 2000 review letter said that the policy would last for another 20 years.
- The 2005 review letter said that the policy would last for another 16 years.

- The 2010 review letter said that the policy would last for another 9 years.

- The 2015 letter didn't give a projection of how long the policy would last but said that the premium wasn't enough to maintain the current level of benefits. It also warned that it was likely that premiums would increase in the future by a significant amount.

- The yearly statements that were being issued showed a year-on-year decline in the policy's underlying fund from £3,404.14 in 2013 to £786.25 in 2020

In making my decision about what Mr D would've done if all the information had been provided, I think it is reasonable to take into account his lack of a response to the warnings that had been provided. I'm not persuaded, on the balance of probabilities, that the provision of further information such as projection of future premium levels, would have made him take him a different course of action.

I say this because he didn't take steps to make the policy last longer after being told repeatedly that the policy would only last for a certain period of time. All the projections from 1995 onwards gave an estimation that the policy would only last until around 2022 at the latest. And the 2015 letter specifically warned that as he got older, the costs of providing his benefits would increase and his premium was likely to continue to increase in the future and by a significant amount. The yearly statements also showed that the policy's underlying fund was going down each year.

So, I think a reasonable amount of information was provided to make Mr D understand that the policy, as it stood, would end by around 2022 at the latest. Because he didn't take any action after receiving this information, I don't think I can fairly say that he would have surrendered the policy or made any other changes to the policy if SLFOC had provided him with more information.

My final decision

For the reasons I've given above, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 16 April 2025.

Marc Purnell
Ombudsman