DRN-4281623

The complaint

Mr and Mrs W are unhappy, in summary, as they don't think Aviva Life & Pensions UK Limited ('Aviva') has correctly administered their reviewable whole of life policy that's held with it.

What happened

I've outlined what I think are the key events involved in the complaint below.

Mr and Mrs W took out a Reviewable Whole of Life policy in or around 1992 with General Accident Linked Life Assurance Limited (Aviva is now responsible for this complaint though, so I will refer to it throughout) for a monthly premium of £24 with a sum assured of £85,000. This was on a maximum cover basis and it was subject to a review at the 10-year anniversary and then regular reviews every five years thereafter.

The 2012 review 'passed', as no changes were required. In the letter Aviva said, amongst other things, that it reviews the policy at regular intervals to check the premium still supports the current benefit level. It said the review is on the progress the policy is making towards sustaining the benefits. It said it would send a review at each contractual policy review date. In bold writing, Aviva said it believed Mr and Mrs W's policy would maintain the benefits and it was unlikely they'd need to take any action now. And it enclosed a projection to indicate how many years their current premium of just over £24 might support the sum assured of £85,000 before the fund value runs out using growth rate assumptions, which showed that it might do so for a maximum of eleven years.

The 2017 review 'passed', as no changes were required. In the letter, Aviva again said it reviews the policy at regular intervals to check the premium still supports the current benefit level. In bold writing and a box at the top, Aviva said it could guarantee the current benefit amount until 2022. It enclosed a projection using growth rate assumptions, which showed that the premium might support the sum assured for a maximum of six years before the fund value runs out. And Aviva said that at the review immediately before that happens it would likely reduce the sum assured, after giving the option to increase the premium instead. It said that, if the priority was to maintain the current benefit level for life and the projection showed this was unlikely, then action should be taken. And that Aviva can provide quotations to show what was needed to do so.

The annual statements Aviva sent Mr and Mrs W up to and including 2018 contained similar information. These set out the current fund value and enclosed a projection, the latter of which Aviva said gave an indication of how long their fund would continue to support their policy benefits. And the projections given in respect of how long their fund would continue to support the benefits gradually decreased over the years, with these reflecting a maximum of thirteen years in 2011 and then six years in 2018, for example.

The October 2019 annual statement Aviva sent Mr and Mrs W said the policy fund/cash in value was just over £1,800 compared to the value just five months before of just over £1,850. It said that the total premiums paid that year (since the last statement in May 2019) was £120 against total policy charges paid of just under £250 and that charges are either

taken from the premium of from the fund by selling units. And the enclosed projection said the policy might support the benefits for a maximum of around four years.

The 2020 annual statement said the policy fund/cash in value was just over £1,500 compared to the 2019 value. It said that the total premiums paid that year was £168 against total policy charges of just under £350, which are either taken from the premium of from the fund by selling units. And the enclosed projection said the policy might support the benefits for a maximum of around three years.

The 2021 annual statement said the policy fund/cash in value was just under £1,400 compared to the 2020 value. It said that the total premiums paid that year was £288 against total policy charges paid of just over £600. It said the charges are either taken from the premium of from the fund by selling units. And the enclosed projection said the policy might support the benefits for a maximum of around three years.

The 2022 review 'failed'. The letter said in bold writing at the top, in a box, that Aviva could no longer guarantee the current benefit until the next review date. And some of the key information provided was that:

- Any change made because of this review would only be guaranteed until 2027, at which point a further change would almost certainly be needed and that further action was likely to be needed at every future review.
- Option 1 – increase the current premium from £24 to just over £55 maintain the sum assured of £85,000 until 2027.
- Option 2 (the default option – which I understand has since been applied in June 2022) – the premium would stay the same and the sum assured would reduce to just under £47,000 until the next review in 2027.
- Option 3 – the premium and benefit amount would remain unchanged, but the guarantee to maintain their benefit amount until the next review would be removed and the cost of the benefit would be taken from their fund value. And as soon as this runs out the policy will terminate with no value.
- The enclosed projections set out that as things currently stood with no changes made and based on investment growth rate projections, the policy might support the benefits for a maximum of around two years. But if they instead chose option 1 or 2 then it could support this for around five years.

The May 2022 annual statement – sent after the 2022 'failed' review but just before the benefits changed via application of the default option in mid-June 2022 – showed that the fund value had now reduced to just over £1,000 compared to £1,400 the previous year. It said the annual premium had continued to be £288 but the total policy charges were just over £625. It said the charges are either taken from the premium of from the fund by selling units. And the enclosed projection said the policy might support the benefits for a maximum of around two years.

Soon after receipt of the above review letter, Mr and Mrs W complained to Aviva that the policy had been mis-sold. They said the policy wasn't suitable for their needs and they were led to believe at the time of sale that their premium would remain at £24 per month throughout, they weren't made aware of the reviews and that the benefit could change.

Aviva sent its final response letter not upholding their complaint. It said that it wasn't responsible for the sale of Mr and Mrs W's policy and whether or not this was suitable for them, as this was sold to them by an independent financial adviser – which I will call 'Firm B'. And, in respect of the reviews, Aviva said it had administered the policy correctly and in line with the policy terms.

Unhappy with this, Mr and Mrs W referred their Aviva complaint to our Service in late 2022. They added, in summary, that they took out the policy to cover their 100% mortgaged property, which at the time they could only afford to pay off the interest on. They were concerned about having protection for them and their intended family. The £24 monthly premium was a considerable cost for them and a lost term commitment, and they told they must pay the premium or they'd lose the benefit. And it wasn't until the 2022 review that they found out the benefit would reduce.

At the same time Mr and Mrs W referred a separate complaint about the sale ('the sale complaint') of the policy against Firm B to our Service. An Ombudsman decided in 2022 that the Firm B sale complaint had been made too late for us to be able to consider it. So, I think it's important to say at this point that my decision here only concerns Mr and Mrs W's complaint about Aviva – I don't intend to comment on Mr and Mrs W's Firm B complaint, which has already had an Ombudsman's decision.

One of our Investigators reviewed Mr and Mrs W's Aviva complaint. They said that as Aviva didn't sell the policy it couldn't be held responsible for what happened at that time. And, in respect of the policy reviews and the way Aviva had managed the policy, they said they weren't asking Aviva to do anything. The Investigator said that Mr and Mrs W's policy information reflected that this was reviewable and that the sum assured could reduce in future. They said Aviva ought reasonably to have known since around 2007 though that significant changes would likely be needed to the premiums or level of cover as Mr and Mrs W got older, as the cost of cover had started to outweigh the premiums paid. And that Aviva's correspondence didn't meet regulatory obligations and standards of good practice. But the Investigator said that, even if Aviva had provided the information it should have, on balance they weren't persuaded Mr and Mrs W would have done anything differently.

Mr and Mrs W didn't agree and asked for their complaint to be considered by an Ombudsman. They added, in summary, that as they contracted for £85,000 in life insurance they feel that everything else is irrelevant. They said that Aviva's 2012 correspondence wouldn't put a member of the public on notice that they should present a claim for breach of contract, the limitation period shouldn't run from that time and that Aviva/Firm B are therefore incorrect.

Our Investigator's view remained the same and the case has been passed to me for a decision.

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.

I think that a number of Mr and Mrs W's points still concern what happened at the time of sale. For example, they feel strongly that they weren't told that the policy was reviewable and that they were led to believe the sum assured of £85,000 and their £24 premium would remain the same. And I think Mr and Mrs W's submissions in response to our Investigator's view on their Aviva complaint also still largely focus on the timescales in which they made their Firm B complaint about the sale of the policy, given they're referred to limitation periods and their awareness in respect of that.

So, to be clear, in the way I've said above, our Service has previously given a separate decision in respect of Mr and Mrs W's Firm B sale complaint and the timescales in which that was made, which I can't comment on. I'm only considering Mr and Mrs W's Aviva complaint here. This means I can't consider their points about what they might have been told (or not

told) by Firm B's adviser in 1992 and/or whether the policy was suitable for them. That adviser was not an appointed representative of Aviva, nor was he acting for Aviva in any capacity. On that basis, Aviva is not responsible for the sale of the policy. This means that my remit here is restricted to the actions that Aviva could be liable for, which means I can only look at whether Aviva has acted reasonably in how it has managed Mr and Mrs W's policy, as the policy provider, since this was taken out. Including whether or not Aviva has treated them fairly by reviewing the policy and making changes to either the sum assured or monthly premiums.

And, having considered this complaint about Aviva, while I understand Mr and Mrs W will be disappointed, I'm not asking it to do anything for the following reasons, which are largely the same as those given by our Investigator.

In reaching my decision I've taken into account the law, any relevant regulatory rules including the principles and good industry practice at the time.

And while I've carefully considered the entirety of the submissions the parties have provided, my decision focuses on what I consider to be the central issues. The purpose of my decision isn't to comment on every point or question made, rather it's to set out my decision and reasons for reaching it.

Relevant considerations

In reaching my conclusions, I've considered, amongst other things:

- The FCA's Principles for Businesses, in particular Principle 6 and Principle 7 (PRIN).
- The FCA's Conduct of Business Sourcebook (COBS), in particular COBS 2.1.1R(1) and COBS 4.2.1R(1).
- The FCA's Final guidance on the "Fair treatment of long-standing customers in the life insurance sector" (FG16/8).

What is the fair and reasonable outcome in the circumstances of this complaint

Mr and Mrs W's policy is a reviewable whole of life policy. I can see that the applicable policy terms from when the policy was taken out set out that, after the first ten years, the policy is reviewed periodically (looking ahead five years) by the provider to establish if the benefits can be maintained until the next review without the need to increase premiums. And if these can't be then Aviva can reduce the benefit amount to such level as it considers can be maintained until the next review. So Aviva is entitled to review the policy and its benefits.

But it might be helpful if I explain more about how the policy works and what I think Aviva should have done, if anything. The key feature of this policy is that part of the premiums Mr and Mrs W were paying throughout the years were to be invested to pay for the increasing costs of life cover later in life. This is because for these types of policies, there's an increased likelihood of increasing life cover costs as the policyholder gets older. While Mr and Mrs W are unhappy with the effect of these increasing costs on the value of the policy, these are simply an inevitable consequence of the policy becoming more expensive as the policyholder gets older. This is very typical for these types of policies. It is also what allows these policies to be more affordable at the outset.

In the early years, when life cover costs are low, part of the premiums are invested to build up a fund that can be used to help pay for the increasing life cover costs in later years. At this stage, the premiums can meet the costs of the cover on their own. However, if the

premiums remain at the same level, there inevitably comes a point where the life cover costs will exceed the monthly premium and units in the investment fund need to be sold to meet the shortfall, reducing the investment fund value over time – unless the fund's growth outpaces the rise in cover costs.

Eventually, regular increases in the cost of life cover will outpace the growth in the fund, so that as units in the fund continue to be sold, it will reach a point when the firm concludes that the premiums being paid and the fund value are no longer enough to pay for the costs of cover. To maintain the policy with its existing life cover, the premiums will need to increase substantially and will continue to increase each year as the consumers get older and the life cover costs increase accordingly, unless the sum assured has been substantially reduced. This is what has happened here in Mr and Mrs W's case.

At this point, there can be several poor outcomes for the consumer. It's possible that the investment fund will be almost completely depleted, leaving little surrender value. Any increase in premiums is likely to be very expensive and potentially unaffordable at a time when the consumer may be retired or close to retirement and have limited means to meet significant increases in costs. Alternatively, if the level of life cover has reduced substantially, the policy may no longer meet the consumer's objectives or ceases to be a cost-effective proposition.

The impact of the sudden and significant changes to the premium or level of life cover that occur at the point the policy fails a review, can be mitigated by adjusting the terms of the cover earlier in the life of the policy. If, for instance, a consumer elects to increase premiums some years before the policy is likely to fail a review, this will have a smoothing effect over time, so that the policy is less likely to fail a review and the sudden and dramatic premium increases down the track can be avoided.

This gives the consumer the chance to set premiums at a more affordable and sustainable level for a longer period – even for the rest of their lifetime. The new premiums will be higher than they were at the outset, but not as high as they would otherwise need to become at the point the policy fails its review.

Alternatively, at that earlier point, a consumer who is faced with significant increases in premiums or decreases in the level of life cover down the track might decide the policy itself is no longer cost effective, or that it is failing to meet its objectives, and elect to surrender the policy. In other cases, a consumer might decide that it is worth maintaining the policy on its existing terms right up to the point that the policy fails a review.

The opportunity for a consumer to make these decisions is a key event in the life of the policy. Given the impact of increasing life cover costs on the investment fund, and in time on the premiums (or sum assured), consumers have important decisions to make about whether to retain the policy, increase the premiums and / or decrease the sum assured during the life of the policy. Those decisions become more difficult the longer the consumer pays into the policy and the options available for mitigating poor outcomes start to diminish. So it is in a consumer's interest to make key decisions at an early stage in the policy's life cycle, and to do so in an informed way, firms need to provide consumers with clear, fair and not misleading information.

Increasing life cover charges and the reviews of the policy

Looking at the available evidence, I can see that in the year 2007 to 2008 the annual cost of cover in this case, including admin charges, was just under £302 – having steadily risen in the preceding years – and it was therefore more than the annual premium amount of £288.

While the cost of cover appears to have decreased the following year, by 2014 this had risen to just over £307 and it had therefore overtaken the annual premiums of £288 again and the cost of cover has continued to rise since.

So, based on the available evidence, overall the policy has been costing more than the premiums paid since around 2007.

What should Aviva have told Mr and Mrs W?

Taking into account the regulatory obligations I have set out above (PRIN) and what I consider to be standards of good industry practice at the time (including the regulator's views as expressed in FG16/8), and in any event what I consider to have been fair and reasonable in the circumstances, I'm satisfied that Aviva should have taken steps to ensure it communicated information to enable Mr and Mrs W to evaluate the impact of the increasing life cover costs on their policy and the options available to them in a clear, fair and not misleading way. This needed to include the risks, costs and benefits associated with those options, as well as giving them clear timelines for the making of decisions where applicable.

In my view, this is something that Aviva needed to do within 12 months of the tipping point being reached – and as I've said, I think it's likely this point occurred in or around 2007. By giving Mr and Mrs W clear information about how much the policy was costing and allowing it to compare those costs with the premiums being paid, Aviva would've been acting consistently with the guidance at FG 16/8 that firms provide "regular communications" with customers – and to ensure that, in their communications, that "firms [include] sufficient and clearly explained details regarding the performance of the product, its value and the impact of fees and charges". Such communications also needed to specifically set out the "value of any premiums paid in over that period", and "charges incurred over the period in monetary figures", including "major components and the charge to the customer for benefits such as life cover and guarantees".

What information did Aviva give Mr and Mrs W?

In my view, communications once the tipping point had been reached should not reasonably provide information in a passive way that required the consumer to draw important inferences for themselves. Aviva should've provided the information in a stark, clear form, including meaningful information about the options available to Mr and Mrs W at this point, together with the costs and benefits as well as time frames for reply. And if, for instance, precise numerical information about the costs of those options could not be given, then at the very least I would expect to see reasonable approximations or illustrative examples so that the consumer could reasonably appreciate the importance of considering options at that point.

Although I don't have evidence of what Mr and Mrs W were told in the years leading up to 'the tipping point' in or around 2007, my experience of these types of complaints suggests it is likely Mr and Mrs W weren't told what the costs of cover were or how much these amounted to, to enable them to weigh up their options and make a fully informed decision about the value of the policy and whether, and on what terms, they wished to retain it

Looking at the 2012 and 2017 review letters, while these reviews 'passed', it's clear that some information was conveyed to Mr and Mrs W and particularly in the 2017 review. For example, Aviva said in this that the current policy might support the benefits for a maximum of around six years before the fund value runs out. So I think it was indicated to Mr and Mrs W how long the policy might currently be sustainable for based on the premium, that this wouldn't maintain the policy for life and they were given a timeframe for when changes might start to need to be made to the policy. Mr and Mrs W were also told that at the review

immediately before that happens action would need to be taken, such as reducing the sum assured or increasing their premium.

But Aviva should have also given Mr and Mrs W sufficient and clearly explained details for them to appreciate how much the policy was actually costing – there was no information about the cost of cover in the letters – and that the gap between the premium and the charges had closed, or was closing, for them to make an informed decision. And the letters didn't give reasonable approximations or illustrative examples of their options, such as the premiums required to make the policy sustainable for life, for example.

As set out above, while the annual statements Aviva sent Mr and Mrs W up to and including 2018 contained projections which went gradually down over the years in respect of how long their fund would continue to support the benefits, these didn't contain details of the policy charges for them to know whether these had exceeded the premiums paid. The annual statements from late 2019 onwards did contain more key information. As well as including the projections mentioned above, these also now set out the total annual policy costs along with the total premiums paid. And I think it was reasonably clear from this that the total costs were exceeding the premiums paid. But Mr and Mrs W weren't given an indication of what they would need to do to make their policy sustainable or what might happen past the next review.

While Mr and Mrs W weren't provided details of the policy costs against the premiums being paid in the 2022 review letter, this did say that Aviva could no longer guarantee the current benefit amount until the next review date and that in future at the 2027 review further change would almost certainly also be needed. Aviva made it clear that if the premium and benefit amount remained unchanged, the guarantee to maintain Mr and Mrs W's benefit amount until the next review would be removed and the cost of the benefit would be taken from their fund value. And that as soon as their fund value runs out the policy with terminate with no value. Aviva again enclosed a projection which showed that as things stood the policy might support the current benefits for a maximum of around two years, or around five if option 1 or 2 was taken. So it again indicated that the premium wouldn't maintain the current benefit level for life and this time it set out that Mr and Mrs W needed to act and it provided them with some options.

So, having taken everything into account, I don't think Mr and Mrs W were provided with enough information about the policy relating to the cost of providing cover. Therefore, I think there was an imbalance of knowledge between it and Aviva, which meant they couldn't make a fully informed decision about what steps they wanted or needed to take following the tipping point being reached. But, for the reasons given below, I'm not asking Aviva to do anything.

What, if anything, would Mr and Mrs W have done differently?

Had Mr and Mrs W been given clear, fair and not misleading information, the options open to them at that point would have been to surrender the policy for the cash in value, increase the premiums to maintain the sum assured, reduce the sum assured or take no action.

On balance and for the reasons set out below, having considered all the submissions and information to decide what, if anything, I think would have likely happened if Aviva had provided all the information it should have, I don't think it's likely that anything would have been done differently in the circumstances.

Mr and Mrs W haven't disputed that their need for the policy has continued. And I think it's clear that they've still wanted the cover but didn't want to pay, and likely wouldn't have paid, any more for it than they have been. I say this because they've kept it in place but with the

same premium, even after having been given some information in 2017 about how long this would sustain their benefits for and that action should be taken if their needs were otherwise and if they wanted cover for life, for example. And despite being given more information in their annual statements from late 2019 onwards, which showed that the cost of cover was exceeding their premiums. They've also kept the policy in place but with the same premium, even after the sum assured had decreased in 2022 and knowing that it could again in future.

So I don't think Mr and Mrs W would have taken a different course of action if they'd been given more information by Aviva and sooner. I think they'd have maintained the premium and that the sum assured would have reduced in the way it has. And this means I'm not asking Aviva to do anything in the circumstances.

My final decision

For the reasons given, my final decision is that I'm not asking Aviva Life & Pensions UK Limited to do anything.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W and Mr W to accept or reject my decision before 24 September 2025.

Holly Jackson
Ombudsman