DRN-4542715

The complaint

Mr and Mrs D complain that Zurich Assurance Ltd have asked them to significantly increase the monthly premiums on a life assurance policy in order to maintain the sum assured following a policy review in 2021.

What happened

Mr and Mrs D took out a reviewable whole of life (RWOL) policy in 1991 for the purpose of family protection in the event of either of them passing away. It initially had a sum assured of £100,000 for monthly premiums of £51.21 and was subject to yearly indexation.

The policy was also subject to regular reviews and following the 2021 review, Zurich wrote to Mr and Mrs D and explained that the cost of providing cover was higher than they expected. At the time Mr and Mrs D were paying monthly premiums of £273.73 for a sum assured of £293,581. In order to maintain the level of cover and the additional yearly indexation increase, the monthly premiums would have to increase from £273.73 to £431.22 for a sum assured of £309,434. If the premiums weren't increased, the sum assured would reduce to £273,223 for monthly premiums of £320.38.

Mr and Mrs D complained to Zurich and said, in summary, that they were unhappy with the outcome of the review. Zurich looked into their concerns but didn't uphold the complaint. They clarified how the review process worked and went on to explain that they regularly reviewed the rates they used to determine the cost of providing life cover. They'd conducted one of these reviews in 2019 and it had shown that their claims experience was higher than expected. Because of this, they'd increased mortality rates for Mr and Mrs D's policy which led to the changes required in the 2021 review.

Mr and Mrs D didn't accept Zurich's findings and asked for our help in the matter. They explained that previous reviews had only seen small increases and they were now concerned that future increases could be significant which would impact the long-term affordability of the policy.

The complaint was considered by one of our investigators who didn't think it should be upheld. She noted that Zurich had requirements under rules set by the regulator, the Financial Conduct Authority (FCA), to pay due regard to the interests of their customers and treat them fairly by providing information to them in a way which is clear, fair and not misleading.

She acknowledged that the policy's premiums had become more expensive over time. But she didn't think Zurich had treated Mr and Mrs D unfairly as the increase in premiums was due to the increased cost of providing life cover as the lives assured got older. She explained that the policy was reviewable and at each policy review, Zurich had met the requirement to provide them with information about the level of premium needed to sustain the policy for life. She didn't think that Zurich would have been aware prior to 2021 that the policy needed any large changes, and had communicated this as soon as they could have done.

Zurich accepted the investigator's outcome, but Mr and Mrs D didn't. They said that the outcome of the 2021 review was disproportional compared to previous reviews. Whilst they'd expected increases in the monthly premiums to maintain the same level of indexed cover, the reasoning behind the proposed increase in premiums was unconvincing and meant that Zurich would be justified in acting in a similar fashion in the future. They thought the proposed increase in premiums was punitive and designed to urge the policy holder to cash in the policy rather than continue with it.

The investigator wasn't persuaded to change her 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 go on to explain why. In making my decision, I've considered if Zurich treated Mr and Mrs D fairly by reviewing the policy and coming to the outcome that they did. I've also considered if they provided Mr and Mrs D with enough information to enable them 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.

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.

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).

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 and Mrs D's complaint against Zurich.

Did Zurich treat Mr and Mrs D fairly?

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 lives assured get older, the cost of providing cover increases and can potentially 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.

At the heart of this complaint are Mr and Mrs D's concerns about the outcome of the 2021 review. They're unhappy that they'd have to pay substantially higher premiums for significantly less life cover. They thought that this meant that Zurich were either grossly underperforming in their core investment business or wished to reduce their liability to the eventual payment of the policy as they'd suggested that there was the option of cashing it in.

I appreciate the concerns Mr and Mrs D have raised and I'd like to reassure them that I've carefully considered everything they'd said and all the evidence they've provided. I don't doubt the impact of the review's outcome, so I've considered if Zurich were within their rights to review the policy and revise their projections.

The terms and conditions of the policy explicitly state that it is subject to regular reviews. The purpose of each review, as I've previously noted, is to ensure that the policy remains on track to provide the chosen level of cover. Therefore, I can't fairly say that Zurich acted inappropriately in reviewing the policy.

I've then gone on to consider the outcome of the 2021 review. I think it's important to note the content of the regulator's guidance in FG 16/18. This provides some background behind why firms review the investment performance and underlying charges of closed book policies such as Mr and Mrs D's.

The regulator's guidance in FG 16/18 said that firms needed to have systems in place to ensure that they could identify where poor outcomes may be occurring and take appropriate action. Zurich have explained that the reason for the changes required was due to the outcome of a wider review of claims they completed in 2019 which had shown that their claims experience was higher than expected.

What this means in practice is that Zurich's charges for providing life cover were too low and needed to be increased. Increasing the cost of providing life cover is allowed under the terms of Mr and Mrs D's policy. They broadly state that each month there will be a risk deduction from the policy. The risk deduction will take into account annual mortality rates for persons having the same ages next birthday as the lives assured, according to a table reflecting the company's experience for persons of the same risk classifications, smoking habits and sexes as the lives assured.

If the premiums weren't increased, then the extra cost of cover would have to be borne by the return from the policy's underlying fund and if this wasn't sufficient then the fund itself would have to be used. This would potentially lead to a poor outcome for Mr and Mrs D as it would mean that the policy wouldn't last as long as originally envisaged. Alternatively, future premiums would have to be increased by an even higher amount than what was proposed in the 2021 review in order to maintain the original sum assured.

I also think the revision to the cost of providing cover was in line with the regulator's guidance under sub-outcome 3.2 of FG 16/18 which said, "Overall expenses are allocated fairly to closed-book products." It doesn't seem unfair for a firm to increase their charges to the reflect the correct amount they are seeing in practice.

I fully appreciate the level of premium increase required was significant, but it is important to point out that this service isn't the industry regulator. This means that we don't have the power to tell an insurer how much to charge a policyholder. An insurer will set their charges based on a number of factors. Provided they treat consumers fairly, they are entitled to make a commercial decision on the level of charges to apply to their policies.

Zurich provided Mr and Mrs D with a number of options following the 2021 review, all of which would ensure that the policy would, in their opinion, last for the rest of Mr and Mrs D's lives. They communicated this in a clear, fair and not misleading way and I don't agree with Mr and Mrs D's comments that the increase in policy costs leaves the door open to future increases.

I say this because future reviews of mortality rates could show that the claims experience is lower than what Zurich previously found and would then result in lower charges. What is important is that Zurich are regularly reviewing the costs of the policy and passing this information on to their customers as per the regulator's guidance.

From what I've seen, this is what they are doing. The changes made to the policy following the 2021 review have ensured that the cost of providing cover is being met by the premiums and the underlying unit fund has continued to grow over time thereby ensuring that the policy continues to meet its original purpose.

I'm also not persuaded that Zurich are trying to reduce their liabilities by trying to make Mr and Mrs D cash in the policy. All the available evidence suggests that their actions have been taken with a view towards ensuring the long-term sustainability of the policy and should prevent large premium increases or reductions in the sum assured in the future.

So having taken everything into account, I'm satisfied Zurich have treated Mr and Mrs D fairly and have provided them with the information needed in order to make an informed decision about the policy. Therefore, I don't think this complaint should be upheld."

Responses to my provisional decision

Zurich didn't respond to my provisional decision. Mr and Mrs D responded and reiterated that they thought the increase was unreasonable.

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.

As no new points or submissions have been provided, I see no reason to depart from my provisional findings.

I fully appreciate that Mr and Mrs D remain of the opinion that the increase was unreasonable. However, for the reasons I provided in my provisional decision – that it wasn't unreasonable for Zurich to make changes to the policy's charges based on the outcome of their claims review and by doing so they are trying to ensure the long-term sustainability of the policy - I'm satisfied that Zurich haven't treated Mr and Mrs D unfairly.

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 and Mrs D to accept or reject my decision before 21 March 2025.

Marc Purnell
Ombudsman