DRN-4669053

The complaint

The trustees of the W Trust, represented by Mr W, 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 2023.

What happened

Mr and Mrs W took out a reviewable whole of life (RWOL) policy in 1992 in order to meet potential inheritance tax liabilities. The policy was subject to regular reviews and following the 2023 review Zurich wrote to the trustees and explained that the cost of providing cover was higher than they expected. In order to maintain the sum assured of c.£230,000, the monthly premiums would have to increase from c.£215 to c.£580. If the premiums weren't increased, the sum assured would reduce to c.£180,000.

Mr W complained to Zurich on behalf of the trustees and said, in summary, that he was unhappy with the outcome of the review. He didn't think that either of the lives assured had reached the threshold for life expectancy that was set when the policy was put in place. He thought the decision was based on poor investment returns and didn't think Zurich's future projections were correct.

Zurich looked into his concerns but didn't uphold the complaint. They noted that they'd previously addressed a complaint about failed reviews in 2021 and reiterated how the review process worked. They went on to explain that the 2023 review had been impacted by ongoing lower than expected performance of the underlying fund invested in, alongside a reduction in their assumption for the rate of future growth.

Mr W and the other trustees didn't accept Zurich's findings and asked for our help in the matter. The complaint was considered by one of our investigators who didn't think it should be upheld. She acknowledged that the policy's premiums had become more expensive over time. But she didn't think Zurich had treated the trustees 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 provided the trustees with information about the level of premium needed to sustain the policy for life.

The trustees didn't accept her findings and said that the outcome of the 2023 review was unexpected and unprecedented. They thought that Zurich hadn't acted fairly and should have considered other options instead of what they'd been presented with – reducing the sum assured by c.£46,000 or increasing the monthly premiums by c.£360.

The investigator reconsidered the complaint in light of the submissions that had been made and issued a revised opinion. She still didn't think the complaint should be upheld but explained that Zurich had an obligation to ensure that their communications were fair, clear, and not misleading, in the trustees' best interests and paid due regard to their information needs.

She noted that the costs of the policy had overtaken the premiums that were being paid in

2019. She thought that Zurich should have made the trustees aware of this “tipping point” as it meant that going forward, the difference between the costs and premiums would be taken from the policy’s underlying investment fund. This would potentially impact the long-term sustainability of the policy as the fund wouldn’t potentially grow as quickly as it did in the past.

However, she thought that even if Zurich had made the trustees aware that the costs had overtaken the premiums, the trustees wouldn’t have taken a different course of action such as surrendering the policy. She noted that Zurich’s reviews had calculated the premium that they thought would maintain the policy for the rest of the Mr and Mrs W’s lives. Therefore, the options that they’d presented to the trustees wouldn’t have been any different even if they’d provided more information about the costs of the policy.

In her opinion, the trustees had a need for cover and based on their circumstances in 2019, she thought it was more likely than not that they would have kept the policy as opposed to surrendering it or seeking alternative cover.

Mr W didn’t accept the investigator’s findings. He thought he should have been advised that the future of the policy was likely to involve substantial reductions in cover or increases in premiums. Whilst he didn’t know exactly what course of action he would have taken at the time, there would have been alternatives available such as cashing in the policy and gifting the money to his family, and he should have had the opportunity to consider them.

He noted that in January 2022, Zurich had offered a substantial increase in cover at no cost which he’d accepted but they’d only provided him with a limited amount of information. He also reiterated the previous points he’d raised about the 2023 review. He thought that the drastic changes were caused by Zurich’s decision to adopt new assumptions of investment growth. The impact of the decision was significant, and the investigator hadn’t said if it was a breach of the regulations.

He believed Zurich were wrong to treat the 2023 review as a normal review with an unrealistic outcome. It was a key event which required a full explanation and an attempt to find mitigating options.

Zurich also didn’t agree with the investigator’s findings. They thought her view on the matter deviated from the findings they’d received from this service on similar cases, and they also didn’t agree that there was an imbalance of knowledge between the parties.

They explained that it was expected that at some point the cost of cover would exceed the premiums being paid. However, any excess cost would be offset by the return on the policy’s underlying unit fund. The policy’s reviews would assess whether the current premium and existing unit fund would be sufficient to meet the cost of the current level of cover over the whole lifetime of the policy.

They explained that the premium at the outset was set so that if it performed in line with their assumptions regarding mortality and investment returns, then the policy would provide a specified amount of life cover for a level premium until a claim was made. Premiums were set on the basis that in the early years of the policy, they would exceed the cost of cover and expenses with the excess being used to build up a unit fund. The unit fund built up would have two impacts:

1. It would reduce the cost of cover going forward because the ongoing cost of cover was based on the excess of the sum assured over the unit fund, and

2. It would provide an investment return, part of which could be used later in the life of

the policy to cover the excess of the cost of cover over the premium paid.

If mortality rates and investment returns were as assumed, then the unit fund would continue to grow by the part of the investment return not used to cover costs and expenses and if their assumptions regarding mortality costs and investment performance were correct, then the policy would continue to provide the same level of cover for the same premium for the whole lifetime of the policy.

When the costs first exceeded the premiums in 2019, it wasn't inevitable that future premiums would increase to maintain the cover. While there were 'not as expected' reviews in 2004 and 2009 caused by poor investment performance, the other reviews prior to 2021 showed that the policy remained on track to continue providing the same or a higher level of cover for the same level of premium. The unfavourable review in 2021 resulted from investment performance being lower than assumed over the years leading up to the review.

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. However, I'd firstly like to address Zurich's point regarding inconsistencies in the investigator's opinion compared to similar cases they have with this service.

I fully appreciate their concern and note the previous communications they've had with our service regarding these products. As a service, we consider each case on its own merits giving regard to the specific circumstances of each case. Outcomes can be different on what appear to be similar cases, but this is down to the individual circumstances of each case.

In the case they'd previously discussed in their communications with us, there was no tipping point where the cost of cover exceeded the premium. The tipping point was a key consideration in the investigator's view on the trustee's case and highlights how similar looking cases can have subtle differences which can impact the eventual outcome. That being said, our approach to certain cases can evolve over time and I'm not bound by opinions we may have given in the past. For the reasons I will go on to provide, I'm satisfied that I've reached a fair and reasonable outcome in the specific circumstances on this case.

I'll now address the issues the trustees have raised relating to the 2023 review. In making my decision, I've considered if Zurich treated the trustees fairly by providing them 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.

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 the trustees' complaint against Zurich.

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 using 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 the trustees' concerns about the outcome of the 2023 review. They've said they were alarmed that over the course of 30 years, they were never made aware that there was any kind of shortfall which subsequently led to the sum assured being reduced.

I've therefore considered if Zurich treated the trustees fairly by providing them with enough information to enable them to make an informed decision about the policy, taking into account the guidance in FG 16/18.

I note Zurich's explanation of the mechanics of the policy. And I also take their point that it was performing as expected, therefore there was no reason to inform the trustees that the cost of cover was exceeding the premiums being paid. However, I think this goes against the expectation to provide consumers with sufficient information as set out in FG 16/18. I think consumers need to be informed when a policy reaches its the tipping point as it represents a key event in its lifetime.

I say this because it represents the point where there is a change in the mechanics of the policy - the unit fund starts being utilised to supplement the premiums. This means that investment performance becomes much more important than it was previously. If there is poor performance then there will likely be an increase in the premiums, potentially significant, that would represent a poor outcome for the trustees.

I think that sub-outcome 2.1 of FG 16/18 specifically addresses the need for consumers to understand the impact of charges in order to make an informed decision and sets out the level of information that should be provided in communications. It says:

"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."

I think the guidance is clear that there needed to be a high level of transparency in communications relating to closed book products, including the impact of fees and charges. I think that once the tipping point is reached, it is imperative that the level of charges and their impact on the policy needs to be disclosed to consumers in a fair, clear and not misleading way. In doing so, firms can ensure consumers are in a position where they are able to make a fully informed decision about whether to keep a policy or not, given the increased risk of changes to the premiums or sum assured going forward.

In my view, the obligation on Zurich to do so is in line with the requirements imposed by PRIN 6 and 7, as well as COBS 2.1.1R(1) and COBS 4.2.1R (1). It is also in line with the illustrations of good industry practice outlined by the regulator in FG 16/8 and, taking all of that into account, is what I would in any event regard as the fair and reasonable response in the circumstances.

The tipping point of the trustees' policy was the policy year ending 28 February 2020. Having passed that tipping point, I have given careful thought to how Zurich were communicating with the trustees. They were conducting annual policy reviews in January of each year which provided them with the opportunity to deliver important messages. I think Zurich should have made the trustees aware of the position of the policy within 12 months after the date when the tipping point was reached, so by the end of February 2021 at the latest.

Taking into account the regulatory obligations I have set out above (PRIN and COBS) 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 Zurich should have taken steps to ensure they communicated information to enable the trustees to evaluate the impact of the increasing life cover costs on the policy and the available options 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 clear timelines for the making of decisions where applicable.

In broad terms I consider it was incumbent on Zurich to have provided the trustees with the following information in a clear fair and not misleading way to enable them to make an informed decision:

- *A clear outline of the existing cover – including the sum assured and premiums.*
- *The current surrender value.*
- *The life cover costs (including administration charge).*
- *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 how long the policy was likely to be sustainable on its existing terms (reasonable approximations would suffice).*
- *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 the trustees information that would allow them to fully appreciate the risks and consequences of not taking any action.*
- *A clear explanation of the poor outcomes a consumer 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 a consumer 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've considered the communications Zurich sent the trustees after February 2020 and I can see that most of the information was being provided. The January 2021 review letter explained that the cost of providing cover was higher than expected. If the trustees wanted to maintain the sum assured of £237,207 for the life of the policy, then they would have to increase the premiums from £215.80 to £313.89.

Alternatively, they could opt to reduce the sum assured from £237,207 to £221,294. The review letter also contained a booklet gave more detail on how the policy worked including what happened when the policy was reviewed, the impact of the different options provided at each review and the factors that affected the cost of providing cover.

However, I'm not satisfied that the information provided fully met the trustees' needs. The main reason for me saying this is because there was no disclosure of the specific level of charges, or an explanation that the costs of the policy were no longer being met by the premiums. Without this level of information, I don't think the trustees would have been able to make a fully informed decision about their available options following each review including whether or not they wanted to keep the policy.

With this in mind, I think communications to the trustees once the tipping point had been reached, should have provided all the information I previously outlined in a clear and accurate format to enable the trustees to make a fully informed decision about what steps they wanted or needed to take to make the policy sustainable for life. I think this was confirmed in firm's obligations highlighted in FG 16/8, that "Communications to customers at the time of key policy events are clear, accurate and enable them to make informed decisions..".

Taking everything into account, I'm satisfied that the trustees weren't provided with enough information about the policy, specifically relating to the cost of providing cover. Therefore, I'm of the opinion that there was an imbalance of knowledge between Zurich and the trustees. This meant that the trustees weren't able to make a fully informed decision about what steps they wanted or needed to take following the tipping point being reached.

What would the trustees have done differently?

I've considered what, if anything, the trustees would have done differently if they'd been provided with all the information I've set out above after the tipping point was reached. They've explained that they might well have considered other options such as surrendering the policy. However, I must balance this with what Zurich would likely have said at the time and take into account the information they were providing.

It's important to remember that Zurich were making their assumptions based on the policy lasting for the remainder of the Mr and Mrs W's lives, and not just until the next review point. So, even if they'd explained that the cost of providing cover was higher than the premiums being paid, there would also have been an explanation that this was how the policy was designed to work. And based on their current assumptions regarding mortality costs and

investment performance, the level of premium being paid would be sufficient to sustain the policy for life.

The original purpose of the policy was to provide a lump sum for the surviving trustees and to mitigate inheritance tax. Those requirements still exist, so I'm satisfied that there is still a need for the policy. There aren't any concerns about the affordability of the current level of premium, but I'm not persuaded that the trustees would have chosen to increase the premiums in any of the reviews since the tipping point was reached in order to ensure the long-term sustainability of the policy.

I say this because they hadn't chosen to increase the premiums when they were given this option in past reviews and instead accepted reductions in the sum assured. The proposed increase in premiums in the 2021 review was from £215.80 to £313.89 and in 2023 it was a potential increase from £215.80 to £580.48. I don't think either of these increases would have been affordable for the trustees so I don't think they would have chosen to increase their premiums even if they'd been made aware of the tipping point.

The 2022 review offered a different option as the trustees were offered the opportunity to increase the sum assured without increasing their premiums. I think this point is finely balanced, but I don't think they would have chosen to keep the sum assured instead of increasing it even if they'd known the true level of the cost of cover versus the premiums that were being paid. I say this for the following reasons:

The booklet provided with the review letters explained that if the review showed that the cost of providing cover was lower than expected then a consumer could either:

- *Keep this cash value in the plan, so the level of cover will remain the same. However, this would mean that they would give themself a cushion in case the cost of cover increased in the future, or*

- *Use the cash value to pay for the cost of extra cover without increasing the premiums if they wanted more cover.*

The trustees were therefore aware of the possibility to build up a cushion but didn't take this option. They'd had a reduction in the sum assured the previous year due to an increase in the cost of cover, so they knew this could happen again. Despite this, they still chose to increase the policy's sum assured so I'm not persuaded that even if Zurich had provided all the information I set out previously, they would have taken a different course of action.

Also, given the ages of the lives assured, it would be very expensive to take out a new policy elsewhere. From what I've seen, their intention was to keep as much cover as possible for the premium they were paying in order to reduce a potential IHT liability/provide a lump sum for the surviving trustees. Taking all this into account, I don't think the trustees would have surrendered the policy.

I appreciate the point the trustees have raised regarding Zurich's decision to revise their assumptions of investment growth in 2023. However, I don't think it was unreasonable for Zurich to take this course of action. I say this because they had a requirement under Outcome 3 of FG 16/18 to give adequate consideration to, and take proper account of fund performance and policy values in a way that ensured they treated their closed-book customers fairly and proportionately. In practice this meant they had to review their investment performance more frequently and ensure their assumptions accurately reflected the level of performance they were seeing.

While the revised assumptions clearly had a negative impact on the trustees' policy. I don't

think Zurich acted unfairly in revising their assumptions to a more accurate level as it meant that consumers were being provided with a more accurate level of information than they were previously receiving.

So, taking everything into account, and despite Zurich not providing the trustees with the level of information about charges being applied to their policy, I don't think the trustees would have taken a different course of action even if this information had been provided."

Responses to my provisional decision:

Zurich responded and said that while they disagreed with some of the comments I'd made, they had no further points to put forward.

Mr W responded to say that he disagreed with my findings. He felt there were points I'd made which didn't accurately reflect the position of the trustees, these were:

- He'd only raised the question of life expectancy to emphasise the seriousness of the decision for policyholders where benefits might reasonably be expected to be payable in the near future.

- He never alleged that the performance was due to mismanagement.

- He also didn't say that Zurich's figures were wrong. The point he made was that the 2023 change in future projections was unexpected and sudden as the previous review in 2022 resulted in an £8,000 increase in cover.

He explained that it was the 2023 review which was the subject of his complaint and didn't think it had been properly considered. He accepted that Zurich were entitled to adopt revised projections. But he thought that none of the previous information they'd provided, or previous decisions made by the trustees could have prepared them for what happened in 2023. He thought Zurich should have sought ways to mitigate the impact of their decision instead of just sending a standard letter without any commentary or realistic options.

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. I fully appreciate the concerns raised by Mr W and I don't underestimate the impact of the outcome of the 2023 review on the trustees. However, in order for me to uphold this complaint, I need to see that Zurich have treated them unfairly.

I'd previously set out why I thought Zurich didn't act unfairly in revising their underlying projections for the policy. I still remain of the opinion that in revising their projections, they've put the trustees in a better-informed position about the steps that needed to be taken to make the policy sustainable for life. And I remain of the opinion that if Zurich hadn't revised their projections, then the trustees could potentially have faced an even worse outcome in the future.

I accept the revision was unexpected, especially after the previous review had been better than expected and increased the sum assured for no change in premium. But I don't think that Zurich would have been aware that their underlying assumptions would change over the next year, so I don't think it was unreasonable for them to offer an increase in sum assured based on their assumptions at the time.

I also don't think that it would have been fair on Zurich to offer mitigating options which weren't based on their projections. For example, if after the 2023 review, they made the decision to limit the reduction in the sum assured or the increase in premiums needed, it would have had the impact of using up more of the underlying fund in order to offset the cost of cover.

It's important to remember that the cost of providing cover was higher than the premiums being paid. If the premiums were set too low or the sum assured set too high, then the underlying fund would be depleted at a faster rate than necessary, and it wouldn't provide the return needed to sustain the policy for its lifetime.

This would mean that drastic changes to the sum assured or premiums would be required in the future which would mean a worse outcome for policyholders. This could lead to a scenario where the policy became unaffordable or the level of cover it provided wouldn't meet its original purpose.

So, having taken everything into account, and while I appreciate this will come as a disappointment to Mr W and the trustees, I'm not persuaded that this complaint should be upheld.

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 Mrs W, Mrs W and Mr W to accept or reject my decision before 3 April 2025.

Marc Purnell
Ombudsman