

The complaint

Mr S complains about a reviewable whole of life (RWOL) policy he holds with Aviva Life and Pensions UK Limited. He's unhappy with the outcome of a policy review held in 2022

What happened

Mr S has held the policy since 1989, it initially provided a sum assured of £40,000 for monthly premiums of £24. Aviva reviewed the policy in 2022 and wrote to Mr S saying that if he wanted to maintain the sum assured of £12,217, he'd need to increase his premiums to £41.43. If the premiums weren't increased, then the sum assured would fall to £5,889.

Mr S complained to Aviva about the outcome of the review, but they didn't uphold his complaint. They wrote to him saying that they'd followed the correct procedure when they'd completed the review. They explained that the outcome of the review was due to the costs of the policy being higher than the premiums being paid. Therefore, in order to sustain the policy, changes needed to be made to either the sum assured or premiums.

Mr S asked us to look into the matter as he was unhappy with the outcome of the review. One of our investigators looked into his concerns, but didn't think his complaint should be upheld. He was of the opinion that Aviva hadn't provided Mr S with all the information they should've done. But he thought that even if they had done so, Mr S wouldn't have taken a different course of action with the policy, such as surrendering it or changing its terms.

Mr S didn't agree with the investigator's findings. As there's been no agreement, the complaint has been passed to me to decide.

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 don't think this complaint should be upheld and I will now explain why. I've carefully thought about the points Mr S has raised, and I fully appreciate how strongly he feels about this complaint. I'd like to reassure him that I've considered all the information he's submitted. However, I haven't commented on all the points he's raised, only on what I consider to be the key issues relating to his complaint. This isn't meant as a discourtesy but instead reflects the informal nature of this service.

I've considered whether Aviva were within their rights to review the policy and make changes to either the sum assured or monthly premiums. In order for me to uphold this complaint, I need to see that their actions weren't in line with how the policy was supposed to operate, or that they treated Mr S unfairly.

The reviewable nature of the policy was a subject of a complaint raised by Mr S in 2005 and it was clarified at the time that it was reviewable and therefore could be subject to change. He was also told that his policy was taken out on a maximum cover basis which meant that it had a high sum assured, but the costs of providing this cover were using the majority of the

monthly premiums that were being paid.

The impact of this was that there weren't much surplus funds left over which could be used to build up an underlying fund. This fund was important as it would be required to make up the shortfall between the cost of providing and the monthly premiums, because at some point the cost of providing cover would overtake the premiums being paid as Mr S got older.

The terms of policy were also highlighted to Mr S at the time, and they say:

"Plan Reviews and Guarantees

The first Plan Review will normally take place after 10 years, followed by further reviews every five years. However a further (or the first) review will take place following the life assured's 70th birthday and annually thereafter.

Shortly before each review the Company will advise the Policyholder whether or not contributions are sufficient to enable the benefits to continue until the next review.

If the benefits cannot be maintained, then normally the Policyholder can opt either to increase the contributions to maintain the same level of benefits, or maintain the same level of contributions and reduce the benefits.

At inception, the benefits will be guaranteed until the first review. Thereafter, the benefits will be guaranteed until the next review provided that the recommendations made at each review are followed."

In my opinion, this clearly shows that the policy wasn't guaranteed and instead was reviewable. And at each review, changes could be made to either the sum assured or monthly premiums.

The main reason for the changes proposed in 2022, was because of the increased costs of the policy, in line with what Mr S was told in 2004. It may be helpful if I provide a bit more detail around how the policy worked. Its costs weren't a fixed sum and would increase as the life assured gets older, but this was how the policy is designed to operate.

At the start of the policy's lifecycle, the premiums being paid are higher than the cost of cover. Any money left after the cost of cover is deducted from the premiums is used to build up an underlying fund. As the life assured gets older, the costs of the policy increase and can exceed the premium being paid, but this can be offset by using the underlying fund.

Firms will carry out 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 policyholder will usually be offered the option of reducing the sum assured or increasing the premium. This will ensure that the underlying fund doesn't run out and is able to continue to sustain the policy.

At the 2022 review, Aviva determined that Mr S' policy wasn't sustainable on its current terms. This was because at the time, the policy had an underlying fund only worth around £37, but the annual charges were around £470 against annual premiums of £288. Therefore, the underlying fund would run out within a few months of the 2022/23 policy year.

This is why Aviva proposed the changes that they did in the 2022 review. By reducing the sum assured or increasing the policy's premiums, there would be excess funds left over each month. These excess funds would be used to top up the policy's investment pot which

would then help to sustain the policy over time. I don't think this was unreasonable, and taking everything into account, I'm satisfied that Aviva didn't act unfairly and were within their rights to review the policy in 2022 and propose the changes that they did.

The next point I've considered is if Aviva gave Mr S sufficient warning about the changes that the policy might need in the future. This is because in order to meet the regulator's requirements, firms need to ensure that they provide policyholders with enough information to enable them to make an informed decision about their options for the future.

This is particularly important from the point where the costs of the policy start overtaking the premiums being paid, as this represents a tipping point where the policy's underlying fund starts being utilised to offset the difference between the costs and the premiums. The costs of the policy will usually continue to increase over time which means that the fund can become depleted.

The impact of this is that significant changes will need to be made to either the premiums being paid or the policy's sum assured which can represent a poor outcome for the policyholder. Therefore, I think that the very latest that consumers need to be put in an informed position about their policy is within 12 months of this tipping point.

From what I've seen, the costs of Mr S' policy overtook the premiums being paid in 2004, then the sum assured reduced which meant the cost of providing cover also reduced and didn't overtake the premiums again until 2016. But the evidence shows that Aviva didn't consistently provide Mr S with all the information they should have done. I haven't seen that they provided him with costs of the policy until 2019, apart from in 2004 when they explained that the monthly costs of the policy were £39.93 and the premiums were £24. They also didn't provide him with projections of how much it would cost to maintain the policy for life.

That being said, Aviva did provide Mr S with some relevant information in their review letters. For example, the review letters from 2014 onwards gave a projection of how long the policy was expected to support its benefits. The review letters from 2019 onwards also said:

"If your priority is to maintain your current level of benefit either throughout life or for a specific number of years, and your projection doesn't show this is likely, we would strongly urge you to consider taking action."

But, as I've previously noted, I'm not satisfied that Mr S was given sufficient information about what the future held for his policy. Therefore, I've considered what course of action he would likely have taken if he'd been put in an informed position.

I think Mr S' actions after the 2004 review are relevant. In 2004, the policy failed a review and Mr S was told that if he wanted to maintain the sum assured of £40,000, he'd have to increase his premiums from £24 to £71.39. And if he didn't, then the sum assured would fall to £12,217. He raised a complaint and in the course of his correspondence with Aviva, he was made aware that the costs of the policy were higher than the premiums being paid. He was also made aware that the policy was on maximum cover basis and what this meant for its long-term sustainability.

He didn't increase his premiums at the time and the policy's sum assured was reduced. He allowed this change to happen, and didn't surrender the policy even though he was in a relatively informed position about how it worked, the basis of cover and the fact that it could be subject to significant changes. If he wasn't prepared to make changes to the policy at that time, then it doesn't seem likely that he would have made any changes if he'd been put in an informed position around the time the costs of the policy overtook the premiums again in 2016.

Mr S has also strongly maintained that he was under the impression that he'd entered into a contract with Aviva to provide a guaranteed sum assured of £40,000 for a monthly premium of £24. He's said that he never read their letters as he had a signed agreement confirming the policy's sum assured and premiums. He's also explained that he was retired and on a limited pension income.

With this in mind, I don't think that he would have taken a different course of action even if he had received ongoing information about the specific level of charges and projections of how long the policy was expected to last on its current terms and what it might cost in the future. If he wasn't reading the correspondence that he received from Aviva, then he wouldn't have been aware of what the future would specifically hold for the policy.

Even if he had been paying careful attention to the content of Aviva's letters, I think that his underlying health issues and lack of disposable income would have made it difficult to seek cover elsewhere. A comparable policy, guaranteed for life, would have been much more expensive than his existing Aviva policy and I'm not persuaded that he would have been able to afford significantly higher premiums than what he was paying. And because the purpose for the policy – providing protection for his family – still remained, I think it's likely that he would've chosen to have keep the policy in place on its existing terms while he could.

Therefore, having considered everything, I don't think this complaint should be upheld. I appreciate this will come as a disappointment to Mr S, but I hope he can understand the reasons why I've come to this conclusion.

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 S to accept or reject my decision before 8 October 2025.

Marc Purnell
Ombudsman