

The complaint

Ms C says Humboldt Financial Limited mis-sold her a critical illness insurance policy ('the policy').

What happened

I issued a provisional decision in May 2024 explaining why I was intending to uphold this complaint. An extract of my provisional decision is set out below.

.....

Humboldt recommended the policy to Ms C so it had a regulatory obligation to ensure that it was suitable for her needs. It also had to provide her with clear, fair and not misleading information about the main features of the policy.

I intend to uphold Ms C's complaint. For the reasons set out below, I don't think the policy was suitable for her needs.

- I'm satisfied that price was an important factor for Ms C when taking out the policy and she ended up reducing the critical illness benefit amount from £100,000 (which she was initially quoted for) to £79,000 to keep the premium lower.
- The planning report prepared by Humboldt's representative dated September 2022 ('the planning report') also reflects that: "this premium was selected on the basis that it was the **maximum** premium which you wished to commit to at this stage" (**my emphasis**).
- The policy premium is recalculated based on Ms C's status at each plan anniversary. And the premium can change depending on her status – ranging from a 2.5% increase if she didn't engage with the insurer's wellbeing programme ('bronze status') to a 0% increase with high engagement ('platinum status'). There was also 'silver' and 'gold' status resulting in a 1.5% and 0.5% premium increase respectively.
- Ms C says that Humboldt's representative told her that for the premium to remain the same each year, she just had to do around 10,000 steps, three times per week. And even though she wasn't a member at one of the insurer's recognised gyms, she was able to work out at her local gym and log her exercise. She says she was told that this would qualify instead of steps. I find Ms C's submissions on this point to be persuasive, consistent and plausible.
- The planning report does reflect that the reason for choosing the policy is because the insurer "offers lower premiums at the start of your plan and keep them lower based on your activity levels to help incentives [sic] you to stay healthy resulting in you less likely to make a claim".
- However, the planning report doesn't contain any information on what Ms C needs to do to, or the points she needs to earn each week/year, to ensure she reached

platinum status and resulting in a 0% increase to her premium the following anniversary year.

- Having looked at the insurer's documents about the wellness rewards, I'm satisfied that if she walked 10,000 steps per day for three days a week, she would've earned 15 points per week. She could also earn five points per workout at one of the insurer's recognised gyms. 15 points per week translates to 780 points and would not have granted her silver status so her premium would've increased by 2.5% on the anniversary year. To reach platinum status (with a 0% increase in premium) she would've needed to earn 2,400 points per year (so around 46 to 47 points per week). Even if she walked 10,000 steps every day of the year, that would've only equated to 1,825 points based on five points per day – still less than the reward points needed to reach platinum status and would've resulted in a premium increase the following year.
- Given what Ms C says about her levels of activity – which I accept – I'm satisfied that she would not have been able to reach platinum status and may have remained on bronze status at the policy anniversary. I'm also therefore satisfied that the premium is always likely to have increased year on year. So, I accept what she says about the policy (and what needs to be achieved to keep premiums low) to be inappropriate for her lifestyle. I don't think this policy was suitable for Ms C's needs given that she wanted to keep her premium low.
- Ms C says that "predictability of outgoings is important to me because there may be times between contracts when I have no income coming in and I need to feel in control of what's going out". I accept what she says about that and is consistent with her actions of wanting to keep the premium low.
- At the time of taking advice from Humboldt, Ms C already had in place a separate reducing life insurance policy (for which she was paying £28 per month) and critical illness policy for around £74 per month. The critical illness policy offered a benefit amount of £100,000.
- So, although the policy Humboldt sold Ms C, was more comprehensive in terms of the number of critical illnesses it paid out on and offered to pay out claims at a lower threshold of seriousness than the insurer Ms C was previously insured by, it offered £21,000 less benefit in the event of a successful claim. At the time of sale it also cost around £12 more per month. Given the monthly premium was also likely to increase year on year as Ms C was always likely to remain at bronze status under the policy's terms and conditions, I don't think the advice to end the critical illness policy she had the benefit of and take the policy was suitable.
- From the email correspondence I've seen between the parties leading up to the sale of the policy and shortly after, I'm satisfied that Ms C was relying entirely on the advice she was being given. Indeed in one email she says: "when it comes to financial stuff my brain retains absolutely nothing". So, if she'd been told that the policy was an unsuitable option for her given her intended exercise activities and need to keep costs low, I don't think she would've taken it.
- Further and in the alternative, I don't think Ms C was given clear, fair and not misleading information about a key feature of the policy, namely that the monthly premium of around £86 "was guaranteed" as set out in the planning report and how she can reach a certain status whereby her premium wouldn't increase.

There's nothing contained in planning report explaining how to reach platinum status and, as set out above, I accept that she was told walking 10,000 steps three days per week would be enough to ensure that her premium wouldn't increase the following year. That wasn't right and was misleading.

For reasons set out above, if Ms C had been fairly made aware at the time of sale about what she'd need to do to reach platinum status – and the number of reward points she'd need to earn – I don't think she would've taken the policy.

Impact

Ms C tried to get her original critical illness policy reinstated when looking to cancel the policy but this wasn't possible. I accept what she says.

She cancelled the policy around nine months after it began and around the same time, she took out a different (third) critical illness policy through a different third party broker with a benefit of £50,000 for £72 per month. She also took out income protection insurance with a benefit amount of £4,000 per month at a cost of around £46 per month.

After Ms C brought a complaint to the Financial Ombudsman Service Humboldt said:

On reflection, I think it is clear we could've done more when working with you on protection advice. I understand why you are upset with the difficulties encountered during process too. You also highlighted the poor communication and distress encountered during this time and I can see where you're coming from. I agree the service received wasn't to the level we should expect...

It subsequently offered to refund Ms C £389.43 (half of the total premium she paid for the policy).

I'm persuaded that Ms C approached Humboldt because she wanted to review the insurance protection she had in place. Had Humboldt acted fairly and reasonably in this case I don't know for sure whether she would have retained the original critical illness policy she had in place. But I find it more likely than not that she would've.

Although, since cancelling the policy, she has taken out additional critical illness cover with a benefit of £50,000, the monthly premium is similar to the premium she was paying for the original critical illness policy with double the benefit. So, I think it's unlikely she would've cancelled it to take out another policy which - although offered additional cover – was of same price and with a significantly less benefit amount.

So, in all likelihood Ms C would've carried on paying for the original critical illness policy rather than taking out the policy Humboldt sold to her, and she's ended up paying £12.22 extra for the policy for around nine months until it was cancelled and replaced with another critical illness policy. I think the policy is unlikely to have been in place had Ms C received the correct advice and clear, fair and not misleading information about the key features of the premium going forwards.

I'm also satisfied that Ms C has experienced unnecessary upset and inconvenience as a result of being sold an unsuitable policy. She's had to spend time speaking to Humboldt to try to understand how the premium works and requesting more information about this after the policy was sold. I also accept that she would be very upset to know that she cancelled her original critical illness policy based on the unsuitable advice she received about the policy – only to have now ended with a third critical illness policy for a similar price to which she was initially paying and with half the benefit amount.

Whether Ms C will need to make a critical illness claim in future (and whether it is successful) is purely speculative at this stage. The circumstances may not arise leading to her making a claim on the policy. It's also possible that she might cancel the critical illness policy before the end date. So, I don't think it would be fair and reasonable for me to ask Humboldt to pay an increased benefit amount to her.

However, losing the opportunity of possibly claiming an increased amount on a critical illness policy, through no fault of her own, I accept, is upsetting. So, overall, I'm also intending to direct Humboldt to pay Ms C £1,000 compensation for distress and inconvenience.

.....

I invited both parties to provide any further information in response to my provisional decision.

Ms C said she had nothing further to add. Humboldt replied, disagreeing with my provisional decision. In summary it said:

- The maximum monthly budget for protection was said to be £100 but the total insurance protection Ms C now has in place is more than that.
- The policy provided other benefits which would've resulted in savings for Ms C such as free drinks and cinema tickets, and reduced gym membership fees.
- The premium wasn't guaranteed to rise. It depended on how Ms C engaged with the benefits and discounts of the policy.
- The Ombudsman has focused too narrowly on the examples of what Ms C could do to achieve platinum status.
- Suitability reports can often be too long and it's not reasonable to add all the activity and benefits that can be utilised under the policy in the report.
- It's not within the Ombudsman's remit to decide whether Ms C would've become healthier or not. And if it is in the Ombudsman's remit, not enough weight has been placed on Ms C statements about wanting to become healthier and the insurer being recommended as the only provider that will reward customers with a reduction of total monthly expenditure through free coffee and cinema tickets etc
- The Ombudsman has assumed that the reference to 'guaranteed' premiums in the suitability report is in relation to 'price not rising' but it's actually in relation to the difference between guaranteed and reviewable premiums.
- There's no consideration of Humboldt's willingness to reasonably end this process with Ms C as soon as it arose.
- The policy Ms C ended up with was 'best in breed' for her.

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 uphold Ms C's complaint because the further points raised in response to my provisional decision don't change my mind. I'll explain why and although I haven't responded to all points made by Humboldt, I have taken them into account.

- I'm satisfied that in addition to the original life insurance policy, since cancelling the policy, Ms C has taken out critical illness cover and income protection cover. The cost of the life and critical illness policies total around £100 so I don't think this is inconsistent with Ms C's needs at the time Humboldt sold the policy to Ms C.
- Whilst the policy may have been capable of providing other benefits to Ms C such as free drinks and cinema tickets, I don't think this means the advice she received to cancel the critical illness policy she had in place and replace it with the policy was suitable. I remain satisfied that the cost of the policy was an important factor for Ms C and there's nothing to suggest that the other ancillary free or discounted items/services she could've benefitted from would've been important to Ms C – and outweighed the likelihood of not being able to progress beyond bronze status and her premium going up each year.
- I've explained in my provisional decision why, given what Ms C says about her lifestyle – which I accept – it's unlikely on the balance of probabilities that the premium wouldn't have gone up given that it's unlikely she would've progressed beyond bronze status. Nothing Humboldt has said in response to my provisional decision convinces me otherwise.
- When considering whether the advice to take out the policy (at the expense of cancelling the existing critical illness policy) was suitable, I'm satisfied that I am entitled to make a finding of fact on the available evidence about whether Ms C is likely to have moved from bronze status, taking into account what's required to do so under the policy requirements. Ms C may have wanted to become healthier but that doesn't mean that the policy was suitable for her needs given the activities she would've needed to have completed each week to have moved beyond bronze status (which ultimately impacted the premium for successive years).
- Even if the policy was 'best in breed' as Humboldt says, that doesn't mean that it was suitable for Ms C's individual needs in at the expense of the existing critical illness policy she in place. And in the circumstances of this particular case, I think it would be fair and reasonable to have reflected in the planning report a brief summary of what Ms C would need to do in order to achieve a different membership status given that I'm satisfied that keeping the premium down was a key motivator for Ms C at the time.
- I've explained in my provisional decision why I'm persuaded by Ms C's testimony, where applicable and I've also carefully considered relevant correspondence from the time when deciding this case as well as all points made by Humboldt.

For the above reasons and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I uphold Ms C's complaint.

Putting things right

I direct Humboldt to pay Ms C:

- the difference in premiums between the original critical illness policy she had the benefit of and the policy for the period of time the policy was in place.

- simple interest at a rate of 8% per year* on the difference of each monthly premium whilst the policy was in place from the date on which each monthly premium paid by Ms C to the date of settlement.
- £1,000 (one thousand pounds) compensation for distress and inconvenience.

This supersedes the offer of £389.43 made by Humboldt which I understand hasn't been paid to Ms C.

* If Humboldt considers it's required by HM Revenue & Customs to take off income tax from any interest paid, it should tell Ms C how much it's taken off. It should also give her a certificate showing this if she asks for one. That way Ms C can reclaim the tax from HM Revenue & Customs, if appropriate.

My final decision

I uphold this complaint and direct Humboldt Financial Limited to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C to accept or reject my decision before 12 July 2024.

David Curtis-Johnson
Ombudsman