DRN-4961417

The complaint

Mr S complains about the way Countrywide Assured Plc has administered his whole of life policy. He is unhappy about the mortality charges associated with the policy and how they are eroding its value.

What happened

In 1988, Mr S took out a reviewable whole of life policy called a Permanent Protection Programme. He paid £15 per month for a sum assured of £47,183 (although not originally, Countrywide are now responsible for providing the policy).

The policy was due to be reviewed after five years, and then every five years until Mr S reached 65, with reviews every year after that. The policy passed its reviews up to 2013.

In 2018 the policy was reviewed, and Mr S was told that to maintain the level of benefit he had, he needed to increase his premium by an additional £12.36. If he chose not to increase the premium, the sum assured would be reduced to £41,869. Mr S accepted the reduction in the sum assured, and therefore did not increase his premium.

In 2023, there was another review which showed that Mr S needed to increase his premium in order to maintain the sum assured. This time, the premium needed to increase by an additional £28.80 per month – or he'd need to reduce the sum assured to £23,858. When Mr S received this letter he complained to Countrywide about the sale of the policy and about the charges eroding the value of it.

Countrywide responded and said it didn't uphold the complaint, and also said it had been made too late. Mr S remained unhappy and referred his complaint to this service.

In July 2024, an ombudsman issued a decision on our jurisdiction to consider the merits of the complaint. In summary he said, the mis-sale complaint had been made out of time, but we could consider the complaint about the charges on the policy value.

One of our investigators issued an assessment on the merits of the complaint about the charges. He didn't think this should be upheld.

In summary he said Countrywide had an obligation to ensure that their communications were fair, clear, and not misleading, in Mr S's best interests and paid due regard to his information needs. It was noted that the costs of the policy had overtaken the premiums that were being paid in 2012. The investigator thought Countrywide should have made Mr S aware of this "tipping point" shortly after this 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, the investigator thought that even if Countrywide had made Mr S aware that the costs had overtaken the premiums, he wouldn't have taken a different course of action such as surrendering the policy. He said this because:

- After the first failed review in 2018, even though the sum assured had reduced, it was still valuable to Mr S and his family as he still considered that it was good value for money at the time.
- Mr S says the policy was taken to provide family protection, and this remains a priority for him. So, having this cover has been important throughout the life of the policy.
- It is unlikely Mr S would have taken an alternative policy if he was given clearer information in 2013, as the options available to him would not likely meet his needs or provide value.
- As life cover remained important, it is unlikely Mr S would have surrendered the policy even if Countrywide had provided clear, fair and not misleading information in its earlier reviews.

Mr S didn't accept the investigators opinion and asked an ombudsman to reach a decision on the merits of the complaint. In summary he said:

- At the time of the 2018 failed review, he assumed (incorrectly) it was linked to a UK market downturn, reducing the lifetime protection from £47,869 to £41,869. He wasn't able to pursue the point at that time and did not have any undue financial concerns with a fall in value to £41,869. He had significantly greater protection from his "death in-service" benefit from his employer.
- He only understood the structural problems with the policy after 2023, when he was faced with a reduction in cover from £41,869 to £23,858. He then recognised a fundamental problem must exist with the policy. His mindset changed from a 'less than gym membership' and time-in-the-market contribution towards a possible mis-selling scenario.
- The original £47,869 was always viewed as a 'nice to have' benefit linked to historical payment from the 1990s. It wasn't continued to ensure his financial security. It was continued because the payments are very small. He had a high salary in his working career with very good death in service benefits, which far exceeded the benefit of £41,869. The policy was seen as a relatively worthwhile bonus linked to many decades of very small payments of £15/month. This is the reason why he never agreed to increase the monthly payment after a review. He did not need the policies protection for his children. He would not have taken out any other death policies if he had cashed in the policy as his family were secure without it.
- He would have cashed in the policy, conditional on information being shared about the projected increased costs reducing the protection cover. This was certainly known in 2018 by Countrywide and may have been known earlier in 2013. If he had known that he would have zero projected value by the time he was 64, then he would have cashed in the product earlier. Even at £15/month it made no sense to throw good money after bad. He is now cashing in the policy. He has no need for the death policy protection that evaporates as he nears his death age.

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.

Firstly, I acknowledge Mr S has made further comments in response to the investigator's assessment about how the policy was sold. But as an ombudsman has already issued a decision on our jurisdiction to consider a complaint about the sale, which concluded it had been made too late, I'm unable to consider anything relating to this. The focus of my decision will be on the merits of the complaint relating to the administration of the policy since it was taken out.

This complaint was prompted by the outcome of the 2023 review. So I've looked into the issues relating to the reviews that have taken place on the policy. Countrywide has provided evidence to show the information it gave Mr S at the historical reviews it carried out since the first review in 1993 up to the last review in 2023.

In making this decision, I've taken into account the following standards:

- The FCA's Principles for Businesses, in particular Principle 6 and Principle 7;
- 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).

With these standards in mind, I think that Countrywide ought to have provided Mr S with clear, fair and not misleading information about the policy. What I've drawn from the guidance is that their communications to him should have included key details about the policy such as its performance, the value of its underlying fund and any fees and charges that had been applied. And they should have provided this information within a reasonable time frame and at the very latest, within 12 months of the point from the costs of the policy overtook the premiums being paid in.

I've reviewed the information contained in the first review letter sent in 1993. This was fairly limited in what it provided to Mr S for him to understand the policy performance and ongoing costs. But it was clear that the policy had passed as it states *"I am pleased to tell you that following the review, we can continue to provide you with the full amount of life assurance benefit which you now have, £47,183. There is therefore no need to take any action with regard to your programme."* A unit statement was provided that showed the value of units held as £243.24. A note was included that explained a significant part of the contributions are used to provide the assurance benefits and this will be reflected in the value.

The 1998 review passed, and the same information was given to Mr S – including an updated unit statement showing the value had increased to £1,232.83. Similarly, the communications at the 2003, 2008 and 2013 reviews all confirmed there was no action needed as the policy was on course to meet the target life cover. But no information was provided about the fees and charges applied.

At the 2018 review, Mr S was informed the review had demonstrated the need to increase the regular premium if the current benefit level was to be maintained. It said an increase of £12.36 to the current £15 was needed, and in the absence of an increase the cover would automatically reduce to £41,869. It asked Mr S to respond to let it know how he wished to proceed. But it doesn't appear he did respond, and the cover was reduced. Countrywide did write to him to confirm this alteration to the policy benefit. The 2023, was also a failed review. As previously set out, this required a larger premium increase of £28.80 per month – or a reduction in the sum assured to £23,858. Again, at neither of these reviews was information given about the costs of the policy.

Having considered the circumstances of this policy, and the outcomes of the reviews. I haven't found the information provided by Countrywide to Mr S was in line with the standards above. For example, whilst the early reviews weren't misleading in telling Mr S that no changes were required, they weren't clear because they didn't set out any of the key information about the costs of the policy or how those costs were increasing. I've not seen any statements which showed this information either and, without it, Mr S was unable to see how his policy was performing and, importantly, how the costs of the policy were increasing.

While the 2018 review, communicated that changes were needed to maintain the cover, there still wasn't information given to set out the current level of charge for the life cover or a projection of what it might be in the future. I also haven't seen Countrywide gave an indication of how long the cover might last if no premium changes were made and only the default reduction in the sum assured that would be applied. From the information provided to us by Countrywide about cost of providing the cover, it seems the costs had already started to exceed the premiums by around the time of the 2013 review. But Mr S wasn't made aware of this.

Despite the failings I've found in the information provided to Mr S as part of the reviews, I don't think better information would have led him to taking different action. I'll explain why.

Mr S has told us that he kept the policy as it provided a reasonable benefit for a relatively low premium. He has argued that he would have surrendered the policy earlier if he would have been made aware that by the age of 64 the policy wouldn't have any value. He has also said he wasn't relying on the cover to secure his financial security and saw it as a nice to have benefit, for a relatively small premium payable.

I acknowledge it does now seem that if no changes are made to the premiums the policy will eventually (and possibly by the time Mr S reaches 64) get to the point where no cover can be provided as the costs will have eaten into the value built up within the policy and the premiums alone can't meet the costs. But I need to consider things without the benefit of hindsight. I need to consider the likely action Mr S would have taken at an earlier point, if he was provided with information he should have been to explain the costs of providing the cover had reached the tipping point where they exceeded the premiums. At this point the policy was still able to provide the original level of cover for the initial premium – and did so up until the 2018 review.

Mr S has been clear that the £15 per month premium was very affordable to him during the lifetime of the policy. He provided information to support that his personal circumstances meant he became financially secure and was benefiting from employment benefits to provide a death in service payout. But he continued with the policy as it was something he was happy to continue to pay for the benefit being provided. So it doesn't seem that reaching the tipping point, would have been the point where Mr S saw no value in the policy. I think it likely, based on his submissions, that Mr S would still have seen value in the policy at this point as the premium amount seems a key factor in his decision to continue with the policy when it was still providing the original level of cover.

The policy did fail a review in 2018, and while he wasn't given all of the information he should have at this time, it does seem Mr S thought the policy was still worthwhile even with a reduced level of cover. I haven't seen he raised any concerns at this point, and the policy continued. Mr S has referred to not understanding the policy at this point, and assumed the issues affecting the policy related to wider market conditions. But he has said he was happy to continue despite the reduction as it was still a sizeable amount of cover and judged valuable by his family for the £15 premium.

I also don't find Mr S would have taken different action at the 2018 review if he had received clearer information about the future of the policy. The reduction in the sum assured at this review was around £5,000 or put another way about 10%. Mr S said the reduced cover was still valuable to his family, since the historical monthly payment of £15 was small in comparison with other household bills, and something he maintained for many years. So I'm of the view, that Mr S would likely have seen value in keeping the policy going for a further five years (until the next review) with the relatively small reduction in cover, rather than surrender it at this point. It's clear from his comments that he didn't want to increase the premiums, but was happy to pay the £15 per month.

Overall, I think the evidence indicates that Mr S wouldn't have made a different decision about the policy if he received better information sooner. It seems most likely he would have still continued with the policy as long as the cover provided remained at level that he was still saw as valuable for the relatively low premium. It was at the point where the cover was going to drop considerably that he reached the position to question the value of continuing to pay £15 per month for it.

So, despite my concerns that Countrywide hasn't demonstrated how it met its obligations, I haven't found reason to say it needs to do anything further. This policy was always subject to review. So, while Mr S now questions the worth of the policy, I don't think better information would have led him to make a different decision about policy. This means I don't find Countrywide needs to do anything to put things right.

My final decision

For the reasons provided, 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 17 October 2025.

Daniel Little
Ombudsman