DRN-5052284

The complaint

Mrs T is unhappy as she doesn't think that Wesleyan Assurance Society ('Wesleyan') has correctly administered the reviewable whole of life policy she holds with it.

What happened

I've outlined what I think are the key events and points involved in the complaint below.

Mrs T took out a reviewable whole of life policy – the Lifetime Account plan – in 1999 after receiving advice from Wesleyan to do so. The monthly premium was initially £30, it provided life and critical illness cover with a total sum assured £250,000 and the policy had an indexation increase option. The policy was subject to reviews, the first of which would take place on the tenth anniversary of the plan and then subsequent reviews would be notified to the policyholder after the first.

I understand that, by 2011, due to indexation the sum assured and premium had increased to a total, including life and critical illness cover, of around £450,000 for a monthly premium of £56.

At times Mrs T explored making a partial withdrawal from the plan's investment value. But on each occasion she chose not to go ahead with that, seemingly after receiving a review letter with her options based on how the plan stood and the impact of a withdrawal on it. For example, while I don't have a copy of the 2012 review letter Mrs T was sent, this seemingly 'failed' given I can see that following this she chose the option of keeping her £56 premium the same but for a reduced sum assured totalling around £423,000, rather than increasing her premium to the £70 per month requested to maintain existing cover levels.

The 2014 review letter said the review is to determine if Wesleyan can carry on providing Mrs T with the same level of cover based on the current policy value and her premiums. And that it couldn't continue to do so. So Mrs T was given the option to keep her existing premium – which was now £59 due to indexation – and reduce the level of cover to around £353,000, increase her premium to £83 and keep her level of cover the same, or surrender her policy. And Mrs T chose to keep her current premium the same but for the reduced sum.

Then, after being informed of the plan's 2014 annual indexation premium increase amount, which meant the premium would increase to £62 per month, Mrs T cancelled the indexation going forwards, which meant her monthly premium remained at £59.

The 2017 review letter Mrs T was sent in response to a partial withdrawal query – which she didn't then go ahead with, so her existing premium and sum assured remained the same – set out that she was interested in keeping the premium at £59 and maintaining the same sum assured or around £353,000, while making a partial withdrawal. The letter said though that based on its review Mrs T's current premium wasn't sufficient to support the level of cover she had over the next five years. So Mrs T was given the following options:

- Increase Mrs T's premium to £73 and keep the cover level the same, but it would use her existing fund alongside the increased premium to meet the cost of providing the

plan's benefits. And at the next review her premium may need to increase further; or
- increase her premium to £85 and keep the cover level the same, which should meet the cost of providing the benefits. But at the next review her premium may need to increase further; or
- keep her existing £59 premium and make the partial withdrawal, but reduce the cover level to around £300,000.

Wesleyan hasn't been able to provide a copy of the review, if any, that it then carried out in 2019.

The 2024 review letter again said the review is to determine if Wesleyan can carry on providing Mrs T with the same level of cover based on the current plan value and her premiums. And that it couldn't continue to do so. Mrs T was given the option to either keep her existing £59 premium the same and reduce the level of cover to around £177,000 (the default option), increase her premium to £141 and keep her cover level of around £353,000 the same, or surrender her policy.

As Wesleyan didn't hear back from Mrs T with a choice, the default option was applied and her sum assured was reduced for the current premium.

In May 2024, Mrs T complained to Wesleyan about the 2024 review letter, unhappy her premium is increasing and by so much, when she'd previously asked for indexation to be removed. And when her paperwork says the premium won't increase by more than 15%.

In June 2024, Wesleyan sent its final response letter not upholding Mrs T's complaint. It explained that, while indexation had previously been removed from the plan, it was policy reviews rather than indexation that had led to the premium increase. It said that the 15% was in respect of annual indexation increases rather than reviews, the latter of which aren't related to indexation. It said reviews are instead concerned with whether the plan value and premium being paid are enough to sustain the cover. And that if the premiums being paid are less than the policy charges being taken from the plan then Mrs T's fund will begin to erode.

Unhappy with this, Mrs T's complaint was referred to our Service. She said she disputes, and is unable to afford, the significant premium increase. She cancelled the indexation as she thought that was what led to the premium increases. And there are indications in the plan documentation that premium increases won't be more than 15% a year. She said Wesleyan should have warned her earlier of the potential premium increases that might be needed. Mrs T doesn't feel this increase should be allowed. Although Mrs T said she doesn't want to lose her plan or have the sum assured decrease in value, and she intends to continue with it, having paid the premiums for over 25 years.

Wesleyan confirmed that it consents to us considering Mrs T's review complaint, if made late.

One of our Investigators reviewed the complaint and said they weren't asking Wesleyan to do anything. In respect of the reviews, they said the plan is reviewable as per the policy terms. They'd seen nothing to suggest the 2024 review was incorrect. And that the 15% cap on increases concerns indexation rather than reviews. Our Investigator said Wesleyan ought reasonably to have known since likely around 2018/2019 though that significant changes would likely be needed to the premiums or level of cover as Mrs T got older, as the cost of cover had started to outweigh the premiums paid. And they weren't persuaded Wesleyan's correspondence met regulatory obligations and standards of good practice. But our Investigator said that, even if Wesleyan had provided Mrs T with the information it should have, on balance they weren't persuaded she would have done anything differently.

Mrs T didn't agree and added that she's still unclear why the requested premium has increased so much. And that after all the payments she has made she wouldn't consider cancelling the plan, but she'd like to go back to the initial premium and sum assured.

Because no agreement could be reached, the case has been passed to me for a decision.

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, while I understand Mrs T will be disappointed, I'm not asking Wesleyan to do anything for the following reasons, which are largely the same as those given by our Investigator.

While I've carefully considered the entirety of the submissions the parties have provided, my decision focuses on what I consider to be the central issues. The purpose of my decision isn't to comment on every point or question made, rather it's to set out my decision and reasons for reaching it.

In deciding this complaint and reaching my conclusions I've taken into account the law, any relevant regulatory rules including the principles and good industry practice at the time. And including, amongst other things:

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

What is the fair and reasonable outcome in the circumstances of this complaint?

While I appreciate Mrs T feels there is a 15% limit on the premium increases in her original paperwork, it's important to explain there are two scenarios where the plan premiums can be increased. The first is at annual indexation and the second is policy reviews.

At indexation in this case, I can see the policy terms set out that Mrs T's policy premiums increased annually by a minimum of 5% and a maximum of 15% due to indexation, which was an optional process. And the process confirmed within indexation letters.

Whereas policy reviews are a separate process (albeit the results may be combined with annual indexation if due at the same time), which focus on whether or not Wesleyan thinks the premiums paid can support the plan's sum assured until the next review date. And the review letters set out the required action needed.

So, the premium increase requested by Wesleyan at the reviews aren't limited to a maximum increase of 15%, as that limit only applied to indexation here.

In respect of the 2024 review, I can see that the applicable policy terms set out, in summary, that the plan is reviewable and that if the benefits can't be maintained until the next review then Wesleyan can reduce the benefit amount, or alternatively the premium can be increased by the insured, to such level as Wesleyan determines can be maintained until the

next review. So Wesleyan is entitled to review the policy, including the premium and cover level, in the way it has.

And, while I appreciate Mrs T's position, I've seen no evidence that the premium increase requested in this case wasn't a legitimate exercise of Wesleyan's commercial judgement. It was entitled to take a reasonable view of the risk posed to it and put a price on that risk. And I think it has done so following a typical process, run by industry professionals.

I think it's helpful at this point though if I explain more about how the plan works and what I think Wesleyan should have done, if anything. The key feature of this plan is that part of the premiums Mrs T was paying throughout the years were to be invested to pay for the increasing costs of cover later in life. This is because for these types of policies, there's an increased likelihood of increasing cover costs as the policyholder gets older. While Mrs T is unhappy with the effect of these increasing costs on the value of the policy, these are simply an inevitable consequence of the policy becoming more expensive as the policyholder gets older. This is very typical for these types of policies. It is also what allows these to be more affordable at the outset.

In the early years, when cover costs are low, part of the premiums are invested to build up a fund that can be used to help pay for the increasing cover costs in later years. At this stage, the premiums can meet the costs of the cover on their own. However, if the premiums remain at the same level, there inevitably comes a point where the cover costs will exceed the monthly premium and units in the investment fund need to be sold to meet the shortfall, reducing the investment fund value over time – unless the fund's growth outpaces the rise in cover costs.

Eventually, regular increases in the cost of cover will outpace the growth in the fund, so that as units in the fund continue to be sold, it will reach a point when the firm concludes that the premiums being paid and the fund value are no longer enough to pay for the costs of cover, as in Mrs T's case. To maintain the policy with its existing cover, the premiums will need to increase, often substantially, and will continue to increase each year as the consumers get older and the cover costs increase accordingly, unless the sum assured has been substantially reduced.

At this point, there can be several poor outcomes for the consumer. It's possible that the investment fund will be almost completely depleted, leaving little surrender value. Any increase in premiums is likely to be very expensive and potentially unaffordable at a time when the consumer may be retired or close to retirement and have limited means to meet significant increases in costs. Alternatively, if the level of life cover has reduced substantially, the policy may no longer meet the consumer's objectives or ceases to be a cost-effective proposition.

The impact of the sudden and significant changes to the premium or level of cover that occur at the point the policy fails a review, can be mitigated by adjusting the terms of the cover earlier in the life of the policy. If, for instance, a consumer elects to increase premiums some years before the policy is likely to fail a review, this will have a smoothing effect over time, so that the policy is less likely to fail a review and the sudden and dramatic premium increases down the track can be avoided.

This gives the consumer the chance to set premiums at a more affordable and sustainable level for a longer period – even for the rest of their lifetime. The new premiums will be higher than they were at the outset, but not as high as they would otherwise need to become at the point the policy fails its review.

Alternatively, at that earlier point, a consumer who is faced with significant increases in premiums or decreases in the level of cover down the track might decide the policy itself is no longer cost effective, or that it is failing to meet its objectives, and elect to surrender the policy. In other cases, a consumer might decide that it is worth maintaining the policy on its existing terms right up to the point that the policy fails a review.

The opportunity for a consumer to make these decisions is a key event in the life of the policy. Given the impact of increasing cover costs on the investment fund, and in time on the premiums (or sum assured), consumers have important decisions to make about whether to retain the policy, increase the premiums and / or decrease the sum assured during the life of the policy. Those decisions become more difficult the longer the consumer pays into the policy and the options available for mitigating poor outcomes start to diminish. So it is in a consumer's interest to make key decisions at an early stage in the policy's life cycle, and to do so in an informed way, firms need to provide consumers with clear, fair and not misleading information.

Increasing life cover charges and what Wesleyan should have told Mrs T

Looking at the available evidence, overall, I can see that by 2018 the total policy mortality costs in this case were just over £704 per annum and therefore close to Mrs T's total annual premium amount of just over £708. And that doesn't allow for the additional £24 annual plan administration cost also being charged. I can also see that, from 2019, the plan's mortality costs alone overtook the same annual premium. So, based on the available evidence, overall, Mrs T's policy has been costing more than the premiums paid since around 2018/2019.

Taking into account the regulatory obligations I have set out above (PRIN) 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 that Wesleyan should have taken steps to ensure it communicated information to enable Mrs T to evaluate the impact of the increasing costs of cover on her policy and the options available to her 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 her clear timelines for the making of decisions where applicable.

In my view, this is something that Wesleyan needed to do within 12 months of the tipping point being reached – and as I've said, I think it's likely this point occurred in 2018/2019. By giving Mrs T clear information about how much the policy was costing and allowing her to compare those costs with the premiums being paid, Wesleyan would've been acting consistently with the guidance at FG 16/8 that firms provide "*regular communications*" with customers – and to ensure that, in their communications, that "*firms* [include] *sufficient and clearly explained details regarding the performance of the product, its value and the impact of fees and charges*". Such communications also needed to specifically set out the "*value of any premiums paid in over that period*", and "*charges incurred over the period in monetary figures*", including "*major components and the charge to the customer for benefits such as life cover and guarantees*".

What information did Wesleyan give Mrs T?

Either within the 2019 review letter if one took place – which was around the time the tipping point had been reached – or within a reasonable timescale after the tipping point was reached, Wesleyan had an opportunity to provide Mrs T with clear information to enable her to consider her options and make a timely decision. Particularly given that, with each year that passed, cover costs would likely continue to increase, making any potential mitigating steps more costly than these otherwise would be over time.

I think Wesleyan should've provided the information I previously outlined in a clear and accurate format, along with clear information about the options available to Mrs T, together with the costs and benefits as well as time frames for reply. And not in a passive way that required the consumer to draw important inferences for themselves. Even if precise numerical information about the costs of those options could not be given, then at the very least I would expect to see reasonable approximations or illustrative examples so that she could reasonably appreciate the importance of considering her options at that point.

As set out above, the review letters provided some information. For example, that the reviews are to determine if Wesleyan can carry on providing the same level of cover based on the Mrs T's current plan value and premiums, and that it can't continue to provide this. But Wesleyan should have also given Mrs T sufficient and clearly explained details to appreciate how much her plan was actually costing. There was no information about the cost of cover in the reviews letters, how these had changed, that the gap between the premium and the charges had closed and how to make the policy sustainable for life, for example. Nor did these give any projections or comparisons based on assumptions, for Mrs T to know the impact of deductions on the plan and of the requested increase in premium.

In summary, I've not seen any correspondence – I've not seen the annual statements that were sent to Mrs T – where Wesleyan provided enough information about the cost of cover or a clear explanation that these were no longer being met by the premiums. Therefore, I think there was an imbalance of knowledge between Mrs T and Wesleyan, which meant she couldn't make a fully informed decision about what steps she wanted or needed to take following the tipping point being reached.

What, if anything, would Mrs T have done differently?

Had Mrs T been given clear, fair and not misleading information, the options open to her at that point would have been to surrender the policy for the cash in value, increase the premiums to maintain the sum assured, reduce the sum assured or take no action.

On balance and for the reasons set out below, having considered all the submissions and information to decide what, if anything, I think Mrs T would likely have done if Wesleyan had provided her with all the information it should have, I don't think anything would have been done differently in the circumstances.

Mrs L said she took out the policy as she was a single parent, who wanted to leave an inheritance for her child's future and to cover funeral costs if she passed away. I understand from Mrs T that by around 2018/2019 she was no longer able to work and receiving benefits. And, while Mrs T's child was grown up, they were a single parent with a small child. So I think the need and desire for the policy to leave a legacy for Mrs T's family remained. And, in addition, the policy has been kept in place. That's despite Mrs T being given some information to know that the premium might need to rise in future, being made aware that the premiums were no longer supporting the sum assured and that this could and would otherwise decrease, in the way it did in 2014 and 2024, for example. All this suggests to me that there has been a continued desire and need for the policy. And I think this is supported by Mrs T's comments that she doesn't want to lose the policy and she intends to continue with it, having paid the premiums for years.

So, I don't think it's likely that Mrs T would have surrendered the policy if Wesleyan had provided her with the information it should have.

In addition, I can see that Mrs T kept the £59 premium the same since 2014, despite knowing the above information and that the sum assured could decrease – and in the way it

then did at times – if she didn't increase it. So I don't think Mrs T was willing to pay, or would likely have paid, any more for the policy than she has.

So, even if Wesleyan had provided Mrs T with the information it should have in the way I've set out above, I'm not persuaded that she would likely have taken a different course of action. This means I'm not asking Wesleyan to do anything.

My final decision

For the reasons given above, I'm not asking Wesleyan Assurance Society to do anything.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss T to accept or reject my decision before 29 December 2025.

Holly Jackson
Ombudsman