DRN-5240226

The complaint

Mrs P1 complains, on behalf of the trustees of the P trust, about a reviewable whole of life (RWOL) policy they hold with ReAssure Life Limited. They're concerned about the sustainability of the policy review due to increases in the cost of providing the life cover following the 2023 policy review.

What happened

Mr P and the late Mrs P took out their Skandia Plan, a type of RWOL policy, in 2002. It was originally administered by Skandia and then Old Mutual. ReAssure now administer the policy so I'll mostly refer to them throughout this decision for ease of reading.

The policy initially had a sum assured of £100,000 for an annual premium of £2,677.54. The sum assured and premiums were guaranteed for the first ten years, but would be subject to regular reviews thereafter. The policy was also subject to optional annual indexation and by 2023 the sum assured had increased to £357,776 for an annual premium of £14,940.68.

Following the 2023 review, ReAssure wrote to Mr P and said that the premiums he was paying wasn't enough to support the sum assured. He was given the options of increasing the premium to £20,164.27 if he wanted to keep the sum assured, reducing the sum assured to £172,742 if he wanted to keep the existing premium or cancelling the policy. He opted to reduce the sum assured, but Mrs P1 complained to ReAssure. She made the following points, in summary:

- The policy had been mis-sold – the salesperson hadn't explained that there was investment risk attached to the policy and Mr P had taken it out on the basis that the sum assured was guaranteed.

- The policy wasn't suitable to cover an inheritance tax (IHT) liability. Alternatives were never discussed; no suitability letter was provided, and its mechanics were not explained which resulted in Mr P accepting indexation increases which had now made the sum assured unaffordable.

- There were ongoing failures in the review process. The reviewable nature of the policy hadn't been explained at the point of sale and the reviews hadn't been undertaken by the firms administering the policy before ReAssure. Mr P had been led to believe that the reviewable nature of the policy was a positive thing i.e., informing him of increased investment returns and sum assured increases.

- The servicing of the policy had been very poor, and the documentation sent to Mr P had added to his distress and anxiety. He'd received a letter in 2023 explaining the need for an increased premium of £14,940 which he'd paid in the belief that it covered the annual premium for 2023. However, a month later another letter came stating that the policy was at risk. After some investigation it came to light that the first letter related to indexation and the latter to the premium review, this was extremely difficult for elderly customers to understand.

- Correspondence from various company take-overs over time had introduced change, confusion and complexity to an already challenging situation.

- The review frequency had changed from annually to every five years, resulting in a significant premium increase. The premiums were projected to increase by 255% at the next review which was a huge worry.

- ReAssure had made several errors including giving incorrect figures and dates, an inability to provide historical payment and review information, no awareness that the policy was under trust or who the trustees were.

ReAssure looked into the concerns that had been made and partially upheld the complaint. They explained that they weren't responsible for any complaints relating to the sale of the policy and this aspect of the complaint needed to be referred elsewhere. They'd looked into the issues around the servicing of the policy and didn't think they'd done anything wrong with the exception of providing incorrect information regarding one of the policyholders. They apologised for their error and offered £300 in compensation.

Mrs P1 didn't accept their findings and asked for our help. The matter was considered by one of our investigators who didn't think the complaint should be upheld. In his opinion, only some of ReAssure's communications had met the standard required by the regulator.

He thought that prior to 2018, they hadn't provided enough information relating to the long-term sustainability of the policy. But from 2018 onwards this wasn't the case, they'd given Mr P clear information including how long they expected the premiums to maintain the sum assured. They'd also given an illustration of the level of premium increase potentially needed after this point and projected how long it would be before the policy would fail a review. The review letters had also outlined the options available to Mr P to ensure the cover was maintained.

He noted the costs of the policy had started to exceed the premiums being paid in 2015. But he thought that even if ReAssure had given Mr P the same level of information about the policy as they had done in 2018, they wouldn't have acted differently. This because Mr P hadn't made any changes after receiving the 2018 letter.

Mrs P1 didn't agree with his findings and made the following points:

- In 2010 Mr P had agreed to increase premiums to £5,217.82, which would likely remain for the next 10 years. This was the final piece of correspondence received from Skandia so Reassure were incorrect in saying the policy was reviewed annually from 2011. She didn't believe any further correspondence relating to the premium was received from Skandia, only a statutory declaration letter and notification of tax change rules in 2013.

- In December 2018, Mr P had unexpectedly received the first review related correspondence from Old Mutual. He was told of a premium increase from £8,403.39, however she couldn't find documentation covering the increase from £5,217.82 to £8,403.39. There was no evidence of the annual indexation option being offered and accepted by Mr P.

- Further correspondence came in March 2019 requesting of a further premium increase requirement to £13,105.86 which was expected to last until 2024. It was at this point she was first alerted to the policy due to being asked to begin contributing to the annual premium, given the financial impact on Mr P.

- The March 2019 plan summary indicated a future premium increase of 255.10% from 2022. At this point, Mr P was dealing with the matter, and it was only when his health deteriorated in 2023 that she was able to undertake a review of the policy and explain the complex mechanics of the policy to him.

- If such a projection or annual reviews had taken place between 2011 and 2018, there would have been an opportunity to make an informed decision including declining the indexation options and potentially reducing the sum assured. This point was missed in 2019 as over £116,000 had been paid into the policy but it only had a surrender value of c.£50,000.

- She didn't think ReAssure had met their regulatory obligations. This was because reviews hadn't been carried out regularly, and when they were, the information gave a false sense that the policy was progressing satisfactorily and that future reviews would result in similarly financially acceptable terms. This wasn't clear or fair and didn't communicate the situation.

- She failed to see how, without correct reviews and projections, Mr P was meant to foresee what lay ahead. The previous firms responsible for administering the policy were misleading in their indication of future premiums and gave no suggestion of massive increases in the future.

The investigator wasn't persuaded to change his opinion so the complaint was passed to me to make a decision and I 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 ReAssure needs to do anything further in order to put things right and I will go on to explain why. However, I'd firstly like to extend my sympathies to all the complainants due to the difficult personal circumstances they've faced over the last few years. I'd like to reassure them that I've carefully considered their testimony and factored them into my considerations.

I've then gone on to consider the complaint points that have been raised. I'd like to reiterate that I am not considering any issues relating to the mis-sale of the policy as it was sold by another firm, so ReAssure cannot be held responsible for their actions. What they are responsible for are any issues to do with the ongoing administration of the policy as they have accepted liability for the actions of the firms who previously administered it.

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.

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 ReAssure. I think the key matter at the heart of the complaint is whether or not ReAssure treated Mr P fairly by providing him with enough information to enable him to make an informed decision about the policy.

Was Mr P provided with enough information about the policy

The policy was taken in 2002 for the purpose of mitigating IHT. The premiums and sum assured were guaranteed for the first 10 years but were subject to change after this time. The main difference between an RWOL policy and a non-reviewable WOL policy is the investment element.

Non-reviewable policies have premiums and a sum assured that doesn't change. RWOL policies work differently, they have premiums and a sum assured that is set for a specific period and then are subject to reviews after a defined period. The reviews are used to determine if any changes are needed to either the premiums being paid, or the sum assured.

This is where the investment element comes into play, premiums are used to purchase units in an investment fund. Units in the fund are then sold to pay for charges on the policy such as the cost of providing cover and administration fees. 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 the accrued funds in 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 several 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.

Reviews can have a vast impact; they may show that premiums need to suddenly increase significantly which may be potentially unaffordable. The alternative to increasing premiums is to significantly reduce the sum assured which could mean the policy isn't fit for its original purpose. Additionally, as time passes the cost of providing cover will continue to increase which may require further changes at future reviews. The investment fund can be used to supplement the premiums being paid but it's very possible it will be completed depleted over time as the cost of cover increases.

However, the impact can be lessened by making changes earlier to the policy. The earlier

premiums can be increased, the better the chance the investment fund will have to continue to build up and grow over time. This means the policy will have a better chance of avoiding significant premium increases or reductions in the level of cover.

If consumers are put in an informed position early on, then they can decide to either make the necessary changes to a policy, or not to continue with it if it isn't cost effective or doesn't meet its original purpose. The later these decisions are left, the more difficult it will be for consumers to have reasonable options to mitigate substantial changes.

With this in mind, I've thought about the trustees' complaint against ReAssure. The available evidence shows that in 2015 the charges on the policy were £7,699.11 vs premiums of £7,639.44. This was an important tipping point for the policy, from this point onwards the underlying fund would have to be used to make up the difference between charges and premiums.

ReAssure were in a position where they had information about the policy that Mr P didn't, such as the level of future mortality costs. The impact of these costs on the long-term sustainability of the policy was a factor that could lead to a poor outcome for Mr P if action wasn't taken. Therefore, I think this was the point where ReAssure needed to provide him with clear, fair and not misleading information about the policy's long-term sustainability, given that it was meant to last for life.

In order to put Mr P in an informed position, ReAssure needed to share the information I've set out below with him:

- *A clear outline of the existing cover – including the sum assured, premiums and current surrender value.*
- *The policy costs (including administration and mortality charges).*
- *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 roughly how long the policy was likely to be sustainable on its existing terms.*
- *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 Mr P information that would allow him to fully appreciate the risks and consequences of not taking any action.*
- *A clear explanation of the poor outcomes he 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 him 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 think ReAssure should fairly and reasonably have provided Mr P with a clear outline of his options as I've set out, within 12 months after the date at which the tipping point was reached, so by the end of 2016.

ReAssure have explained that the policy was being reviewed each year to see if it was expected to last for at least five more years. If it wasn't, then a review offer would be sent to the customer, warning them how long their cover will last. They would also be invited to increase their premium to maintain their cover or reduce their cover and maintain the premium; based on a further five more years of cover.

I appreciate Mrs P hasn't been able to find documentation covering the increase in premium from £5,217.82 to £8,403.39. ReAssure have said that Mr P had accepted all the increases in premium between 2010 and 2014. He didn't accept the 2015 increase but then accepted the 2016 increase. I've seen Mr P's response to the 2016 annual review where he opted to accept the increased sum assured of £313,839 and increased premiums of £8,403.39. I'm satisfied that despite not seeing all the responses to the annual reviews, it's more likely than not that Mr P accepted the increases that ReAssure said he did.

I've gone on to consider the evidence I've been provided with regarding the communications ReAssure sent Mr P after 2015 and I'm not satisfied that they met his information needs until the December 2018 policy review letter. The evidence I've been provided with shows that prior to the December 2018 review letter, Mr P wasn't given the level of detail, as I've set out above, that he needed to make an informed decision.

I can see that the annual reviews contained some commentary about how long the policy might be sustainable for based on the level of premiums being paid at the time. However, there was no mention of the costs of the cover until the February 2017 statement, but even then, there was no mention of the impact of these costs and the options available to mitigate this impact.

I think it's important to remember the confirmation of 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..". With this in mind, I think communications to the Mr P once the tipping point had been reached, shouldn't have provided information in a passive way that required them to draw out important inferences for themself.

I think ReAssure should've provided the information I previously outlined in a clear and accurate format, along with clear information about the options available to Mr P at this point, together with their costs and benefits as well as time frames for reply. 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 they could reasonably appreciate the importance of considering their options at that point.

Taking everything into account, I'm satisfied that Mr P wasn't provided with enough information about the long-term sustainability of the policy until December 2018. Therefore, I'm not persuaded ReAssure took the necessary steps to address the imbalance of knowledge and therefore didn't allow Mr P to make an informed decision about what steps he wanted or needed to take to make the policy sustainable for life when they needed to.

What would Mr P have done differently?

Mrs P1 has said that Mr P didn't understand the mechanics of the policy until 2023, it was at this point that she reviewed the policy and was able to explain to him how it worked. She's said that if projections had been provided between 2011 and 2018, then there would have been an opportunity to make an informed decision.

I take the point she's made and as I've noted above, I think the information needed to be shared by the end of 2016. ReAssure didn't provide the information it needed to, so my role is to consider what Mr P would've done had he been given this information. In coming to this

conclusion, I've considered Mrs P1's testimony. But I've also considered Mr P's behaviour following the 2017, 2018 and 2019 reviews.

I think these review letters are relevant because they set out the information that I think should've been sent to Mr P in 2016. They were sent only a relatively short time after, so I consider Mr P's behaviour when receiving those letters to be persuasive evidence of what he would've done had he received this information sooner.

The 2017, 2018 and 2019 review letters gave stark projections about what would happen to the policy in the near future:

- *I've seen a snapshot of the 2017 review letter which projected that the premiums would increase from £8,403.39 to £27,876.87 by March 2024 and then to £52,429.37 by March 2029.*

- *The December 2018 review letter projected that premiums would increase from £8,403.39 to £29,840.35 by March 2022 and then to £50,228.64 by March 2027.*

- *The December 2019 review letter projected that premiums would increase from £13,105.86 to £37,126.50 by March 2024 and then to £58,154.99 by March 2029.*

I appreciate that Mr P was elderly and may not have fully understood the mechanics of the policy, but this would've been the case regardless of when he received the letters, even if ReAssure had provided the required information by 2016. The key question here, in my opinion, is whether he would have taken a different course of action in 2016 if that were the case, and from what I've seen, I don't think he would have.

I think the projections were very clear and ought to have made him aware that the policy, as it stood, wasn't sustainable. The fact that he didn't take any action after receiving these review letters is, in my opinion, a persuasive indicator of what he would have done if ReAssure had shared the required information from the end of 2016 onwards.

Based on his actions, I think it's more likely than not that he wouldn't have done anything even if ReAssure had shared the required information. Taking everything into account, and while I appreciate this will come as a disappointment to the trustees, I don't think I can fairly uphold this complaint.

Responses to my provisional decision

ReAssure accepted my findings and didn't have anything further to add. Mr P1 disagreed and made the following points:

- The communications from ReAssure were misleading and the annual indexation option letters didn't mention the impact of increasing the sum assured. This meant that Mr P would effectively have seen the indexation option as a way of increasing the size of his investment and keeping up with inflation. However, while it may have appeared attractive, it came with the disadvantage as premiums at the next review would have to increase massively to pay for the increased sum assured. So, in reality, the effective size of the investment, far from increasing, was being eroded to help pay for the increased sum assured.

- Based on his assessment, the tipping point of the policy came earlier than 2016, probably around 2013.

- Cancellation was never a realistic option as it was a whole of life policy, not term. Mr

P considered the policy to be a sensible way to put funds aside to cover his potential IHT liability and the more money that he put into the policy, the more difficult it would have been to cancel it. Had it been cancelled at any point after 2013, the policy would have lost money. The earliest that the trustees could have realised the situation was when a proper review was sent in 2018. By the time they'd all understood it and explained to Mr P how the policy actually worked in 2023, it was well past the point of no return. This was surely one of the reasons why insurers were required to provide timely information, which ReAssure had clearly failed to do.

- He questioned whether it was right that cancellation should be the only alternative offered by ReAssure. The regulator's guidance under FG 16/18 - *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* - implied that a more constructive solution should be offered in the event of a failing outcome.

- There was a failure by both the insurer and regulator to assess the fundamental suitability of the product throughout its lifetime, not simply at initial sale.

- There had been a failure to properly take account of the customer's circumstances, including their likely increasing vulnerability due to ageing and inability to comprehend a sophisticated insurance product. Mr and Mrs P's only other savings consisted of ISAs and Premium Bonds. Therefore, was it really reasonable to assume, simply because Mr P accepted an increase in premiums, that he fully understood the product's features and the consequences of that choice?

- He questioned whether ReAssure had a responsibility to consider that the increasing age of the customer may be making them increasingly vulnerable and the product less and less suitable. And if ReAssure automatically assumed acceptance when they heard nothing from the customer. If they did, was this fair and reasonable?

- Given that I'd identified specific failures on the part of ReAssure, he was surprised that that no sanctions or consequences had been proposed for these breaches, despite their adverse impact on the customer's fair treatment. He also thought that I seemed to give the benefit of the doubt to the insurer, not the customer.

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 not minded to change my provisional decision and uphold this complaint. I appreciate that accepting the annual indexation reviews would have had some impact on the policy. However, I've factored this into my considerations about when ReAssure should have provided further information about the policy.

I'm satisfied that they should have done so within twelve months of the tipping point being reached in 2015. They didn't provide the level of information required until they sent Mr P the 2018 review letter. But, for the reasons I gave in my provisional decision, I don't think that even if they had provided the information earlier, it would have led to Mr P choosing a different course of action such as surrendering the policy earlier or making changes to the sum assured or monthly premiums.

I note the point Mr P1 raised about the tipping point being reached earlier, but I haven't seen any evidence to support this claim. The table below gives the costs of the policy compared to the premiums that were being paid and shows that the tipping point was reached in the

policy year ending in 2015:

Year	Annual Premiums	Annual Policy Costs
2002	£2,677.54	£34.58
2003	£2,945.30	£135.47
2004	£3,239.83	£265.61
2005	£3,563.82	£438.85
2006	£3,920.21	£668.22
2007	£3,920.21	£883.73
2008	£4,312.24	£1,234.20
2009	£4,743.47	£1,712.42
2010	£5,217.82	£2,256.15
2011	£5,739.61	£3,012.89
2012	£6,313.58	£3,969.30
2013	£6,944.94	£5,085.53
2014	£7,639.44	£6,566.80
2015	£7,639.44	£7,699.11
2016	£8,403.39	£9,593.01
2017	£8,403.39	£10,861.29
2018	£8,403.39	£12,276.54
2019	£13,105.86	£15,907.84
2020	£13,105.86	£18,723.76
2021	£13,105.86	£21,001.49
2022	£13,105.86	£24,214.74
2023	£20,164.27	£22,106.82

I appreciate the point the trustees have raised that cancelling the policy would be difficult, especially as its original purpose of mitigating an IHT liability still remains. I'd like to reassure the trustees that I've fully considered the range of different options that were available and whether or not Mr P would have taken any of them if better information had been provided.

The other options available were reducing the sum assured or increasing the premiums to maintain the level of cover, but they also came with potentially negative consequences. For example, reducing the sum assured might mean that the policy wouldn't be able to meet any potential IHT liability. And increasing the premiums to maintain the cover for life might be unaffordable.

The reason why I don't think any of these other options would have been taken is because of the lack of any changes following some of the later communications from ReAssure, especially the 2018 and 2019 review letters which gave stark projections about what would happen in the future if changes weren't made to the policy.

I appreciate Mr P may not have been able to fully understand the complexities of the policy, but I think the letters gave clear warnings about the future changes the policy would require. The examples below show the projections that were given for the policy's charges and future premiums and the invitation to contact ReAssure if further information was required:

	Old charge rates	New charge rates	Change
Total charge for your cover over one year	£14,448.84	£17,438.18	+£2,989.34
Total charge for your cover over five years	£88,177.35	£110,552.28	+£22,374.93

Please contact us if you would like to know more about the new rates, including examples of what the charges for your cover may be over different time periods.

What premium might you need to pay in future?

In approximately three years you will need to increase your premium if you want to keep the current amount of cover.

We cannot be certain of when you will need to increase your premium, or what the increase will be, as this is affected by your investment growth and our charges - neither of which is guaranteed.

We can however give you the following estimated figures of the smallest increase we will be able to offer, assuming the reasonable rate of growth shown above, our current charges, and using your current level of cover:

Review Date	Age of youngest life assured	Yearly premium	Increase in premium
Current premium		£8,403.39	
from 20 March 2022	87	£29,840.35	255.10%
from 20 March 2027	92	£50,228.64	68.33%
from 20 March 2032	97	£72,072.22	43.49%
from 20 March 2037	102	£98,987.73	37.35%
from 20 March 2042	107	£93,324.35	-5.73%

The table shows a limited number of future reviews to give you an idea of the increases that may be required to maintain your cover. The premium gets higher over time as the cost of cover goes up as each life assured gets older.

If you always make the smallest increase in premium then an increase will be required approximately every five years for as long as you keep the same level of cover. The amount of the increase is based on a number of factors (including the age of the people covered and the type of cover), and it will increase over time.

Alternatively, you may decide to keep your current premium and instead reduce your cover at your reviews. If you do this, your cover would be reduced approximately every five years in a similar fashion.

If you need the cover to last for a long time, it is likely to be more cost-effective to make a change now which could support your cover for longer, rather than make the minimum change every five years.

We can provide you with further information on this so please contact us if you would like to discuss your future reviews.

Further information

You can contact us at **reviews@omwealth.com** or on **0808 171 2576** to discuss any of these options in more detail. We can provide a projection of how any proposed changes may affect your plan.

In my opinion, despite the failings of previous letters, the 2018 and 2019 review letters were clear, fair and not misleading and provided the information needed to make an informed decision. And because no changes were made after receiving these letters, I can't fairly say that if this information had been provided earlier, it would have resulted in a different outcome. It isn't the case that I am simply taking the side of the insurer, I need to be fair to both parties and I hope my explanation shows the rationale behind the outcome I've reached.

I've also considered the other points that have been raised. There wasn't any requirement for ReAssure to carry out ongoing suitability assessments so I can't say they've acted unfairly in not providing this service. They also didn't make any changes to the policy, such as increasing premiums, without confirmation from the policyholders.

I fully accept the trustees' disappointment with how things stand and the lack of any consequences for ReAssure. But this service isn't the regulator and doesn't look to fine or punish businesses. Instead, out remit is to look at individual complaints and where a business has acted unfairly or made an error, we'd look to put the consumer back in the position they would have been in, had the error not occurred.

I'm satisfied that for the reasons I've provided, the trustees are now in the position they

would have been in, if ReAssure had provided the information they should have done after the policy reached its tipping point. Therefore, I won't be asking ReAssure to do anything else to resolve this complaint.

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 P, Mrs P1, Mr P1 as trustees of the P Trust to accept or reject my decision before 11 April 2025.

Marc Purnell
Ombudsman