DRN-5272437

The complaint

Mr and Mrs J, as trustees of the J trust, complain about a reviewable whole of life (RWOL) policy they hold with Countrywide Assured Plc. They are unhappy with being asked to pay a higher premium in order to maintain the sum assured and think Countrywide have failed to explain why the changes were required.

What happened

Mr and Mrs J took out the Permanent Protection Plan, a type of RWOL policy, in 1990 for the purpose of mitigating inheritance tax (IHT). It initially had a sum assured of £100,000 for monthly premiums of £45. The policy was reviewed every five years until either of the lives assured reached 65 when the reviews would be performed annually.

The policy passed all the reviews until the 2022 review. The outcome of the review was that Mr and Mrs J needed to pay an additional £12.00 per month to keep the sum assured. If they didn't increase their premiums, then the sum assured would fall to £99,784.

They declined to increase their premiums, so the sum assured reduced, but the policy failed the next review in 2023. The outcome of the 2023 review was that the premium needed to increase by £39.48 a month to keep the sum assured. If they didn't increase their premiums, then the sum assured would fall to £80,119.

Mr and Mrs J complained to Countrywide and expressed concern at the potential changes and said that their understanding of the original contract they took out was that there would be no changes to premiums or policy benefits. Countrywide looked into the concerns they'd raised but didn't uphold the complaint as they thought it had been made too late.

They were of the opinion that Mr and Mrs J ought to have been aware of the reviewable nature of the policy as it had been reviewed many times since 1995. As they didn't complain within six years of taking out the policy or within three years of having awareness of its reviewable nature, they thought the complaint had been made outside of the timescales set by the regulator.

Mr and Mrs J didn't agree and raised further concerns that the original agreement didn't contain a specific reference to the potential impact of the reviews. They also raised concerns about the outcome of the review, they wanted to know how a 20% reduction in the sum assured could be justified and asked questions about the performance of the underlying fund and cost of providing cover. They also asked Countrywide to provide them with a projection of what the policy's benefits might be in 2039 as they were concerned that it might be worth nothing if the sum assured continued to reduce. Countrywide provided them with further details about the policy, but Mr and Mrs J weren't satisfied with the response and asked us to help.

The complaint was considered by one of our investigators who didn't think it had been made too late and gave Countrywide her reasons why. Countrywide accepted her findings on our jurisdiction to consider the complaint, so she went on to consider the merits of the complaint. Mr and Mrs J then raised concerns about the outcome of the 2024 review where they were

told the sum assured would reduce further to around £69,000 if the premiums didn't increase by £27.84.

The investigator considered the points that had been raised but didn't uphold the complaint as she didn't think Countrywide had acted unfairly by reviewing the policy. This was because it had always been meant to have regular reviews and this was made clear in the documentation provided to Mr and Mrs J when they took out the policy.

However, she thought that Countrywide ought to have been aware that the premiums or sum assured would change significantly in the future. And they should have communicated this to Mr and Mrs J by 2015 at the latest, as that was when the policy's charges were higher than the premiums being paid. But she thought that even if they'd done so, Mr and Mrs J wouldn't have done anything different and would still have kept the policy.

Mr and Mrs J didn't accept her findings. They accepted that they'd implicitly agreed to the reviewable nature of the policy when they'd taken it out. However, they thought that Countrywide had an obligation to explain the calculations behind the changes that were required to the policy. The investigator wasn't minded to change her opinion so the complaint was passed to me to review.

I recently 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 think this complaint should be upheld and I will go on to explain why.

Were Countrywide within their rights to review the policy?

I've firstly considered if Countrywide acted fairly by reviewing the policy. Having reviewed the available evidence, I think they were. The terms and conditions of the policy explicitly state that that it isn't guaranteed and is reviewable. Section 11 of the terms say:

"(i) Until the Person Insured reaches the age of 65, we will review your Programme and the benefits it provides every five years from the Programme commencement date. After age 65 we will review your Programme and the benefits each year. We call these Reviews. They take place on Review Dates.

We also reserve the right to conduct a Review at any time if "Preferred Terms" no longer apply to the Person Insured or at any time after the first five years if there are other circumstances which in our opinion warrant an additional Review.

If there are two Persons Insured then "the Person Insured" means the older of the Persons Insured.

(ii) When we conduct a Review we will determine the maximum Life Assurance Benefit which can be provided under your Programme up to the next Review Date. We will take into account:

> *(a) The Investment Benefit value of your Programme at the time;*
>
> *(b) The charges to the Life Assurance Benefit and the Contribution Waiver Benefit and other deductions expected to be made up to the next Review Date;*
>
> *(c) The future allocation of units up to the next Review Date;*

(d) Any other factors which we consider to be relevant.

(iii) If the existing Life Assurance Benefit, at the time of the Review, exceeds the new maximum set by us, then on the Review Date we will reduce the Life Assurance Benefit to the new maximum.

This will not be less than the minimum necessary for your Programme to remain a qualifying policy, in accordance with Schedule 15 of the Income and Corporation Taxes Act 1988.

(iv) If the Life Assurance Benefit is reduced as a result of any Review, you may ask to start a new Programme in accordance with Condition 12."

I think this shows that Mr and Mrs J ought to have been aware the sum assured was subject to review, wasn't guaranteed and could change after being reviewed. Therefore, I don't think I can fairly say that Countrywide have acted inappropriately in reviewing the policy, so I won't be asking them to do anything in respect of this complaint point.

Did Countrywide provide Mr and Mrs J with enough information about the policy?

I've then gone on to consider if Countrywide treated Mr and Mrs J fairly by providing them with enough information to enable them to make an informed decision about the policy. 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. Having taken all these elements into account, I've set out below what I consider to be the key factors:

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 Mr and Mrs J's complaint against Countrywide.

At the heart of this complaint are Mr and Mrs J's concerns about the outcome of the 2023 and 2024 reviews. They are worried that if the sum assured continues to fall at the same rate

going forward, then the sum assured will reduce to nothing. As previously noted, the outcome of the reviews was that the sum assured would fall from £100,000 to £69,007 if the premiums weren't increased significantly. I don't think it's unreasonable to suggest that this was unexpected, given that the only the 2022 review had previously failed, and even then, it only resulted in the sum assured reducing by £216.

I think the results of the 2023 and 2024 reviews were poor outcomes for Mr and Mrs J, which Countrywide should have identified and taken action to address. In my opinion, they needed to put Mr and Mrs J in a fully informed position about the policy through the provision of clear, fair and not misleading information about the long-term sustainability of the policy.

I appreciate that Mr and Mrs J were told at the outset about the reviewable nature of the policy and the potential impact of this on the premiums and sum assured. But I think the regulator's guidance in FG 16/18 is clear that customers should "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." With this in mind, I don't think it is sufficient to solely rely on warnings that were given when the policy was taken out.

I think it is important to remember that Countrywide were in possession of information about the policy that Mr and Mrs J didn't have. An example of this is the level of future mortality costs. The impact of these costs was a factor that could lead to a poor outcome for Mr and Mrs J if action wasn't taken. The table below shows what they were paying each year in premiums versus the cost of providing them with cover and also what the underlying fund value was:

Policy Year	***Premiums Paid***	***Total Charges***	***Fund Value***
19/9/1995 - 19/08/1996	*£540.00*	*£67.27*	*£1,820.34*
19/9/1996 - 19/08/1997	*£540.00*	*£72.12*	*£2,537.30*
19/9/1997 - 19/08/1998	*£540.00*	*£77.56*	*£3,217.18*
19/9/1998 - 19/08/1999	*£540.00*	*£84.45*	*£3,953.11*
19/9/1999 - 19/08/2000	*£540.00*	*£91.59*	*£5,089.74*
19/9/2000 - 19/08/2001	*£540.00*	*£97.15*	*£4,874.97*
19/9/2001 - 19/08/2002	*£540.00*	*£106.12*	*£4,525.35*
19/9/2002 - 19/08/2003	*£540.00*	*£119.24*	*£5,194.99*
19/9/2003 - 19/08/2004	*£540.00*	*£133.31*	*£5,833.25*
19/9/2004 - 19/08/2005	*£540.00*	*£150.48*	*£7,338.71*
19/9/2005 - 19/08/2006	*£540.00*	*£170.02*	*£8,450.78*
19/9/2006 - 19/08/2007	*£540.00*	*£221.48*	*£9,154.22*
19/9/2007 - 19/08/2008	*£540.00*	*£222.51*	*£9,035.54*
19/9/2008 - 19/08/2009	*£540.00*	*£261.72*	*£8,586.38*

19/9/2009 - 19/08/2010	*£540.00*	*£297.87*	*£9,825.25*
19/9/2010 - 19/08/2011	*£540.00*	*£342.74*	*£9,597.58*
19/9/2011 - 19/08/2012	*£540.00*	*£398.98*	*£10,932.39*
19/9/2012 - 19/08/2013	*£540.00*	*£458.06*	*£12,247.98*
19/9/2013 - 19/08/2014	*£540.00*	*£528.04*	*£12,803.02*
19/9/2014 - 19/08/2015	*£540.00*	*£609.62*	*£13,192.22*
19/9/2015 - 19/08/2016	*£540.00*	*£708.78*	*£14,079.92*
19/9/2016 - 19/08/2017	*£540.00*	*£807.68*	*£15,100.42*
19/9/2017 - 19/08/2018	*£540.00*	*£931.54*	*£15,230.35*
19/9/2018 - 19/08/2019	*£540.00*	*£1,080.44*	*£15,025.56*
19/9/2019 - 19/08/2020	*£540.00*	*£1,253.05*	*£13,955.62*
19/9/2020 - 19/08/2021	*£540.00*	*£1,445.00*	*£13,184.05*
19/9/2021 - 19/08/2022	*£540.00*	*£1,658.20*	*£13,244.41*
19/9/2022 - 19/08/2023	*£540.00*	*£1,930.02*	*£11,235.99*
19/9/2023 - 19/08/2024	*£1,013.76*	*£2,355.52*	*£10,875.70*

What this table highlights is the fact that Mr and Mrs J's policy had reached an important tipping point in the policy year 2014 - 2015. It was at this point that the costs of the policy had overtaken the premiums that were being paid in. This can lead to several poor outcomes such as:

- *The investment fund being completely depleted as it is being used to make up the difference between costs and premiums*
- *The potential for the level of cover to be significantly reduced and therefore not being suitable for the original purpose it was taken out for*
- *The potential for significant increases in the premiums being paid in order to keep up with the ever-increasing cost of cover at a time when a consumer may be retired or close to retirement and have limited means to meet significant increases in costs*

But these outcomes can be avoided by making changes to the policy earlier in its life. If, for instance, changes are made before there is a vast difference between the costs of the policy and the premiums, then the investment fund can continue to grow over time. This would mean that the policy is less likely to fail a review and the significant premium increases or reductions in the sum assured later down the line can be avoided.

I think this is fair as it gives the consumer the chance to set premiums at a more affordable and sustainable level compared to what they would need to pay if changes were made later down the line. Also, if a consumer is put in an informed position about the potential changes

that may be needed, they might choose to surrender the policy before the investment fund is depleted. 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.

Given that these polices are meant to last for the whole of a consumer's life, it was crucial that they are given the opportunity to make the policy last as long as possible. In Mr and Mrs J's case, the purpose of the policy was to mitigate IHT, and this need wasn't likely to change. As I've previously noted, it was important that they were provided with information about the long-term sustainability of the policy in a clear, fair and not misleading way.

If they didn't have this information or were provided with it too late, then their options to keep the policy going would be reduced. This was because the cost to do so would simply be too great or they would have to reduce the sum assured to a level which wouldn't make it suitable for its original purpose.

RWOL policies generally have set periods for policy reviews where a firm will update a consumer about the performance and sustainability of the policy. For Mr and Mrs J's policy, reviews took place every five years and then annually when either of them reached 65.

The policy has been reviewed annually since 2014 and I've seen all the review letters since 1995. Up until 2022 all the reviews passed, and the letters said:

"Your policy conditions require us to review your Permanent Protection Programme on a regular basis and such a review has now been completed. 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, £100,000. There is therefore no need to take any action with regard to your policy.

Further reviews will be conducted according to the timescale set out in the policy conditions and we will of course let you know when these take place. If you have any questions please contact the Customer Services department on the direct line number above."

The failed 2022 review was the first to require any changes to the policy. It said:

"Your policy conditions require us to review your Permanent Protection Programme with us on a regular basis and such a review has now been completed. Your policy provides you with a significant level of life assurance benefit. This amount of benefit is guaranteed, without the need for you to provide any further evidence of health, as long as you pay any increased premiums calculated at review.

The review has demonstrated the need to increase the regular premium if the current level of benefit is to be maintained. The current benefit of £100,000 is being provided for a monthly premium of £45.00. As from 19 September 2022, this premium will need to increase by an additional £12.00 a month to provide the same benefit. In the absence of an increase, the benefit will automatically be reduced to £99,784. Please let me know as soon as possible how you wish to proceed……"

The failed review letters from 2023 and 2024 had similar wording to the 2022 letter. What is clear is that there was no information being provided about the underlying costs or long-term sustainability of the policy.

I think the yearly reviews provided Countrywide with the opportunity to deliver important messages to Mr and Mrs J. This is important because one of the main threats to the long-term sustainability of the policy was the impact of the ever-increasing mortality costs for the reasons I've previously set out. In order to mitigate this threat, Countrywide needed to

share the information I've set out below with Mr and Mrs J:

- *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 and Mrs J information that would allow them to fully appreciate the risks and consequences of not taking any action.*

- *A clear explanation of the poor outcomes they 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 them 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).*

As I've previously noted, premiums stopped meeting the life cover costs in the policy year 2014-2015. In that year Mr and Mrs J paid £540 in premiums but the charges on the policy came to £609.62. This was an important tipping point and meant that units from the investment pot would need to be sold down to offset the difference between premiums and charges.

Life cover costs would continue to increase as Mr and Mrs J got older, so over time more and more units would need to be sold to offset the difference. Therefore, the tipping point represents a moment in time where unless action is taken, there is a significant risk that the policy will become unsustainable on its existing terms, and substantial increases in premiums, or significant decreases in the sum assured, would be required at some point in the future.

With this in mind, I think the policy year 2014-2015 was the point I consider Countrywide should have taken action. They should have provided Mr and Mrs J with clear, fair and not misleading information in a timely manner to enable them to weigh up their options and make a fully informed decision about the value of the policy and whether, and on what terms, they wished to retain it.

In my view, the obligation on Countrywide to do so is in line with the requirements imposed by PRIN 6 and 7, as well as COBS 2.1.1R(1) and COBS 4.2.1R (1). It is also in line with the illustrations of good industry practice outlined by the regulator in FG 16/8 and, taking all of that into account, is what I would in any event regard as the fair and reasonable response in the circumstances.

Having reached that tipping point, I have given careful thought to how Countrywide were

communicating with Mr and Mrs J. Reviews were taking place annually at that point with the next one due in July 2016. In FG16/8, the regulator says: '…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.'

It goes on to say that if a firm identifies an issue with its long-term policies, it regarded a six-month period as a reasonable time frame for the firm to take certain steps. Within that six-month period, it would expect firms to clearly highlight and define the issue, escalate appropriately, create a plan to resolve as soon as possible, and have obtained sign-off by the relevant board/committee.

With this in mind, I think Countrywide should fairly and reasonably have provided Mr and Mrs J with a clear outline of their options as I've previously set out, within 12 months after the date at which the tipping point was reached, by around August 2016 at the latest. They received a review in July 2016 which would have been the ideal opportunity for Countrywide to provide them with the necessary information.

I've reviewed the July 2016 letter and it doesn't contain any of the information I set out previously that needed to be shared with Mr and Mrs J in order to mitigate the threats to the long-term sustainability of the policy. I've also considered the communications Countrywide sent Mr and Mrs J after this point and I'm not satisfied that they met their information needs. There was no mention of the costs of the cover and no consideration given to the future impact of ever-increasing charges on the policy. There was no other commentary about the policy itself – for example how long the policy might be sustainable for or what might happen in future if the fund value reduced too much. I don't think this is in line with their obligation to "… consider whether a product continues to provide a fair outcome to the customer."

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 Mr and Mrs J 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 themselves.

I think Countrywide should've provided the information I previously outlined in a clear and accurate format, along with clear information about the options available to Mr and Mrs J 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 can't see that Mr and Mrs J were ever provided with any information about the impact of the charges on their policy. They were never given an indication of what they would need to do to make the policy sustainable or what might happen in the future past the next review. Therefore, I'm not persuaded Countrywide took the necessary steps to address the imbalance of knowledge and therefore didn't allow Mr and Mrs J to make an informed decision about what steps they wanted or needed to take to make the policy sustainable for life.

What would Mr and Mrs J have done differently?

I've considered what, if anything, Mr and Mrs J would have done differently if they'd been made aware by August 2016 that there was a gap between the cost of providing cover and their premiums. As previously noted, the July 2016 review was a good opportunity for Countrywide to tell them that the policy, as it stood, was unlikely to be sustainable in the long

term. And if steps weren't taken at that time to either increase the premiums or decrease the sum assured (with clear information about what those changes would cost them), they would likely be faced with far more significant adjustments at a later time when such adjustments might not be affordable.

I'm satisfied that this message would have clearly highlighted to Mr and Mrs J that there were real risks in choosing to leave the policy as it was. I've considered what they would have done this information.

The purpose of the policy was to mitigate IHT. However, I think that cost would have been a significant factor in their considerations. In 2016 Mr J was in his mid-seventies and Mrs J was in her late sixties. They still had a IHT liability and were in receipt of pension income from private and state pensions. Given their age it was unlikely that they would have found an affordable policy with guaranteed premiums which provided the sum assured they required.

This point is very finely balanced, but I don't think that they would have continued with a policy where they would have to pay significantly higher premiums to maintain the sum assured. The policy pays out on the second death, and they've said they would have based any decision on whether to keep the policy on their probable life expectancy. They've explained that they are both in good physical and mental health, especially Mrs J who is still very active.

So, while the surrender value in 2016 was well below the sum assured of the policy, I don't think Mr and Mrs J would have chosen to pay significantly higher premiums for another 15 or so years. Also, at the time, the premiums would have had to increase by around £22 per month just to meet the cost of cover until the next review took place. Given that they weren't willing to accept a £12 increase in 2022 and complained about the £39.48 increase in 2023, I don't think it's likely that they would have accepted any increases in 2016. I also don't think they would have chosen to accept a significant reduction in the sum assured as they had a specific sum in mind to cover their IHT liability.

Therefore, based on the balance of probabilities, I think it is more likely than not that they would have surrendered the policy if they'd been made aware of the changes required to sustain the policy for life. The policy had a fund value of around £14,000 in 2016 and I think they would have chosen to take this sum, not pay any further premiums and look to find another way to mitigate their IHT liability.

As I've previously set out, Countrywide should have put Mr and Mrs J in a fully informed position by July 2016, so I think it's fair that any compensation ought to run from that point. I've set out how things should be put right below.

Putting things right

I think fair redress would be for Countrywide to pay Mr and Mrs J the July 2016 surrender value, plus 8% per year simple interest from that time until the date of settlement.

They should also refund the premiums paid towards the policy from July 2016 onwards plus 8% per year simple interest from the point of payment until the date of settlement.

This means the policy would end on this basis. Therefore, Mr and Mrs J may wish to seek independent financial advice on the impact the outcome will have on their individual circumstances and needs."

Responses to my provisional decision

Mr and Mrs J accepted my provisional findings and didn't raise any further points. Countrywide broadly accepted my comments regarding their review letters, but they didn't agree with some of the key conclusions I reached and made the following points:

- The decision suggested that Mr and Mrs J could have taken action in 2016 to mitigate future reviews by choosing to pay additional money into their policy. However, with this type of policy it wasn't possible for policyholders to choose to increase their payments at will. Additional payments could only be made if the policy failed a review. However, the money was not paid into the original policy, but instead would be used to set up a balancing policy, which would provide the required top up to the sum assured of the original policy, thereby maintaining the overall level of cover.

- They noted the comments about potentially reducing the sum assured in 2016 to mitigate future reviews. However, customers couldn't just pick any amount of cover they wished. This type of product was set up on a minimum, standard or maximum cover basis, with each level providing a set amount of cover. The only way for Mr & Mrs J to future-proof their policy in the way suggested, would have been for them to reduce it from the maximum basis it was set up on, to the minimum basis. However, this would have reduced the cover to £13,770, far short of the £100,000 they required for IHT purposes. Therefore, it didn't seem likely they would have taken that course of action either, given that they have maintained that they still required the full amount of cover for IHT.

- The provisional decision said that as Mr & Mrs J were not prepared to accept previous increases to the monthly premiums, they would not have accepted one in 2016, had it been required at that point. Firstly, this appeared to contradict the earlier suggestion that they may have considered paying additional money into the policy at that point to mitigate future reviews. Secondly, whilst Mr & Mrs J may not have been happy about the increases, the fact is that ultimately they did choose to pay the increases following the 2023 & 2024 reviews. This resulted in balancing policies being set up to preserve the overall level of cover. They could only assume that the reason Mr and Mrs J did not increase payments in 2022 was because the reduction in the sum assured was negligeable compared to the proposed increase (£144 in extra premiums p/a vs £216 of cover). The fact that they subsequently chose to increase their premiums in 2023 & 2024 would suggest that they would have agreed to pay increased premiums in 2016 as well, had it been required.

- Mr & Mrs J had been clear throughout their complaints that their primary aim was to maintain the level of cover for IHT purposes. This would appear to contradict the notion that they would have surrendered the policy in 2016 had more information been provided. Their needs in that respect in 2016 appeared to be the same as they were now, and I'd acknowledged in the decision that this was unlikely to change. Also, given their ages at the time it was unlikely that they could have obtained a comparable product elsewhere. The decision referred to them potentially looking for another way to mitigate their IHT liability, but this appeared to be purely speculative. Mr & Mrs J had always been aware that surrendering the policy was an option open to them, and had they been minded to do so and seek an alternative IHT solution then it would be reasonable to have expected them to do so following the failed reviews in 2022, 2023 or 2024. The fact that they did not at those points suggests they would not have done so in 2016 either, even if they'd been given more information at that point.

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 reconsidered everything in light of the new submissions made by Countrywide, I'm still of the opinion that this complaint should be upheld and I will now explain why.

I take the points Countrywide have made regarding how the policy works. However, as they have pointed out, it would have been possible to change the terms of the policy. I note they've only mentioned the potential change to minimum cover, but there would also have been the option to change to standard cover. This would have reduced the amount of cover but not by as much as a change to minimum cover. There would then have been the option to set up a balancing policy, also on a standard cover basis, to maintain the original amount of cover.

This option would potentially have been expensive and therefore potentially unaffordable for Mr and Mrs J. But, for the reasons I gave in my provisional decision, Countrywide should have informed Mr and Mrs J in 2016 that the policy as it stood was unsustainable and provided them with options to make it sustainable for life. They would then have been in a fully informed position and been able to decide if they wanted to keep the cover as it was, take steps to make it sustainable for life or make alternative arrangements.

I note the concerns Countrywide have raised about the redress I've proposed. As I said in my provisional decision, this point is finely balanced. I've based my decision on what Mr and Mrs J have explained about their circumstances and also the scale of the potential changes that would have been needed in 2016 in order to make the policy sustainable for life. I think it is likely that the increase in premiums that would have been required to do so would have been significant and therefore potentially unaffordable for Mr and Mrs J.

While I agree that they had a need to mitigate their IHT liability, I also think that the ongoing costs of the policy would have been a key consideration for them. Using the cost of cover in the policy year ending August 2024 as an example, Mr and Mrs J would have to pay premiums of c.£195 just to meet the cost of providing cover.

Given what they've said about their circumstances - that they're both still in good physical and mental health and living off pension income - I'm not persuaded that they would have chosen to keep the policy in 2016 on the terms that would have been required to make the policy sustainable for life.

I don't agree that my comment that Mr and Mrs J could have sought other ways to mitigate their IHT liability is speculative. There are clearly ways to mitigate IHT other than life insurance. I appreciate they haven't surrendered the policy after being made aware of the increases required in 2023 and 2024. But I think that had they received communications from Countrywide in 2016 which fully met their information needs and in particular, contained an estimation of the premium which would make their policy sustainable and an indication, in monetary terms, of how much their policy was going to continue to cost in the future, they would have surrendered the policy at the time.

So having taken everything into consideration, I remain of the opinion that Countrywide haven't treated Mr and Mrs J fairly and need to put things right as I've set out below.

Putting things right

I think fair redress would be for Countrywide to pay Mr and Mrs J the July 2016 surrender

value, plus 8% per year simple interest from that time until the date of settlement.

They should also refund the premiums paid towards the policy from July 2016 onwards plus 8% per year simple interest from the point of payment until the date of settlement.

This means the policy would end on this basis. Therefore, Mr and Mrs J may wish to seek independent financial advice on the impact the outcome will have on their individual circumstances and needs.

My final decision

For the reasons I've given above, my final decision is that this complaint should be upheld and Countrywide Assured Plc should put things right as I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr J and Mrs J as trustees of the J Trust to accept or reject my decision before 28 February 2025.

Marc Purnell
Ombudsman