DRN-5369769

The complaint

Mrs W complains, through her representative, about how Scottish Friendly Assurance Society Limited (SF) have administered a reviewable whole of life policy she holds with them. She's unhappy that they missed reviews which caused the policy to lapse and doesn't think they've provided her with enough information about the policy to enable her to make proper decisions.

What happened

Mrs W and her late husband (for ease of reading I will mainly refer to Mrs W) took out the Free Spirit Plan, a type of reviewable whole of life (RWOL) policy, in 1990 for the purpose of family protection on a joint life, second death basis.

It initially had a sum assured of £100,000 for monthly premiums of £202.22 which would reduce to £117.22 in 1992. It was subject to optional indexation and was reviewable after the first ten years, then every five years after that until either Mr or Mrs W reached 65, at which point it would be reviewed annually.

There is limited information available about the early reviews, but the information provided shows that in 2008 the sum assured was £111,277.23 for monthly premiums of £130.44. By that time the policy was being reviewed annually and it passed all the reviews until 2019.

In December 2022, SF wrote to the late Mr W - who by that time had unfortunately passed away - and said that they'd discovered that the unit value of the policy had fallen to zero in July of that year. This meant that the policy should have lapsed, and they shouldn't have collected any further premiums after that time. They apologised for their error and refunded the premiums that shouldn't have been collected.

Mrs W complained to SF in July 2023 as she was unhappy that the policy had lapsed and she hadn't been made aware. SF looked into the concerns that had been raised and upheld the complaint. They explained that they'd failed to carry out the annual reviews that were due in 2020, 2021 and 2022. In their opinion, this meant that Mrs W had benefitted from retaining the sum assured while paying a lower premium than what would have been required if the reviews had taken place.

They went on to say that as no reviews had taken place, the savings element of the policy had fallen due to covering the difference between the reduced premium level and higher mortality charges. Because of this, the policy now had a negative balance, and they weren't able to honour the sum assured. They apologised and explained that they'd now completed backdated reviews for the periods they'd missed. The outcome of the backdated reviews was as follows:

- The 2020 review would have passed, and the policy had a unit value of £12,400 in August 2020.

- However, the 2021 review would have failed, the unit value would have been £6,500 and the sum assured would have reduced to £90,100.

- The 2022 review would also have failed, and there would have been a negative policy balance of -£150.

- This would have meant that at the next review in 2023, Mrs W would have had to pay a monthly premium of £880 in order to maintain a sum assured of £11,000. The reason the new premiums would be so high was because of a negative balance on the policy of -£2,274.28, so the increased premium would bring the policy back into a positive position as well as meet the cost of cover.

They gave Mrs W two options. She could return the premium refund she'd received and proceed with a sum assured of £11,000 and premiums of £880. Or she could keep the premium refund, but the policy would remain out of force.

They also apologised for writing to the late Mr W as they'd been notified of his passing and offered £400 in compensation for the distress and inconvenience Mrs W had suffered.

Mrs W didn't accept their findings and asked for our help. The matter was considered by one of our investigators. He was of the opinion that SF hadn't treated Mrs W fairly. He thought that SF ought to have been aware that the premiums or sum assured would change significantly in the future. And they should have communicated this to Mrs W by 2015 at the latest. Had they done so, he thought she would have surrendered the policy as she wouldn't have been able to afford the potential increases in the future.

SF didn't accept his findings and made the following points, in summary:

- The investigator had referred to the level of risk not being suitably advised to Mrs W in relation to the policy reviews and the potential effect this could have on charges for the policy in the future. But she'd been given a key features document which stated:

    - *Premiums are reviewed. You may find you have to pay more in the future for the same level of life cover. This will depend on the level of life cover chosen and how much your money grows.*

    - *This amount may even go down in later years because the case of life cover is high as you get older. There may be little or nothing to come back to you even after many years.*

    - *If you stop paying regular premiums the life cover, in many cases, will cease.*

    - *Charges may be higher than expected, and the cost of life cover at any given age might be increased.*

- The point of sale documentation Mrs W was given stated:

    - *"If at any such Review the Society considers that the Accumulated Unit Value is insufficient to support the Guaranteed Sum Assured and Insurance Protection Cover charges up to the next Review Date, the Society shall notify the Owner who shall elect to:- (i) increase the premium, or (ii) reduce the Guaranteed Sum Assured."*

- Mrs W's complaint was that the policy lapsed and she wasn't notified. They'd compensated her accordingly and given her a number of options to enable her to continue with the policy. But, the investigation and response went into points Mrs W hadn't raised and SF hadn't been provided with the opportunity to investigate those

points.

- SF had only acquired this book of business in 2015. The investigator had given feedback on the wording of reviews being unclear. However, they felt their current letters were worded correctly.

- The policy documentation provided at the outset confirmed there was a risk of the policies going into a negative balance, therefore Mrs W could have contacted them sooner if she had any concerns.

- She was also receiving annual statements outlining the policy's balance, which the investigator didn't appear to have considered. Due to this, they would question whether some of the points the investigator had made would be time barred as they occurred over six years ago and they felt enough of an indication of the status of the policy had been provided to Mrs W.

- The investigator seemed to be making assumptions on what Mrs W would have done in surrendering the policy. But they hadn't been able to identify any instance where she'd mentioned this course of action. On the contrary, in her complaint to SF, Mrs W had expressed a desire to continue with the policy.

- Mrs W was still benefiting from life cover even when the reviews weren't done, up until the point when the policy lapsed in 2023. This point appeared to have been overlooked to find the best resolution for the customer, rather than the complaint being assessed fairly. They thought the proposed resolution was over-reaching and lacked any sense.

- The investigator had referred to the fact that SF should have been aware of the potential outcome of future reviews beyond the policy's next review date. They'd discussed this with their Actuarial Team who didn't think that this would be feasible. Market conditions impacted unit growth, future charging levels and ultimately the outcome of a review. For this reason, reviews were carried out at relatively short intervals, and it was their opinion that SF should not be producing figures beyond that.

The investigator wasn't persuaded to change his opinion so the complaint was passed to me to make a decision.

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.

Has Mrs W been treated fairly?

I've considered the errors SF made in missing reviews and in sending a letter to the late Mr W after they'd been made aware he'd passed away. SF have apologised for their error, reconstructed the missed reviews and offered £400 in compensation for the distress and inconvenience they caused.

I think finding out that a policy you'd paid into for over 30 years had lapsed, and that a business had been writing to your deceased husband after you'd made them aware of his passing would cause a considerable amount of distress and inconvenience. However, taking everything into account, I'm satisfied £400 is sufficient compensation and I don't think SF need to do anything further regarding this aspect of the complaint.

I've then gone on to consider if SF treated Mrs W fairly by providing her with enough information to enable her 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 Mrs W's complaint against SF.

At the heart of the issue is the policy lapsing because its unit value was completely diminished by the time of the 2022 review. I don't think it's unreasonable to suggest that this was a poor outcome for Mrs W, and one that SF should have identified and taken action to address. I appreciate SF's point that they only acquired this book of business in 2015, but I haven't seen anything to suggest that they didn't also take on any responsibility for any associated liabilities.

In my opinion, they needed to put Mrs W in a fully informed position about the policy. I note SF's points about Mrs W being given warnings from the outset about the reviewable nature of the policy and the potential impact of this on the premiums, sum assured and cost of cover. 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 SF were in possession of information about the policy that Mrs W 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 Mrs W if action wasn't taken. The table below shows what she was paying each year in premiums versus the cost of

providing her with cover:

Policy year	***Charges***	***Premiums***
20/9/08 - 20/8/09	*£1,851.21*	*£1,565.28*
20/9/09 - 20/8/10	*£2,213.23*	*£1,565.28*
20/9/10 - 20/8/11	*£2,394.04*	*£1,565.28*
20/9/11 - 20/8/12	*£2,641.37*	*£1,565.28*
20/9/12 - 20/8/13	*£2,832.44*	*£1,565.28*
20/9/13 - 20/8/14	*£3,280.37*	*£1,565.28*
20/9/14 - 20/8/15	*£3,884.23*	*£1,565.28*
20/9/15 - 20/8/16	*£4,348.73*	*£1,565.28*
20/9/16 - 20/8/17	*£4,740.24*	*£1,565.28*
20/9/17 - 20/8/18	*£5,279.38*	*£1,565.28*
20/9/18 - 20/8/19	*£6,282.80*	*£1,565.28*
20/9/19 - 20/8/20	*£7,408.83*	*£1,565.28*
20/9/20 - 20/8/21	*£8,523.30*	*£1,565.28*
20/9/21 - 20/8/21	*£9,902.02*	*£1,565.28*

What this table highlights is the fact that Mrs W's policy had reached an important tipping point in the policy year 2008-2009. 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 pot 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 pot 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 pot 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 Mrs W's case, the purpose of the policy was to leave a lump sum for her children, and this need wasn't likely to change. Therefore, it was important that she was put in an informed position by SF about the sustainability of the policy as soon as reasonably possible. In order to do so, SF needed to provide her with information about the policy in a clear, fair and not misleading way.

If she didn't have this information or was provided with it too late, then her options to keep the policy going would be reduced. This was because the cost to do so would simply be too great or she 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 Mrs W's policy, it was due to be reviewed on its tenth anniversary then every five years thereafter and then annually when either of the lives assured reached 65. Mrs W's policy was being reviewed annually since at least 2008.

The yearly reviews provided SF with the opportunity to deliver important messages and to provide fair, clear and not misleading information to Mrs W. This is important because one of the main threats to the long-term sustainability of Mrs W's policy was the impact of the ever-increasing mortality costs for the reasons I've previously set out. In order for Mrs W to mitigate this threat, SF needed to share the information I've set out below with her:

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

- *A clear explanation of the poor outcomes she 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 her 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, Mrs W's premiums stopped meeting the life cover costs in the policy year 2008-2009. In that year she paid £1,565.28 in premiums but the charges on the policy came to £1,851.21. 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 Mrs W 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 2008-2009 was the point I consider SF should have taken action. They should have provided Mrs W with clear, fair and not misleading information in a timely manner to enable her to weigh up her options and make a fully informed decision about the value of the policy and whether, and on what terms, she wished to retain it.

In my view, the obligation on SF 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 SF were communicating with Mrs W. Her reviews were taking place annually at that point with the next one due in September 2010. 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 SF should fairly and reasonably have provided Mrs W with a clear outline of her options as I've previously set out, within 12 months after the date at which the tipping point was reached, by around September 2010 at the latest.

I've considered the communications SF sent Mrs W after the tipping point was reached and I'm not satisfied that they met her information needs. I've seen most of the review letters issued between 2008 and 2019. Up until 2016 the letters simply confirmed that no changes were required to the sum assured or premiums and gave no further details.

From 2016 onwards the letters gave a bit more detail and started to mention that the level of cover may not be sustainable for life. They said:

"Life cover can be sustained over the next review point. However, this level of life cover may not be sustainable for the rest of your life…. You should remember that the greater your life cover the more will be deducted from your Plan value. Furthermore, if the level of your selected life cover is too high, it's possible that your Plan value could run out of funds and

your life cover would cease…..A proportion of your premium is currently funding your life cover benefit, so it is likely that at subsequent reviews you will need to make a choice between increasing your premium to maintain your cover, or accepting a reduced level of cover."

There was no mention of the costs of the cover and little 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 when the fund value might be exhausted. I don't think this was 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 Mrs W once the tipping point had been reached, shouldn't have provided information in a passive way that required her to draw out important inferences for herself.

I think SF should've provided the information I previously outlined in a clear and accurate format, along with clear information about the options available to Mrs W at this point, together with their costs and benefits as well as time frames for reply. I note the point SF has made regarding the difficulty in projecting outcomes past the next review, but even if precise numerical information about the costs of those options could not be given, then at the very least I would expect to see reasonable approximations or illustrative examples so that she could reasonably appreciate the importance of considering her options at that point.

Taking everything into account, I can't see that Mrs W was ever provided with any information about the impact of the charges on her policy. She was never given an indication of what she would need to do to make her policy sustainable or what might happen in the future past the next review. Therefore, I'm not persuaded SF took the necessary steps to address the imbalance of knowledge and therefore didn't allow Mrs W to make an informed decision about what steps she wanted or needed to take to make her policy sustainable for life.

What would Mrs W have done differently?

I've considered what, if anything, Mrs W would have done differently if she'd been made aware by September 2010 that there was a gap between the cost of providing her with cover and her premiums. I think the September 2010 review was an opportunity for SF to tell her 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 her), she would likely be faced with far more significant adjustments at a later time when such adjustments might not be affordable for her.

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

The purpose of the policy was to leave a lump sum for her children. However, I think that cost was a significant factor in her considerations. In 2010 she was in her mid-seventies and the late Mr W was over eighty and they were both reliant on pension income. This would have meant that it would have been unlikely that they would have found an affordable policy which provided the sum assured they required. But I don't think that they would have continued with a policy where the sum assured would keep reducing based on the level of premiums they could afford.

Based on the balance of probabilities, I think it is more likely than not, that she would have surrendered the policy if she'd been made aware of the likely increases in premiums that would have been required to sustain the policy for life. As I've previously set out, SF should have put Mrs W in a fully informed position by September 2010, 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 SF to pay Mrs W the September 2010 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 September 2010 onwards (that haven't already been refunded) 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, Mrs W may wish to seek independent financial advice on the impact the outcome will have on her individual circumstances and needs.

They should also pay Mrs W £400 in total for the distress and inconvenience they caused her if they haven't done so already."

Responses to my provisional decision

Mrs W accepted my provisional decision and didn't make any further submissions. SF didn't accept my findings and made the following points.

In considering whether Mrs W had been treated fairly, it was important to take into account the nature, and aims, of this type of product and the customers' intention when they took it out. They asked us to consider the question of fair treatment in the context of the following points:

- This was a long-term product intended to offer the comfort of a sum assured (SA) on death and was not designed to be a savings policy. This was a benefit that most customers find particularly valuable when they (and any dependents/beneficiaries) are younger and typically more vulnerable to the financial effects of the policyholder's death.

- The fact that this was a life assurance rather than a savings product was made clear in the Key Features document, which clearly stated *"If your priority is for savings we suggest you discuss an alternative with your financial adviser".* This was an advised sale with the benefit of advice from an IFA. It was more likely than not that the adviser considered Mr and Mrs W's circumstances holistically and identified a need for life cover as opposed to savings and would have fully explained the difference between the two and the essential mechanics of the product in addition to product disclosures provided.

- Most policies were typically set up on a first death basis, this particular policy was established on a second death basis. This choice offered significant advantages for estate planning, such as providing funds to cover inheritance taxes and ensuring a legacy for beneficiaries. A client seeking immediate financial support upon the first death would generally choose a first death policy. This demonstrated that Mrs W's ultimate objective was focused on long-term life insurance.

- The statements from at least 2008 showed a gradual decline in the number of units

held. The fact the customers chose to continue with their cover rather than surrendering when the units were declining again confirmed their priority was to keep their cover in place.

- The customers contacted SF in 2016 and 2017 regarding the status of their policy and their options, and on both occasions decided to retain the policy rather than surrender it. Given their clear engagement with the review letters and the disclosures which those letters contained, it was reasonable to deduce that the customers continued to take this decision up until the point at which the policy lapsed.

- They thought it was clear from the facts of this case that Mrs W and her late husband took the policy out later in life (at the ages of 56 and 61 respectively) with a view to achieving life cover, and having the comfort of knowing that their beneficiaries would benefit from as high a SA as possible for as long as possible. This was a benefit they received (in exchange for an unchanged premium for over 30 years) right up until 2022 when the policy lapsed in accordance with its terms. This period of cover includes the 2021 policy year, when SF provided cover with the full SA and an unchanged premium despite the fact that the policy would have failed a review.

They then made the following points around the question of whether they provided appropriate information about the policy. They noted my comments regarding the information provided to Mrs W regarding her policy, including the FCA's guidance in FG 16/8. They didn't agree that they failed to give Mrs W adequate information. They asked me to note:

- The expected standards of customer disclosure had clearly evolved over time, and it was for this reason that the FCA used FG16/8 to clarify its expectations for the industry around firms' treatment of their longstanding customers. The evolution in regulatory expectations (and the communication of those expectations) led to increased disclosures in SF's review letters.

- They pointed to the following excerpts from FG16/8, which highlighted that the guidance is not binding and wasn't to be used as a prescriptive checklist of required disclosures, but rather should be used by firms to consider how they were communicating information to customers, and also that it was not intended to be a retrospective application of regulatory requirements:

    - "1.9 It is not our intention to expect firms to disregard or amend the original T&Cs of a policy or to apply current regulatory requirements retrospectively to closedbook products so that customers would always receive the best outcomes.

    - 1.10 However firms should not rely just on T&Cs to defend outcomes that are unfair under our Principles for Businesses (the Principles), and our guidance describes additional actions that firms should consider to improve outcomes and/or satisfy legally enforceable customer expectations from communications made at the time the customer signed up to the policy. It is for firms to determine circumstances where the rigid application of a T&C may result in an unfair outcome to a customer or group of customers, and firms may wish to consider whether it is appropriate to disapply the T&C in that specific circumstance. This guidance is not binding on firms and is used to illustrate ways (but not the only ways) in which firms can comply with relevant rules and Principles. FCA guidance in general does not set out the minimum standard of conduct needed to comply with a rule, nor is there any presumption that departing from guidance indicates a breach of a rule."

- They believed that the review letters issued from 2016 gave Mrs W enough information to be aware of the current status of the policy and highlighted that changes would likely be needed in the future.

- From 2016 onwards, the review letters were enhanced and became more detailed. They confirmed the level of life cover, premium payable, and surrender value. They also explicitly drew customers' attention to the fact that the plan could lose value and subsequently cease, and confirmed that it was likely the customers would need to make a choice in the future between increasing the premium to maintain cover or accepting a reduced level of cover. They also gave the customers alternative options (i.e. surrendering the policy) and explained that they may wish to seek independent advice (both points suggested in FG 16/8).

- They'd also provided estimates to the next review date and noted that their actuaries had confirmed that they did not believe it would not have been appropriate to project the change in premium over a longer time horizon with any degree of accuracy, as this would have required SF to estimate future changes in mortality rates and speculate as to investment returns achieved on the investment component of the policy. Although a range of outcomes could have been provided (for example, high growth / medium growth / low growth investment scenarios), it was not clear that this information would have been at all helpful to the customers; it would likely have shown that premiums were sustainable for life in some scenarios and not sustainable in other scenarios. It is not clear what the customer could have meaningfully done with this type of projection and the data would likely have been confusing for them to interpret. Had Mrs W wished to re-evaluate whether to cash in the policy, she could have taken financial advice following a premium review as recommended in the review letter.

- SF's processes and the design of the policy took into account the risk that the passage of time could adversely impact on the outcome the customer receives. This is the reason for the decreasing intervals between policy reviews as the customer gets older, and the increased customer contact (annually after the customer's 65th birthday) to regularly remind customers of their plan value, premium amounts and options.

They raised the following points relating to what alternative decisions Mrs W might have taken had different information been provided.

- I'd said that by making changes to the policy earlier in its life, Mrs W could have prevented the depletion of the investment. However, it's unclear what changes I had in mind which could allow the investment pot to continue to grow over time and also avoid significant premium increases or reductions in the SA later down the line. This policy wasn't an investment policy, and as the charges increased either premiums needed to go up or the investment pot would decrease. The only way to avoid this was to reduce the SA (or potentially to invest aggressively and outside the customer's risk appetite/appropriate investment profile for this type of product).

- They considered that Mrs W's objective was to maintain as great a SA as possible for as long as possible, and (particularly given that this was an advised sale and she clearly considered the various options in 2016 and 2017), they didn't consider that she would have cashed in the policy as I suggested.

They thought that Mrs W received a good outcome, considering the policy's nature and aims

and asked me to consider the following points:

- With this type of product, there was no definitive 'good outcome' for customers at reviews without an up-to-date picture of their health. In particular, if a customer was in poorer health it was almost invariably in their best interests to keep the policy in force and retain the high value life cover. SF had no way of knowing the health of the policyholder and it didn't seem reasonable, or appropriate, to conclude that they should have speculated on the customer's health and offered advice on this basis.

- Mrs W's main objective was to retain life cover for as long as possible. If SF had taken action sooner to address the decreasing value of the policy, this would have resulted in an earlier decrease to the SA or an increase in premium which would not have been a good outcome for her based on her objective.

- Although there were some unfortunate oversights which meant some reviews were missed, these did not result in customer detriment. Their failure to carry out a review in 2021 meant Mrs W benefitted from a higher level of cover and lower premium than she ought to have been paying under the terms of the contract.

- They'd already offered to put Mrs W back in the situation she would have been in had the reviews taken place (i.e. the option of increasing her premium to the sum needed to put the plan into a positive position and meet the SA and continuing with the policy, or keeping the premium rebate and allowing the policy to remain lapsed), although we appreciate that maintaining life cover is expensive for a customer in their 90s.

- They believed that the standard I was applying was a "best outcome" standard, not a "good outcome" standard. This went beyond Principle 12, which is a higher standard than Principle 6, the prevalent regulation for most of this customer's policy lifetime, and was not the intention of FG16/8 as noted above.

They raised the following points around the circumstances in which the complaint had been made:

- They highlighted that the complaint had been raised on the policyholders' behalf by their son.

- Mr and Mrs W had been receiving the statements and review letters and had engaged with SF throughout the term of the policy including making contact to enquire about the current status of their policy and the options available to them.

- There was no suggestion that the complainants' son was a party to their discussions with their adviser which led to the decision to take out the policy. He also wasn't a party to the enquiries that were made to SF in 2016 and 2017, and he wasn't the recipient of the product literature, statements or review letters.

- For these reasons, they believed that there was sufficient evidence to support that Mr and Mrs W understood the policy and the options available to them. Whilst the customers' son may not have understood the policy his parents bought or their reasons for doing so, this wasn't a valid reason for complaint.

Points regarding my interpretation of the tipping point

- I'd determined that the tipping point was in 2008/2009 as this was the point at which

the mortality charges exceeded the premiums. However, this was factually incorrect and did not take into account the way in which the product operated.

- The policy was designed with an investment element which generated returns each year, based on the investment performance of the unit-linked funds which the policyholder selected. This allowed the policyholder to benefit from investment growth and reduce the cost of the life cover. If the returns generated by the investment element were in excess of mortality charges, the policy would remain sustainable even if the mortality charge was higher than the premiums being paid.

- The change in value of the unit holding demonstrated this clearly. In 2008 the unit value was £22,725 and in 2018 it was £21,535 (having increased to over £27,000 in 2014). It had hardly changed over the ten-year period and did not provide evidence to support my view that the policy had reached a tipping point in 2008/2009 as I'd suggested. In this period, although the mortality charges exceeded premiums paid, the policy had been sustained by the positive investment performance which was exactly how the product was designed to operate.

- They accepted that the policy's value fell rapidly in 2020 and that the tipping point may have been reached at that point in time. Due to an error on their part, the premium reviews were not undertaken in 2020 or 2021, which would have highlighted this tipping point and resulted in an increase in premiums. However, this error was in Mrs W's favour, as she continued to benefit from the full life cover amount during the 2021 policy year without having to pay an increased premium.

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 still of the opinion that this complaint should be upheld. I will now explain why. It may be helpful to explain that I don't intend to respond to every point that has been raised. Instead, my focus will be on what I consider to be the material points which SF have commented on and provide my reasons.

I note the points SF have raised about the clarification provided by the regulator in FG 16/8. But I'm not persuaded that I'm using the guidance in FG 16/8 to retrospectively apply standards. I've previously set out statements from the regulator which explained that the expectations set in FG 16/8 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.

To reiterate, the feedback statements below explain why the guidance provided by the FCA in 2016 wasn't setting new expectations but was simply reminding firms of their expectations under existing Principles and COBS rules which had been in place since 2001 and 2007 respectively.

- *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."

Given that FG 16/8 sought to remind firms of their expectations, it's important to understand how the guidance applies to RWOL policies. While it isn't prescriptive, what we can draw from FG 16/8 is that the FCA had concerns about the standards of communications that were being issued to many consumers. The thematic review on the fair treatment of customers in the life insurance sector (TR16/2) set out that firms who sent out regular communications would "*need to include more information such as charges and fund performance*".

The findings in TR 16/2 as well as the finalised guidance in FG 16/8 identified examples of substandard communications. TR 16/2 noted that "*Disclosure of on-going charges was particularly poor in many cases. Most firms did not provide any information on charges and fees to most closed-book customers, with some firms only partially disclosing the charges, this may have created a misleading view to the customer of the actual costs of maintaining the policies."*

So, in my opinion the FCA made it clear that greater disclosure of ongoing charges was required. The most significant charge that applies to RWOL policies is the cost of providing cover. Therefore, these charges and their effect on the performance and long-term sustainability of the policy, need to be disclosed in a fair, clear and not misleading way.

It is with this in mind that I've considered if SF treated Mrs W fairly. I appreciate the points SF have raised relating to their treatment of Mrs W, but given that the policy is a long-term product, consumers need to be put in a fully informed position, particularly relating to its long-term sustainability.

The policy was intended to last for the rest of Mrs W's life and not just for a limited period of time. I accept that the policy offered a high sum assured for relatively low premiums at the outset, but this potentially wouldn't be the case for the entire life of the policy. This is why Mrs W needed to be put in an informed position about the policy, and well before the point where the policy could only be maintained at a prohibitive cost, or the sum assured would have to fall to a level where it may not be fit for its original purpose.

I think there was information which should have been made available to Mrs W about changes that could have been made earlier in the life cycle of the policy that might have made it more affordable over the long term, or made her think about whether the long-term costs of the policy would be affordable for her.

This information should have been presented to her within the timescales I previously set out – within twelve months of the tipping point being reached – and long before the policy lapsed. In my opinion, it isn't fair or reasonable that the policy's charges reached a level six times that of the premiums being paid but Mrs W wasn't made aware of what was happening.

I'd like to stress that I've very carefully kept in mind the reviewable nature of the products and the fact that they weren't intended to be a savings plan. But given that the primary purpose of these policies was to provide whole of life cover to consumers who had a need – I think that the underlying fund was key to ensuring that the policy would last for as long as it was required.

In order for a consumer to be treated fairly, they needed to be informed about the risks of the underlying fund being depleted and any potential mitigating options. This is important because once the fund is depleted and unable to offset the difference between the cost of

cover and the premiums being paid, significant changes will be needed to maintain the level of cover being provided.

The main reason why the fund may become depleted, subject to any underlying growth, is the costs of cover exceeding the premiums. I think it therefore follows that when this point is reached, consumers ought to have been specifically made aware of it – because from that point onwards the policy becomes wholly reliant on the growth of the underlying fund for it to be sustainable for life. This is why I consider the tipping point to be such a key moment in the policy's lifecycle.

I don't accept that the tipping point of Mrs W's policy was after 2009. While the underlying fund continued to grow until 2017, this was purely down to increases in the unit price of the underlying fund as no additional units were being added to the fund after 2008. As the cost of cover increased over time, more and more units would have to be sold down to meet this cost which would have the ultimate effect of completely depleting the fund.

Because of this, I don't think the tipping point should be as SF have suggested - the point where the policy value falls rapidly. I think that this point would be much too late for a consumer to take any meaningful action to ensure the long-term sustainability of their policy.

I'm satisfied that the tipping point should be as I set out in my provisional decision – the point where the costs of the policy exceed the premium being paid. I think this is reasonable as from this point onwards, the mechanics of the policy change and the underlying fund starts being used to supplement the premiums being paid.

And this is why I think that once the tipping point has been reached, the costs of the policy and their impact on the policy need to be clearly and properly disclosed in order for the policyholder to be in an informed position. Policyholders need to be made aware that their policy has reached this important milestone, its implications and the options to mitigate any potential poor outcomes so that they could make an informed decision about what to do next, if anything.

They can then weigh this up in the context of their own circumstances and objectives, taking into account the risk of the fund being depleted in future and its likely impact on the ongoing costs of maintaining the policy. Without this knowledge, consumers can't reasonably understand their policy or the options they need to take to sustain it.

I appreciate that any projections provided by SF at the time of the tipping wouldn't necessarily be 100% accurate. But I think a projection based on the underlying assumptions around future mortality costs and expected fund growth would have put consumers in a much more informed position than not receiving any information at all.

I don't think the policy reviews that SF provided to Mrs W gave this level of detail as they only forecast the sustainability of the policy until the next review point. A positive review without any context about the policy's charges could lead a consumer to think that the policy was in good health when the reality of the situation could be very different. Therefore, I remain of the opinion that consumers needed to be given reasonable projections and also made aware of potential mitigating options at the time of the tipping point.

I disagree that Mrs W received a good outcome because she benefitted from a higher level of cover and lower premium due to the missed 2021 review. The policy was meant to last for her life and the fact that it lapsed meant that she received a poor outcome, one that could have potentially been avoided if she'd been made aware of her options at the appropriate time.

If she'd chosen to either increase her premiums or reduce the sum assured from the time of the tipping point, the policy would have stood a much better chance of remaining in place for the rest of her life. I don't think this represents trying to get the best outcome for Mrs W. I think it represents a fair outcome in terms of trying to put her back in the position she ought to have been in if her information needs had been met.

So, it is for these reasons why I remain of the opinion that this complaint should be upheld, and Mrs W receive the surrender value from 2010 and a refund of premiums. I appreciate she chose to keep the policy running up until the point it lapsed but I think this was a decision that she made without being in an informed position.

If she was in an informed position, I think it's more likely than not that she would have chosen to surrender the policy in 2010 for the reasons I gave in my provisional decision – essentially that the costs of the premiums required to maintain the sum assured going forward would have been too great for her to bear as both her and her late husband were reliant on limited pension income at the time.

Putting things right

I think fair redress would be for SF to pay Mrs W the September 2010 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 September 2010 onwards (that haven't already been refunded) 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, Mrs W may wish to seek independent financial advice on the impact the outcome will have on her individual circumstances and needs.

They should also pay Mrs W £400 in total for the distress and inconvenience they caused her if they haven't done so already.

My final decision

For the reasons I've given above, I uphold this complaint. Scottish Friendly Assurance Society Limited need to put things right as I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W to accept or reject my decision before 11 April 2025.

Marc Purnell
Ombudsman