DRN-5561401

The complaint

Mrs T complains about Aviva Life & Pensions UK Limited, referred to as "Aviva".

In summary, she says she's unhappy about Aviva's decision to refuse her request to top up her single life reviewable whole of life (WOL) policy – referred to as "the Policy" – which caused the policy to lapse.

To put things right, she'd like Aviva to reinstate the policy, and accept the £1,000 contribution.

Mrs T is being assisted by her husband, Mr T.

What happened

In February 1989 Mrs T took out the policy through her broker Jani and Associates Overseas Ltd (Jani) – with Equity and Law – with a £660 annual premium (due every year on the renewal date), for a £150,000 sum assured, increasing by 5% a year.

I note the subsidiary benefits included "Further Assurance Option" but not accidental death. The investment contribution (the amount deemed to be applied from each renewal contribution for investment) was as follows: Initially £445, until February 1993 inclusive, and thereafter £636.

I note the policy was due to be renewed in 1999, and thereafter every five years until the life assured becomes 75 years of age. But this didn't happen. Instead in February 1996, the policy was made a "fully paid policy", which is also when the last premium was paid. I understand that no premiums have been paid since.

The policy was eventually, after numerous changes, taken over by Aviva.

In March 2023, Mrs T sent Aviva a cheque for £1,000, to top up her policy. In April 2023 she received a heath declaration to complete, in May 2023, Aviva sent a chaser. Upon completion, in July 2023 Aviva notified her that it couldn't accept the £1,000, because its underwriters couldn't apply the top up on medical grounds. In other words, there's an option to top up, but it requires a health declaration and Mrs T hadn't mentioned certain details about her health when the policy was taken out. In due course Aviva returned the money to Mrs T.

Since January 2024, the policy has lapsed, so she's been without cover since then.

Mrs T lodged a complaint with Aviva, which it refused. In summary it said that although there was an option to top up the policy, it requires a full health declaration from Mrs T, and if there's any information that wasn't mentioned when she took out the policy, it automatically declines request.

Unhappy with Avia's response, Mrs T referred her complaint to our service. Mr T said that they were assured that the health declaration was a formality, after all she hadn't applied for a new policy. Moreover, her health isn't the same as it was 34 years ago and has over time changed.

Mr T also said that under the original terms of the policy Mrs T's allowed to top up the policy, irrespective of any new terms. Aviva is at fault for not accepting the payment and causing her policy to lapse.

One of our investigators considered the complaint and initially thought it should be upheld. In a view dated October 2024, in summary, she said:

- Aviva in its response to our service said that it was informed by its compliance manager that there was a "special agreement" in place for policies sold by Jani, where additional lump sums could be paid to a "paid-up" policy (without underwriting) to extend the policy term.
- She's seen no evidence (from the policy documentation) that a health questionnaire is needed before the policy can be topped up.
- Aviva refused to provide the medical evidence upon which it made its decision.
- To put things right, Aviva should reconstruct the policy, based on it accepting the top up payment.
- Aviva should also pay Mrs T £200 compensation for the distress and inconvenience caused by the service provided, including refusing to top up the policy.

Mr T, on behalf of Mrs T accepted the investigator's view and said it was "*an amazing summary".* Aviva disagreed with the investigator's view and provided further information in support of its position, and in summary said:

- The last premium was paid in 1996, and the policy has been converted to a fully paid policy since then.
- Mrs T sent a single premium in 2023 to keep the cover in place for longer, but the policy lapsed since January 2024.
- The reason it couldn't accept the premium was because it received the health declaration and couldn't provide cover on the same terms as before.
- The policy terms and conditions on page 9 provide information regarding non-payment of renewal contributions.
- It was in no way obliged to accept the premium offered in 2023 and had good reason not to reinstate the policy and place it back on risk for the death benefit of £165,375.

The investigator having considered the additional points, was persuaded to change her mind. In a subsequent view (dated December 2024), in summary, she said:

- The crux of the complaint is that Aviva declined Mrs T's attempt to top up her policy.
- Aviva has since provided a copy of the Policy Rule Booklet ("the rulebook") Under the Further Assurance Option, contrary to what Aviva said, the option to top up the policy is exercisable on the date on which the life assured attains the age of 45 – because of this reason, she can't ask Aviva to reinstate the policy.
- The evidence shows that Mrs T requested a top up of the policy in March 2023, at the time she was 65 years of age. As this was older than the age at which top up is allowed, Aviva hasn't done anything wrong.
- The above notwithstanding, it should still pay Mrs T £200 compensation for the service provided.
- Aviva failed to provide correct information about why it declined to top up her

policy, and delayed providing information needed to investigate the complaint.

Whilst Aviva accepted the investigator's latest view, Mrs T disagreed with it. There's since been much correspondence between Mr T, and the investigator in relation to why he feels that the investigator's initial view was correct, and why Aviva has been unfair.

In summary, Mr T made the following key points:

- He begs to differ with the investigator's latest conclusion.
- The investigator, in agreement with Aviva, previously said:
- "*Under the Further Assurance Option of the booklet, it's explained that contrary to what Aviva says, the option to top up the policy is exercisable on the business' terms and condition but with no health evidence being required. However, it went on to further explain that this option ceases to be exercisable on the date on which the life assures attains age forty-five*".
- Page 14 and 15 of the rulebook is complicated. It refers to increasing the insurance value, upon birth of a child, or adoption of a child. Such a right should expire when one is not of a child bearing age (aged 45).
- This is a red herring. There's been no children (adopted or born), and no attempt to increase the amount of cover.
- The only attempt is to pay the premium before the policy lapsed. This right is in the rulebook, as well as in the letter supplied.
- This is his last attempt at persuading the investigator/our service that Mrs T/they acted fairly, and in good faith.
- He's not an insurance specialist, but only bought the policy in good faith. He/they trusted that they'd get what they'd paid for.
- In 1989, they were living in Africa, with their son. They each bought a policy – although only Mrs T's policy is the subject of compliant.
- The product was sold as a multi-plan, with an element of investment and life insurance.
- They were sold a product whereby they paid a certain amount of money in the investment funds, which Equity and Law assumed would provide enough of a return to pay for the insurance premiums until death.
- In any case, the rulebook is long and confusing and subject to interpretation. It's important to remember that this is a life policy, and if the premiums are paid, the policy provider has to pay out on death.
- Put simply, an investment was made, and returns were used to pay the life insurance premiums up until the age of 110.
- Statements provided showed how much the of investment return was used to pay for the premium. If the insurance didn't do well, Mrs T had the option to top up which is what she did.
- A letter dated 22 October 2023, from their agent, which discusses the fund not doing so well, and confirming that AXA Equity and Law will allow single premium injections.
- The second page of the letter suggests that investors might want to wait for the markets to bounce back. There's no mention of health checks.
- Page 13 of the rule book says no health evidence is required.
- Page 6 talks about the mortality charge, a premium that must be paid and has been, before the policy lapsed. No mention of health evidence.
- Page 9 talks about renewal contributions. This was paid by the investment fund, until it ran out. Again, no mention of health check.
- This is a WOL policy, not a term assurance, so until death so long as premiums are paid.
- In this case, it was expected the investment would cover the premiums. The premium

paid was to simply pay for life cover that the policy couldn't cover.
- Mr T's policy lapsed a few years ago, but he was too late, he was determined the same wouldn't happen to Mrs T's policy.
- That's why, long before the funds were depleted, he planned to top up the fund by sending the £1,000.
- Aviva asked for the health questionnaire but there was nothing to say a health declaration was required.
- Aviva's refusal to top up the funds is completely unfair. He hopes Aviva can be convinced to meet its obligations.

The investigator having considered the additional points wasn't persuaded to change her mind. In summary, she said:

- She can't see anywhere that policyholders are allowed to make an additional lump sum payment into the policy, so unless Mr T can provide the evidence to the contrary, it would be unfair to ask Aviva to accept this payment.
- Despite what she was told about the "special agreement" (for policies sold by Jani), there's no such provision within the rulebook she's since been provided with, except in the case of further assurance which is why she's had to change her outcome.
- Nevertheless, Aviva should still pay £200 compensation for the poor service provided.

As no agreement had been reached, the matter was passed to me for review.

In mid-March 2025, I issued my provisional decision, a copy of which is stated below and forms part of my final decision. In the decision 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, subject to any further submissions, provisionally I'm going to partially uphold this complaint.

On the face of the evidence, and on balance, I think Aviva behaved unreasonably by not providing a clear answer as why it couldn't to add the £1,000 lump sum payment to the policy (despite Mrs T instructing it to do so) causing her distress and inconvenience. Aviva should pay her £200 compensation for the distress and inconvenience caused.

That above notwithstanding, I can't safely say that Aviva did anything wrong by refusing to add the £1,000 lump sum contribution. I also don't think that Aviva refusing to add the money caused the policy to lapse as suggested by Mr T.

Before I explain why this is the case, I'd like to thank the parties for their considerable patience whilst this matter has awaited review by an ombudsman, due to the current demand for our service.

I also think it's important for me to note I very much recognise Mrs T's (and Mr T's) strength of feeling about this matter. Mr T has provided detailed submissions to support the complaint, which I've read and considered carefully. However, I hope she won't take the fact my findings focus on what I consider to be the central issues, and not in as much detail, as a discourtesy.

The purpose of my decision isn't to address every single point raised. My role is to consider the evidence presented by Mr T and Aviva, and reach what I think is an independent, fair, and reasonable decision based on the facts of the case.

I can only consider the points that are material to this complaint, namely the administration of the policy by Aviva. I'm unable to consider the suitability of the policy and the advice given at the point of sale – albeit I'm aware the issue is important to Mrs T (and Mr T).

The adviser had the responsibility to make sure any recommendation made was suitable for Mrs T's circumstances and needs.

The type of policy Mrs T is complaining about is known as a 'reviewable' whole of life insurance. There was some suggestion that the policy might've been non-reviewable, but on the face of the evidence I don't think that's correct. It's not set up for a specific term but is instead designed to pay out on death whenever it occurs.

I think it's important to make clear that at the start, the amount of cover and annual premiums are based on assumptions about a number of different factors, including the future cost of life cover and investment performance, that aren't known at the start.

In simple terms, each premium paid into the policy is split two ways. The first part is used to pay for the cost of cover in that year. The remainder is invested into a fund or funds. The cost of the cover is not fixed and actually increases with age. The hope is that the investment element will grow enough to fund the shortfall when the policy reaches the point that the cost of cover becomes greater than the premium.

Policies are reviewed regularly to check how they're performing against the original assumptions. At each review, the insurer also needs to make new assumptions about the cost of cover and investment performance in the future.

Given the above, on balance I don't think the unhappiness expressed by Mr T has meant that Aviva has been unable to live up to its undertakings or has behaved unreasonably in relation to the policy.

Once these calculations are completed, the insurer can determine whether the policy has 'passed' the review, usually meaning no changes to cover or premium is required. Or 'failed', usually meaning the policyholder will be offered the choice of either paying a higher premium to maintain the same level of cover or accepting reduced cover for the same premium. This is generally how reviewable whole of life policies operate and isn't unique to Aviva.

The above notwithstanding, in this case I note that the policy was made paid up in 1996, before its first official review date in 1999 (according to the key policy documentation). This means that no policy reviews were ever carried out to see if the premiums were enough to maintain the sum assured. Consequently, I think the policy eventually lapsed in January 2024, simply because it was unsustainable – having had no contributions paid for 28 or so years – and not because Aviva had refused to pay in the £1,000 into the policy.

I should also point out that Aviva refusing to pay this money into the policy didn't cancel the policy either. They are two separate and unconnected points that Mr T appears to be confused by.

On the face of the evidence, and on balance, it's likely that the policy became paid up because Mrs T stopped paying the regular contributions. The consequence of this is that no contributions would thereafter be due, therefore its arguable that Aviva couldn't make this contribution even if it wanted to.

So, in this case, the policy, albeit a WOL policy, continued for as long as it was sustainable, and Mrs T had the benefit of life cover from 1989 to 2024. I appreciate that "projections" were made at the outset, but whilst done in good faith they were only projections and not guaranteed, so the fact they weren't subsequently fulfilled isn't something that I can blame Aviva for. Nevertheless, in the event of a valid claim it's likely the policy would've paid out the sum assured. And it's unlikely that the policy would've lapsed if the contributions had been paid as and when required.

I note Page 9 of the rulebook under the heading "Non-Payment of Renewal Contribution" in section four of the rules – which Aviva referred to – states:

"If any Renewal Contribution is not paid in the manner specified in the section headed 'Renewal' above and conditions (a) and (b) below are satisfied, the Policy will be converted to one under which there would be no further Renewal Contributions payable. The date of such conversion will be the due date of the first unpaid Renewal Contribution. The Sum Assured will remain unchanged. Any Subsidiary Benefits will lapse and Options in Section Five will be cancelled.

Conversion is subject to the following conditions:

> *(a) that at least one year's Renewal Contributions have been paid, and*
> *(b) that the Accumulation Unit Value on the date of conversion is not less than an amount to be determined by the Society according to its Practice at the time"*

The above rule explains what happened with Mrs T's policy in 1996 – which is when it became a fully paid-up policy – for lack of payment of premiums. Consequently, no further contributions would be payable which may explain why none were paid from this point onwards, until Mr T attempted to do so on Mrs T's behalf, in March 2023, roughly 28 years later. But as I alluded to above, despite what Mr T says, I don't think an additional contribution was possible in any event.

Because Mrs T's policy was paid up, it was also excluded from numerous other options that were available under the policy rules. One of them being able to pay missed premiums within 12 months of when they were due. This rule doesn't allow Mrs T to pay premiums into a paid-up policy whenever she likes.

Despite what Mr T says about the "Revival" of the policy on page 10 of the rulebook, I don't think he's correct. The revival is only in relation to a renewal contribution not being paid in the manner specified – that can be revived within 12 months of when the contribution is due. This doesn't apply to a paid-up policy which hasn't had premiums paid since 1996.

I also don't agree with Mr T's reference to the phrase "each time you make payment" in a statement automatically implies that Mrs T can add funds to the investment account at any time. It's likely that this is just standard wording used in the statement that Mr T has misinterpreted.

Based on page 12 of the rulebook, under the heading "Option to alter the Sum Assured or Renewal Contribution", (before the policy became paid-up) Mrs T had the option to alter the sum assured (in other words, reduce it), so that the policy would continue at the same premium – or increase the premiums so as to maintain the sum assured, but she didn't. Instead, she stopped paying the premiums. It's arguable that reducing the sum assured (before deciding to stop paying premiums) would've allowed Mrs T to keep the policy going for longer albeit with a lower level of cover.

I note Mr T says that he realised that there'd be no funds left and that's when he sent Aviva £1,000 on behalf of Mrs T to cover the premiums for the next year, but that's not how things work once a policy is paid up. Despite what he says, I've seen no evidence that he could make additional payments into a policy once it is paid up.

I'm mindful of the investigator's comments in relation to page 14 of the rules under the heading "Further Assurance Option" but I don't think its relevant in this instance and not something that Aviva has put forward as a reason either. But if I am wrong about the applicability of this section, based on what the investigator says, for an additional policy to be issued (subject to the policy's terms and conditions) and no health evidence being required, the option ceases when the life assured reaches the age of 45 and I'm mindful that Mrs T at the time was 65.

The above notwithstanding, I'm unable to safely say that Aviva has given Mrs T a clear answer as to why it requested a medical declaration and/or why it was unable to add the £1,000 lump sum contribution into her policy. So, I think Aviva should pay Mrs T £200 compensation for the distress and inconvenience caused.

It's important to clarify several unrelated points that appear to be muddying the waters but aren't directly related to Mrs T's complaint against Aviva.

Firstly, an insurer can't generally decide to end a life cover policy because the life assured's health has changed over time. This is something that an insurer will consider at the outset as I alluded to above. But this is not what Aviva has done here.

Secondly, an insurer can decline a policy, and/or refuse to pay out – if it transpires that that a policyholder has for example 'deliberately' or 'recklessly' withheld medical information when it was requested – but I don't think this is relevant to Mrs T's case either.

If it was, and I thought Mrs T had provided inaccurate or incomplete medical information – which I don't believe she did – I don't think Aviva would be wrong to refuse to continue with the policy – but it would raise additional questions about the premiums paid and what happens to it. But as I said before, this isn't what I'm dealing with here, so I don't need to consider this any further.

Given the above, I don't think Aviva could revive Mrs T's policy that was paid up. It's generally not possible to do so. The suggestion that it also can't continue to provide cover because (36 years on) Mrs T's health has changed is also not what Aviva is saying here.

It seems to me that Aviva was probably going to use the £1,000 to issue an additional policy, perhaps linked to Mrs T's policy (although I accept this isn't what Mrs T wanted in any case), which is probably why Aviva subsequently said it couldn't on the same terms as her original policy, because her health isn't the same. In this context I'm unable to say that Aviva behaved unreasonably. However, I think Aviva should've done more to clarify the reasons for its refusal and why Mrs T couldn't pay into a paid-up policy.

If Mrs T wanted a new policy, she could apply for one (either with Aviva or a different business) but given the state of her health, she'll probably have to pay much more for it.

In conclusion, on the face of the evidence, and on balance, despite what Mr T says, I don't think the policy lapsed because Aviva declined to apply Mrs T's £1,000 lumpsum contribution to the policy. I'm mindful that this policy, take out in 1989, was paid-up since 1996 (with a £165,375 sum assured) and no additional contributions being made, simply couldn't be sustained.

On balance I'm satisfied the documentation supplied by Aviva was reasonably clear, unambiguous, and not misleading. As the policy provider I don't believe it was obliged to do any more. Aviva couldn't have predicted the level the premium would increase to in 35 years rendering the policy unsustainable (especially where the policy was paid-up) and in fairness, I don't think it was obliged either.

I'm mindful that Mr T mentioned that if all else failed, Mrs T reserved the right to take legal action to ensure that Aviva fulfils its commitment. It's a matter for him and Mrs T whether (or not) she takes legal action. It's not something that I can comment up. It's also not a reason to uphold this complaint and give them what they want.

I appreciate that Mrs T (and Mr T) will be unhappy that I've upheld the complaint but still haven't given them what Mrs T wants. But on the face of the available evidence, and on balance, despite what they say, I can't give her what she wants."

I gave the parties an opportunity to respond to my provisional decision and provide any further submissions they wished me to consider before I considered my final decision, if appropriate to do so.

Aviva responded and accepted my provisional decision. In short, it said it had no more to add and was happy to settle this outcome.

Mrs T (and/or Mr T on her behalf) didn't provide a response.

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, in light of no new response from Mrs T (and/or Mr T), and Aviva accepting my decision to partially uphold this complaint remains the same, principally for the same reasons, as set out in my detailed provisional decision.

In other words, despite being given further time and opportunity to respond to my provisional decision, I'm satisfied that no new material points have been made that persuade me I should change my decision.

On the face of the evidence, and on balance, I think Aviva behaved unreasonably by not providing a clear answer as why it couldn't to add the £1,000 lump sum payment to the policy (despite Mrs T instructing it to do so) causing her distress and inconvenience. So, I still think Aviva should pay her £200 compensation for the distress and inconvenience caused.

That above notwithstanding, I can't safely say that Aviva did anything wrong by refusing to add the £1,000 lump sum contribution. I also don't think that Aviva refusing to add the money caused the policy to lapse as suggested by Mr T.

In other words, on the face of the evidence, and on balance, despite what Mr T says, I don't think the policy lapsed because Aviva declined to apply Mrs T's £1,000 lumpsum contribution to the policy. I'm mindful that this policy, taken out in 1989, was paid-up since 1996 (with a £165,375 sum assured) and no additional contributions being made, simply couldn't be sustained.

On balance, I still don't think the unhappiness expressed by Mr T has meant that Aviva has been unable to live up to its undertakings or has behaved unreasonably in relation to the policy.

Putting things right

To put things right, Aviva Life & Pensions UK Limited should pay Mrs T £200 compensation for the distress and inconvenience caused.

My final decision

For the reasons set out above, and in my provisional decision, I partially uphold this complaint.

Aviva Life & Pensions UK Limited should pay Mrs T redress as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs P to accept or reject my decision before 12 June 2025.

Dara Islam
Ombudsman