DRN-5661943

The complaint

Mrs S complains about the way Countrywide Assured Plc administered her Reviewable Whole of Life policy and, in particular, the level of premiums it required her to pay following the 2019 review which left her with limited choices and benefits under the policy.

What happened

Mrs S took out a Capital Plan with Premium Life Assurance Company Ltd in August 1984. This was a reviewable whole of life policy which included Permanent Total Disability (PTD) benefit. Countrywide now administers this policy and I'll be referring to it throughout this decision. Mrs S's initial premium was £12 per month with a sum assured of £49,031. During the years Mrs S was offered increases in the sum assured (and consequently in her premium) in line with inflation.

In 2019 Mrs S received two letters – a June 2019 letter which asked her to increase her premium as part of an inflation review and a review in August 2019 which said that the premium she was paying was no longer enough to maintain her benefits. At this point she was asked to increase her premium from £72.07 to £351.34 per month or reduce the sum assured from £136,601 to £30,289. Mrs S has explained that she'd been out of work for some time and could not afford this increase.

In January 2020 Mrs S was sent another letter. This explained that as she had left her premium unchanged and had not reduced the sum insured, the units in the policy had now all been used up to cover the shortfall between the premium and the policy charges. As a result, Mrs S needed to increase her premium to over £365 per month, or reduce the life cover to £27,036.

Shortly after the August 2019 review, Mrs S also enquired about making a PTD claim. This took some time and in the meantime Mrs S remained unhappy with the outcome of the review and what had happened with her policy. This meant that a claim was not submitted until October 2020. At this point, Countrywide explained that:

- The PTD claim would be reduced on a sliding scale from when she turned 51 until she turned 65, which was in October 2020. This meant she wasn't entitled to the full PTD benefit;

- In addition, Mrs S's benefit had reduced to £27,036 in January 2020 – so the sliding scale applied to that sum.

All this meant that instead of receiving payment in excess of £130,000 which is what she was expecting, Mrs S was offered just over £1,800 as settlement for her PTD claim. Mrs S didn't accept the payout.

Mrs S complained about both the review in 2019 as well as the communications around her PTD claim in 2020 which was dealt with under a separate reference and is not the subject of

this decision.

Countrywide looked into her concerns but didn't think it had done anything wrong. In short it said that it had complied with the terms and conditions of the policy and explained why the policy charges had continued to increase as she got older. It said that she had opted after certain failed reviews not to increase her premiums and this is what caused the investment units in her policy to be entirely depleted.

Mrs S remained unhappy and referred her complaint to this service. One of our investigators looked into her complaint. In summary, he concluded that Countrywide had not supplied Mrs S with the information she was entitled to throughout the years to make informed decisions about her policy. But he thought that given Mrs S's need for the policy and her testimony, it's unlikely she would've surrendered the policy sooner. However, he thought that if Mrs S had known how expensive her policy would become in future, she likely would've made her PTD claim within 52 weeks of stopping work – this would've happened in or around April 2019. At this point the PTD benefit was still over £130,000 and whilst the sliding scale would've continued to apply, it's likely the payment would've been substantially higher than the £1,800 she was offered in 2020.

Mrs S didn't fully agree with the outcome but explained that she understood why it had been reached. Countrywide provided no comments in response to the investigator's assessment, so the case was passed to me to decide.

I previously issued a provisional decision in which I concluded that:

- Countrywide's communications throughout the years were not fair, clear and not misleading and were not sufficient to allow Mrs S to understand the situation with her policy and how much the life cover costs were outweighing the premiums she was paying in. Furthermore, those communications also didn't show her disability cover reducing in line with the sliding scale that was part of the terms and conditions – so I could understand why it was a shock to Mrs S when she came to claim under the policy, to be told she was only entitled to a portion of the sum she thought would be paid out.

- I was persuaded by Mrs S's submissions that she wouldn't have surrendered the policy had she had more information, but would've instead taken action on the policy to both increase her premiums and reduce the sum assured in order to ensure the policy was sustainable for as long as possible.

Countrywide initially accepted my provisional decision. Mrs S also initially accepted my decision, but asked some further questions – eventually, she said that if she'd known in 2019 about the situation with the policy, she would've made a claim under the permanent disability cover she had.

As a result of Mrs S's submissions, the investigator asked Countrywide for some further information – but received no reply. I also wrote to Countrywide but received no reply. So I issued a second provisional decision in June 2025. In it I said:

"The current issue in dispute is around Mrs S's permanent disability cover, so this decision will focus on that aspect. This is because I've received no comments that would cause me to question my findings around the standard of Countrywide's communications.

In my first provisional decision, I concluded that between 2010 and 2011, Countrywide ought

to have written to Mrs S and explained the situation with her policy – namely the fact that she was now paying less in premiums than the policy was costing and laying out in a fair, clear and not misleading way the risks of her making no changes to the policy. In particular, it ought to have given her a much clearer indication of the likely future impact of the costs of providing life cover and disability cover. Armed with this information, Mrs S could've made a number of decisions about her policy at that time. I provisionally said that in light of Mrs S's ongoing need for the policy and her personal circumstances at the time of the tipping point and since, I was persuaded that she would've made certain changes to the policy that would've allowed it to be more sustainable. As a result, I didn't consider she would've made a claim on the policy in 2019, because that would've brought the policy to an end.

However, given Mrs S's subsequent submissions, I've been persuaded to change my findings on that. I say this because by 2018, Mrs S would also have known that it was likely that further changes would be required in future – in fact that's one of the concerns she expressed after my provisional decision. She explained that she was worried that she'd need to make increases to her premiums again in future and this was more and more difficult as she wasn't working.

So I'm persuaded that the main impact of not knowing the situation with her policy and how much it was costing was that she did not consider making a claim for permanent disability sooner than she did. In response to my provisional decision, Mrs S explained that:

- *She was still expecting her disability claim to be processed based on whatever the higher amount of the policy value would've been in March 2019.*
- *She wanted the opportunity to make her claim again.*

I've reconsidered my findings and given due consideration to Mrs S's comments – I'm satisfied that her testimony is plausible and credible, and borne out by the fact that she did lodge a claim in late 2019 when she received more information about the situation with her policy. She did not proceed with it because of the drop in value in her policy.

It's also clear that her claim met all of Countrywide's requirements under the policy – as it did consider her claim and made an offer under the policy.

However, when it considered Mrs S's claim, the value of the Permanent Disability cover had reduced to £27,036. The terms and conditions of the policy explain that in relation to PTD the sum insured "will be deemed to reduce to zero on the 65th birthday by equal annual amounts commencing on the 51st birthday (or the first birthday after the Commencing Date of the policy if later)". By the time she made her claim in 2019, her entitlement was reduced to 1/15th of the sum insured of £27,036. So Countrywide offered to pay Mrs S £1,802.

The investigator has already explained why the sliding scale applies, and Mrs S has raised a separate complaint about the information sent to her throughout the years and how misleading it was. I'm satisfied that Countrywide did nothing wrong here and applied the terms that were relevant to the claim.

The only issues I'm considering here are:

- *When would Mrs S have lodged her claim and how old would she have been?*
- *What would the value of the sum insured have been then?*
- *Did she need to wait 52 weeks before having her claim accepted, or did she only need to wait 3 months?*

The starting point is establishing when Mrs S stopped working as a result of her disability. The contemporaneous notes I have of Countrywide considering Mrs S's claim in September 2019 show that she told them she'd stopped work in March 2019 as a result of her disability. This is a handwritten note, but I've given it some weight as it was contemporaneous.

However, Mrs S has consistently said that she stopped working in March 2018 and this was the basis of her PTD claim in late 2019 – I can see this is what she told Countrywide in the forms she was required to complete.

Taking into account all the evidence available, I think Mrs S's testimony has been consistent and credible in referring to March 2018 as the time when she stopped working due to her disability – so I think this should be the relevant date. This means that if Mrs S had known, as should've been the case, just how much her policy was costing and how likely it was that it would fail a review in the short term, I think this is when she would've made her claim for PTD under her policy. At this point, her claim would not yet have been accepted. This is because she needed to prove that the period of disability had lasted a certain amount of time.

I've very carefully considered this point – bearing in mind that Countrywide has provided no comments on this issue.

The terms and conditions of Countrywide's policy, under "Permanent Disability Benefit" say:

"Permanent inability to Work - the Person insured becomes totally, permanently and irreversibly disabled as a result of injury or illness so as to be unable to obtain an income from any work or occupation whatever. This inability to work must first occur prior to normal retirement age of the Person Insured (or prior to age 65 if earlier) and ***must have continued for at least 52 weeks****." (my emphasis)*

This means that if Mrs S had made her claim in March 2018, it would've been assessed and paid out in March 2019 – so she would've received 2/15ths of the sum insured of £136,601.

But Mrs S has produced another point of sale document. This document contains "Definitions of Disability" and is clearly highlighted as a document that accompanied the policy schedule and terms and conditions. This document says:

"Permanent Inability to Work - the Person insured becomes totally, permanently and irreversibly disabled as a result of accident or disease so as to be unable to work at his or her normal job or any other job which he or she is capable and reasonably suited for. This inability to work must first occur at least 24 months prior to normal retirement age of the Person Insured (or at least 24 months prior to age 65 if earlier) ***and must have continued for at least 3 months.****" (my emphasis)*

This is material because if the period was only 3 months, Mrs S would've been entitled to 3/15ths of £132,500.

In coming to a decision on this, I've noted that the definition in the document produced by Mrs S is the same as the definition contained in the terms for a claim under the Waiver of Premium benefit she also had as part of her policy.

This portion of the terms defines permanent disability in the same way and specifically makes reference to the fact that the benefit would only be paid 3 months after the commencement of disability.

Furthermore, the copy of the policy I have says, in section 1 "General" –

"Other definitions which also apply throughout the policy are included in other sections". This suggests that the relevant definitions are contained within the policy document itself.

I've also taken into account that the document Mrs S has provided was not intended to be stand-alone – in other words, it is not a contract on its own. There were clearly other pages to it and more context around this definition. The policy terms and conditions are attached to the form that Mrs S signed at the time she took out the policy and are a complete record of the product she took out at the time. I'm satisfied they were issued to her at the same time, even if I accept that Mrs S has no recollection of having seen it.

Taking all this into account, I'm persuaded that the relevant definition, as it applies to a payment under PTD, is the one contained in the policy terms and conditions that were issued to Mrs S when the policy was sold to her. This means that her claim would've been paid out in March 2019, not June 2018.

This also means that Mrs S, who had not yet turned 64, would've been entitled to 2/15ths of £136,601. In addition, had she made a claim in March 2018, she would also have received waiver of premium benefits from June 2018 (i.e. three months after her disability). So Mrs S should receive that too.

This means that to put Mrs S back in the position she would've been in March 2019, Countrywide must:

- *Pay Mrs S £18,213 (which was 2/15ths of £136,601) plus 8% per year simple interest on this sum from March 2019 to the settlement date;*
- *Refund her premiums since June 2018, plus 8% per year simple interest to the settlement date;*
- *No further premiums to pay going forward as her policy would've come to an end.*

I also award £500 for the distress and inconvenience this whole matter has caused Mrs S. It's clear to me that not being given clear communications about this key element of protection planning has caused her stress and anxiety, at a very difficult moment in her life.

Mrs S has claimed compound interest – but this isn't what the service awards. The service awards 8% per year simple interest – in other words it isn't compounded – in cases where a consumer is deprived of money they otherwise would've had the benefit of."

Mrs S agreed with my provisional decision. Countrywide did not reply.

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 the matter again, I see no reason to depart from my provisional conclusions – so I confirm them here as final.

Putting things right

In order to put matters right for Mrs S, Countrywide Assured Plc must, within 28 days of when we tell it Mrs S has accepted this final decision, do the following:

- Pay Mrs S £18,213 (which was 2/15ths of £136,601) plus 8% per year simple interest

on this sum from March 2019 to the settlement date;

- Refund her premiums since June 2018, plus 8% per year simple interest to the settlement date;

- No further premiums to pay going forward as her policy would've come to an end.

I also award £500 for the distress and inconvenience this whole matter has caused Mrs S. It's clear to me that not being given clear communications about this key element of protection planning has caused her stress and anxiety, at a very difficult moment in her life.

My final decision

My final decision is that I uphold Mrs S's complaint and award the compensation above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S to accept or reject my decision before 13 August 2025.

Alessandro Pulzone
Ombudsman