

The complaint

The trustees (Mr and Mrs K and Dr D) of Mr and Mrs K's trust ('the Trust') complain about failed reviews of a reviewable Whole of Life policy – the Adaptable Life Plan ('ALP') held with Zurich Assurance Ltd ('Zurich').

What happened

I've outlined what I think are the key events involved in the Trust's complaint below.

In late 2002 Mr and Mrs K received advice from Allied Dunbar Assurance plc (Zurich is now responsible for this complaint though, so I will refer to it throughout) to take out an ALP.

The ALP commenced in May 2003 on a joint life second death basis. The schedule said the sum assured was £261,600 and that the initial annual premium was just over £2,084.

Zurich have provided annual review outcomes from 2013. The 2013 review failed and Mr and Mrs K were given two options, either increase the yearly premium to just over £2,400 to maintain the current sum assured, or reduce that to just over £241,600. And the sum assured was seemingly reduced as a result.

At the next review, in 2018, Mr and Mrs K were given the option to keep their annual premium the same at just over £2,084 but for an increased sum assured of just over £261,000. And the sum assured was kept the same at just over £241,600.

At the 2020 review, Mr and Mrs K were again given the option to keep their annual premium the same at just over £2,084 but for an increased sum assured of just over £261,000. And, on this occasion, they chose to take up that increase in the sum assured.

The 2021 review failed. Mr and Mrs K were given two options, either increase the yearly premium to just over £3,350 to maintain the current sum assured or reduce that to just over £220,400. And the sum assured was reduced.

Soon after receiving the review letter, a complaint was made to Zurich which said, in summary, that they were shocked it had been able to reduce the sum assured to the extent it had, that it could still make further annual reductions and they felt it had reviewed the plan prematurely. Mr and Mrs K said that the policy had been mis-sold, as this wasn't explained to them at the point of sale and, if it had been, they'd have taken out term assurance cover with lower premiums.

On 6 May 2021, Zurich sent its final response letter not upholding the complaint. It said, amongst other things, that:

- It didn't agree the plan had been mis-sold.
- When it carries out a review it aims to ensure the fund value growth, plus future premiums, will be enough to cover the benefit it expects to pay out and costs of maintaining the plan.

- The review is an automated calculation that does a comparison using for example, current assumed growth rates and mortality rates and by making assumptions. And where there is difference between the assumptions made and what has actually happened and the cost of cover is higher than expected, for example, then changes to the plan will be needed which mean the sum assured will reduce unless premiums are increased.
- As life expectancy decreases with age, then the older the lives assured means the additional payment required will be greater to cover the shortfall in cover, the cost of which is now more expensive.
- A review it carried out in 2019 of the rates it used to determine the cost of cover found that its claims experience on similar plans was heavier than expected, which resulted in an increase in the mortality rate for plans reviewed from November 2020.
- Zurich detailed what had happened at each of the reviews and it said that the increase in premium in the 2021 review included the increased cost of maintaining the sum assured of just over £261,000 based on its latest mortality assumptions.

The 2022 review then failed. Zurich said in the review letter that it was making some changes to the cost of cover, as explained in an enclosed leaflet. It said changes in performance and trends in life expectancy have the greatest impact on cost of cover. It said the review was to ensure their level of cover and what they pay was properly matched. And that, as the cost of cover was higher than expected, Mr and Mrs K were given two options. These were to either increase the yearly premium to just over £3,650 to maintain the current sum assured or reduce that to just over £178,200. And the sum assured was reduced.

Shortly after, a complaint was made to Zurich about this which said, in summary, that it had reduced the sum assured by around 32% at a time when average life expectancy in the UK has remained stable despite Covid-19. And that the comments made in the 2021 complaint remained part of the 2022 complaint.

In May 2022, Zurich sent its final response letter which addressed the 2022 reduction in cover. It said, in summary, that the purpose of the review is to see if the current premium is sufficient to continue providing the same sum assured. It said that the 2022 review letter contained a leaflet which explained that, based on its claims experience and future expectations, it had increased the charges made for life cover in 2020, and that it had already addressed the reasons for that in its 2021 final response letter. And, from early 2022, it had also implemented a growth rate assumption change for future expected investment returns from 6.25% to 4.75%, based on its belief there was likely to be a significant and sustained investment outlook change.

Towards the end of May 2022, unhappy with this response, the complaint was referred to our Service concerning the 2021 and 2022 reviews, and the mis-sale of the policy. And on the basis that the 2021 and 2022 complaints were felt to be, in essence, identical and that the action complained of in 2021 had simply been repeated in 2022.

Zurich said that the 2021 complaint had been referred to our Service more than six months after it had given its May 2021 final response letter, which was too late for us to consider the concerns detailed in it and it didn't consent to us considering this late.

One of our Investigator's said, in summary, that as the 2021 complaint hadn't been referred to our Service within six months of Zurich's 2021 final response letter this meant it had been referred to us too late to consider it under the rules we're bound by, set out in DISP 2.8. And she wasn't aware of any exceptional circumstances, such as severe ill health, which prevented the 2021 complaint being referred to us any sooner. She said this meant that,

even if Mr and Mrs K felt the 2021 and 2022 complaints were similar (or even identical), we could only consider the complaint about the 2022 review.

In respect of the merits of the complaint, our Investigator didn't uphold it. The Trust didn't agree and said, in summary, that:

- We should examine whether Zurich's actuary fairly reduced the sum assured to just over £178,200 over two years notwithstanding scarcely any change in average life expectancy in the UK. It can't be that they are entitled to reach any conclusion that they wish to.
- We've said Zurich carried out an assessment of mortality rates based on trends experience and industry information that could impact the cost of future claims, as well as investment performance, resulting in an increased cost of cover. But we've provided no evidence to support that these trends and information justified Zurich's decision, when the Trust's information suggests otherwise. And the fact that its clients died earlier than anticipated shouldn't impact their particular case.
- The reason for taking out the plan was for inheritance tax purposes, but if they'd known the possible magnitude of the changes then they would have taken out term assurance instead.
- They've since surrendered the policy but haven't put in place other cover.

Because no agreement could be reached the case was passed to me for a decision.

I issued a provisional decision. I said, in summary, that Mr and Mrs K's sale complaint will be addressed in a separate decision. I said this decision only concerns the Trust's complaint about the policy reviews. I explained that we don't have jurisdiction to consider some aspects of the review complaint though and, in respect those we can consider, I said I'm not asking Zurich to do anything.

While Mr and Mrs K responded unhappy with the outcome given in the separate decision on their sale complaint, we received no response or further comments in respect of my provisional decision – which is largely repeated again below – concerning the policy reviews, despite sending a reminder of the response deadline.

What I've decided – and why

While I appreciate the trustees will be disappointed, my decision remains the same as that set out in my provisional decision, which I've largely repeated again below.

Our jurisdiction

Eligible complainant

I think the crux of the complaint concerns the reviews Zurich carried out which led to a substantial decrease in the sum assured for the premium paid, as well as the mis-sale of the policy. And I appreciate Mr and Mrs K have said they are complaining as joint policyholders, as well as in their capacity as trustees of the Trust, alongside Dr D.

The rules we're bound by, set out in Dispute Resolution ('DISP') Rules – found in the Financial Conduct Authority's handbook, say in DISP 2.7.1R that a complaint can only be dealt with by our Service if brought by or on behalf of an eligible complainant though.

And this means that, in this decision, I will only address the aspects of the complaint the Trust can bring about the policy, which concerns the reviews Zurich carried out. This is

because the policy is set up in trust and the reviews complained of are events that have happened since it was set up as such. The Trust is therefore the eligible complainant under the rules we're bound by in respect of these.

Turning to the mis-sale complaint, Mr and Mrs K in their capacity as consumers are the eligible complainants in respect of the advice given by Zurich, distinct from the Trust. So I haven't commented on or addressed any complaint about the advice given here – I've given a separate decision about the sale in Mr and Mrs K's names, given they maintained that they're unhappy with what happened at the time of sale.

Our time limits

Our Service doesn't have a free hand to consider every complaint brought to us. As set out above, we must follow the DISP rules that we're bound by.

And DISP 2.8.2R says that, unless the business consents, we can't consider a complaint if it's referred to us more than six months after the date on which it sent its final response. That is, unless, in the view of the Ombudsman, the failure to comply with the time limit was as a result of exceptional circumstances. And the rules give an example of exceptional circumstances as where the complainant has been or is incapacitated.

The 2021 complaint was first referred to us in May 2022, which was more than six months after Zurich's final response letter was given in May 2021. And Zurich hasn't consented to us considering this late.

I recognise the Trust has said that the 2021 complaint is identical to the 2022 complaint, that the action complained of in 2021 has simply been repeated in 2022 and so the 2021 complaint should also be considered. And I appreciate the 2021 complaint was referred to us after the Trust had also later complained about the 2022 review.

But Zurich gave its answer in respect of the 2021 review in its May 2021 final response letter and it didn't address this again, or any further, in its 2022 final response letter, which I can see instead focused on the 2022 review.

And I think the 2021 and 2022 reviews are standalone events. Each review involves Zurich making a new assessment of the policy at that specific point in time. And I think that process is a distinct event, it can result in several outcomes, some of which can change the basis on which the policy is run. It follows that each review can give rise to a separate complaint about whether the outcome of the assessment is fair and reasonable. And I think that is what happened here.

Zurich explained in its 2021 final response letter that the parties had six months to refer the complaint to our Service if they remained unhappy. And as the 2021 complaint wasn't brought to us until more than six months later, it has been referred to us outside our timescales. And I've seen nothing to suggest that exceptional circumstances exist to explain the delay in this being referred to our Service. This means we can't consider the complaint about the 2021 review.

The merits of the complaint

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I'm not asking Zurich to do anything, for the reasons set out below.

In deciding this complaint I've taken into account the law, any relevant regulatory rules including the principles and good industry practice at the time.

While I've carefully considered the entirety of the submissions the parties have provided, my decision focuses on what I consider to be the central issues. The purpose of my decision isn't to comment on every point or question made, rather it's to set out my decision and reasons for reaching it.

In reaching my conclusions, I've considered, amongst other things:

- The FCA's Principles for Businesses, in particular Principle 6 and Principle 7 (PRIN).
- The FCA's Conduct of Business Sourcebook (COBS), in particular COBS 2.1.1R(1) and COBS 4.2.1R(1).
- The FCA's Final guidance on the "*Fair treatment of long-standing customers in the life insurance sector*" (FG16/8).

When considering the Trust's complaint about the sum assured having substantially reduced following the 2022 review, I think it's helpful to explain firstly how reviewable Whole of Life policies generally work in practice. The premiums paid cover the cost of life cover (mortality cost) and any charges. Anything above that is invested to build up a fund. At the start, when the cost of life cover is lower, more of the premiums are invested. Zurich have explained that the cost of providing cover is based on the sum at risk – the difference between the sum assured and the fund value. They've said the policy is designed so that the fund builds up over time to meet the sum assured on death. This means the sum at risk should steadily reduce – and can significantly reduce – as customers get older to offset the increase in the mortality charge.

Businesses will undertake reviews to ensure that the policy can continue to provide the chosen level of cover. They will look at a number of different factors such as the size of the investment pot, current mortality rates and investment performance. If they decide the policy isn't sustainable at its current premium, the consumer will usually be offered the option of reducing the sum assured or increasing the premium.

I think it's important to note that when Zurich set up such a policy, and at each review, it was focused on making the policy last for the remainder of the policyholder's life. It would always have been Zurich's expectation that at some point the cost of cover would exceed the premiums being paid, but that this would be offset by the return provided by the policy's underlying unit fund. So, if all the assumptions it makes are accurate, no increase of premium would be needed for the life of the policy. Though that of course couldn't be guaranteed, as the review relies on assumptions about future events.

The opportunity for consumers to make decisions about key changes to the policy is a key event in the life of the policy. I think that there was an expectation reiterated in FG 16/18 that consumers needed to be provided with sufficient information about their policies to be able to make informed decisions about them. I think this is particularly relevant in relation to the point in time when the 'tipping point' is reached. The point at which the mortality charges, or the policy costs, exceed the premiums being paid.

Zurich hasn't provided our Service with information about the tipping point, despite our Investigator having asked it for this, for me to see if and when I think the policy costs exceeded the premium, and for me to therefore say whether or not I think Zurich provided the Trust with the information it should have at that relevant point to allow it to make an informed decision about the policy.

However, even if the policy costs did at some point exceed the premium and Zurich didn't provide the information it should have at the time, such as details of the policy costs or whether or not these were being met by the premiums, I'm not persuaded the Trust would have done anything differently if Zurich had done what it should have and within a timely manner. I'll explain why.

Had the Trust been given clear, fair and not misleading information, the options open to it at that point would have been to surrender to policy for the cash in value, increase the premiums to maintain the sum assured, reduce the sum assured or take no action.

It's important to remember in the circumstances that Zurich was making its assumptions based on the policy lasting for the remainder of Mr and Mrs K's lives, and not just until the next review point. So, even if it had provided the Trust with the cost of cover and explained whether or not this was now higher than the premiums being paid, there would also have been an explanation that this was how the policy was designed to work. And that, based on its current assumptions – which could change in future – regarding mortality costs and investment performance, the level of premium being paid or those that it set out now needed to be paid based on current assumptions, would be sufficient to sustain the policy for life. So that communication wouldn't have required the Trust to make any changes.

In addition, while I recognise the Trust did surrender the policy seemingly following Zurich's May 2022 final response letter, in previous years when the policy failed reviews the Trust kept the policy rather than surrendering it, for example in 2013. And even after Zurich's first final response letter following the 2021 review – which I think gave the Trust more information about the cost versus the premium – and despite knowing the sum assured could reduce further again in future, the Trust didn't surrender the policy until after another review in 2022. So I don't think it's likely that the Trust would have done so any sooner.

I also note that the Trust kept the premiums the same throughout the policy, knowing the sum assured could, and had, decreased (except on one occasion when this increased for same premium, as below) if they didn't increase the premium. So I don't think the Trust was willing to pay, or would likely have paid, any more for the policy than it had been.

While the Trust did take up Zurich's 2020 offer to increase the sum assured for no increase in premium, I don't think it's likely to have chosen to keep the lower sum assured instead of increasing this to provide a 'cushion' in case the cost of cover increased again in future, even if it had known what that cost versus the premium being paid was. I say this because by that point the Trust knew, or should reasonably have known, from previous experience in 2013 that the sum assured could decrease if payments didn't support the level of cover and that this could therefore happen again in future. And it had been given some information in a booklet sent alongside the letter which said that keeping the sum assured the same in 2020, rather than increasing it, could help in that case in future. But the Trust still chose to increase the sum assured for the same premium.

So, in summary, even if Zurich should have and didn't provide the Trust with all the information it needed to in the way I've set out above, I'm not persuaded that the Trust would likely have taken a different course of action.

The Trust has also said that we should obtain evidence from Zurich to show that its actuary reached a fair decision in respect of the review, as they feel that contrary to what Zurich has said life expectancy has remained stable, for example. Respectfully though, it's for me to determine what information I think is necessary to reach my decision. As per the terms and conditions of the policy, Zurich is entitled to carry out reviews. It has explained that the changes in 2022 have mainly come about because of changes in its growth rate assumption

and in mortality rates following a review it carried out in 2019 review. I've no reason to doubt this or Zurich's calculations and it is within its rights to amend its assumptions, which it has already explained are based on *its* experience and expectations.

So, in summary, for the reasons given, I'm not asking Zurich to do anything.

My final decision

For the reasons given, I'm not asking Zurich Assurance Ltd to do anything.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms D, Mr K and Mrs K as trustees of the K Trust to accept or reject my decision before 30 September 2025.

Holly Jackson
Ombudsman