DRN-3918759

The complaint

Mr P has complained about advice received from Phoenix Life Limited when taking out a Whole of Life policy in 1988.

Mr P is being represented in his complaint by a Claims Management Company (CMC). For ease I will refer to all actions as being those of Mr P.

What happened

Mr P took out a whole of life policy after taking advice from Phoenix in 1988 and there was an amendment made in 2003. The policy was surrendered in 2009.

Mr P complained to Phoenix saying there was no explanation of how the plan worked or whether he was provided with documentation from it to read and review. He said he should have been advised to resolve his debt issues before committing to the policy. He said he has paid substantial amounts in premiums and it's no surprise that he struggled to pay them. He asked for the premiums to be refunded with interest.

Phoenix said it was a reviewable whole of life policy that Mr P took out in 1988. It said it was designed to provide a lump sum in the event of death or critical illness. It said its adviser carried out a financial analysis and found that Mr P's priority at that time was critical illness cover. It said at that time it would have been reasonable advice to have the policy alongside life protection as it was the only way to get critical illness cover. It added that its records showed the policy was assigned to a bank in 1992 and then re-assigned back in 2009. It said this suggests there was a need for the cover.

Mr P remained unhappy so brought his complaint to our service where one of our Investigators looked into what happened. They didn't uphold the complaint saying they were satisfied the policy was suitable. They said Mr P was self-employed at the point of sale and their priority identified by Phoenix was to protect him against long term illness and disability. They also concluded that although Mr P was using his overdraft it didn't negate the need for protection or make the policy unaffordable.

Mr P disagreed saying he was still of the view that the business shouldn't have advised him to have it. He also added that although the premium increases were explained, actual reviews of the policy weren't. So as Mr P's complaint hasn't been resolved between the parties, it has come to me for a decision.

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.

Mr P has said there has been no explanation from Phoenix about how the policy worked or whether he was provided with documentation for him to read and review.
Given that the policy was sold in 1989 and surrendered in 2009 I don't think it's unreasonable that Phoenix no longer has this documentation from the time of sale. This is

quite some time ago and so it's not unusual for such paperwork to no longer be available. In these circumstances it wouldn't be fair of me to decide that Phoenix had done something wrong simply because they were, understandably, unable to provide documentation about how the policy worked.

But what I do have to look through is a financial analysis form that the adviser from Phoenix completed when they discussed with Mr P his needs. This led to the adviser recommending the whole of life policy and Mr P taking it up. So, I have been able to read through this document to give me an idea about what the parties discussed at the time.

What I have been able to see on this form is that Mr P was married with two children and was self-employed. The policy was for whole of life and critical illness with a sum assured of £50,000. The analysis form showed that Mr P did have an overdraft and limited savings. Mr P said Phoenix shouldn't have advised him to take out the policy until he had resolved his debt issues. I can see that the adviser had recorded down on the analysis form that he had an overdraft. I can't be sure what was discussed between the parties at that time but based on what was recorded down on the analysis form, I haven't seen enough that would suggest to me Mr P had issues with affordability. At least not enough that would make the policy unsuitable for him.

It looks to me, on balance, that Mr P's needs were taken into consideration including affordability and the adviser went ahead and recommended a whole of life policy with critical illness cover. On the form I can see that Mr P had prioritised critical illness cover as his number one concern at the time and his needs were reflected in the policy the adviser recommended for him.

Mr P said that whilst it was the case that premiums for the policy were explained, the process of having reviews weren't and the risks association with that.

I wasn't party to conversation when the advice was given but I think, on balance, it is reasonable to assume that the long-term nature of the policy was discussed and taken into consideration. To uphold this complaint and say that policy was mis-sold I would need to be persuaded that the policy was unsuitable. And I haven't seen any persuasive evidence to show that's the case.

The policy was seemingly what Mr P wanted at the time, in particular the critical illness cover element. The policy was assigned to a bank from 1992 up to 2009 and so seemed to provide valuable cover up until it was surrendered. Having carefully considered everything I'm satisfied the policy was suitable for Mr P and provided the cover he required at the time.

My final decision

For the reasons I've explained above, my decision is that I do not uphold this complaint. Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P to accept or reject my decision before 18 August 2023.

Mark Richardson
Ombudsman