

medical “non-disclosure” in insurance

This is a factsheet for consumers who have a complaint about an insurance company turning down an insurance claim – because of so-called medical “non-disclosure”.

if you have a complaint like this, first of all you need to tell your insurance company that you’re not happy – and give them the opportunity to look into things and put right any problem

This factsheet gives you more information about the kind of issues the insurance company will need to look into, when it considers an insurance claim that involves so-called medical “non-disclosure”.

If you remain unhappy after the insurance company has reviewed your case and told you what it thinks, we may be able to help.

There is more information on our website about how and when we can step in (www.financial-ombudsman.org.uk) – or take a look at our leaflet which your insurance company should give you. (Or call 0300 123 9 123 for a leaflet.)

This factsheet sets out the kind of issues that the ombudsman service would also need to consider, if you referred a dispute like this to us.

what is a complaint about “non-disclosure”?

These are complaints about an insurance claim that has been declined by an insurance company – because the company believes the consumer failed to provide (or “disclose”) accurate information about their medical history, when they applied for (or renewed) their insurance policy. This is sometimes also referred to as “misrepresentation”.

what are insurance companies entitled to know?

Insurance companies are entitled to know about a consumer’s medical history – so that they can properly assess the risk they are insuring.

Insurance companies should ask clear questions when a consumer applies to take out an insurance policy with them. And consumers should answer clear questions from insurance companies to the best of their knowledge and belief.

what if I gave the information to the business I bought the insurance through?

People often take out insurance through a business such as an insurance broker, a financial adviser or a bank – rather than dealing directly with the insurance company that actually insures them.

In these cases, the business that the consumer has direct contact with is known technically as the “intermediary” – because this business acts as the “middle man” between the consumer and the insurance company.

If the “intermediary” was acting – technically speaking – on behalf of the insurance company, then the insurance company *cannot* claim that information you gave to the “intermediary” wasn’t properly disclosed.

But if the “intermediary” was acting – technically speaking – on *your* behalf, as the consumer, then it would not automatically be assumed that the insurance company would know the details you gave the “intermediary”.

Deciding whether the “intermediary” you dealt with was technically acting for the insurance company or for *you* depends on:

1. whether the “intermediary” was “tied” to just one insurance company (or a small number of companies) – and could only offer *their* products; *or*
2. whether the “intermediary” was independent – and could advise on (or arrange) insurance from a wide range of insurance companies.

Generally speaking, if you dealt with an “intermediary” that falls into the first of these two categories (as described at 1 above), it’s likely that the “intermediary” was technically acting on behalf of the insurance company.

But if you dealt with an “intermediary” that falls into the *second* of these two categories (as described at 2 above), it’s likely that – technically speaking – they were acting on *your* behalf.

the insurance company has “avoided” my policy – what does this mean?

If a consumer did not provide information that they were asked for when they took out (or renewed) an insurance policy, the insurance company may be entitled to decline any subsequent claim – on the basis of the consumer’s “non-disclosure”. The insurance company may also be entitled to “avoid” the policy.

To “avoid” a policy is a technical term. It means cancelling the insurance policy as if it had never been taken out.

“Avoiding” an insurance policy is the strict legal consequence of “non-disclosure” – failing to provide relevant and accurate information to the insurance company.

However, to be able to “avoid” a policy, the insurance company has to show that it would *not* have offered the same policy at the same price – if it had known the true facts.

This means that when the ombudsman service is looking at a dispute about whether an insurance company was entitled to cancel (“avoid”) a policy, the insurance company has to persuade us that inaccurate information from the consumer led (“induced”) the company to offer insurance on terms (and at a price) that would not otherwise have applied.

what if the insurance company already knew the information?

If the insurance company already had the information that it asked the consumer for – or if it should have realised that the information the consumer gave was inaccurate – then the company may *not* be able to claim that the consumer’s failure to disclose that information entitled it to “avoid” the policy or decline the claim.

what is the ombudsman’s approach to “non-disclosure”?

When the ombudsman service deals with a dispute involving an insurance claim that an insurance company has declined – because the consumer failed to disclose accurate information about their medical history – we will look at whether:

- the insurance company asked a clear question about the information it wanted;
- the consumer provided inaccurate information; *and*
- the insurance company relied on the inaccurate information when they accepted the consumer’s application.

If we find all these to be the case, we will *still* want to get to the bottom of *why* the consumer did not provide the accurate information as required.

This means deciding whether we think the consumer’s “non-disclosure” was “innocent” or “negligent” – or whether it was “deliberate or without any care”.

what kind of decisions can the ombudsman service make in these cases?

If we decide – after considering all the individual facts and circumstances – that the consumer answered questions and gave information to the best of their knowledge and belief, we may conclude that there was no “non-disclosure” – or that any “non-disclosure” by the consumer was “innocent”.

In cases like this, we may tell the insurance company to reinstate the policy and pay the claim. Alternatively, we may sometimes tell the insurance company to consider the claim, if it hasn’t already done so – to decide whether it’s medically valid.

If this leads to further disagreement between the consumer and the insurance company, we can look at this as a separate complaint.

If we decide that the “non-disclosure” by the consumer was “negligent”, we may tell the insurance company to reinstate the policy on the terms that *would have* applied – if the company had been given accurate information at the outset.

Depending on the terms that then apply, we can tell the insurance company to:

- pay the claim in full; *or*
- pay a proportion of the claim (in cases where the insurance company would have charged a higher premium if it had known the information); *or*
- *not* pay the claim (in cases where the insurance company would have excluded cover if it had known the information).

However, we may agree that the insurance company was *entitled* to decline the claim, if we decide – after considering all the individual facts and circumstances – that the consumer deliberately did not disclose accurate information about their medical history, or did so without any care.

phone **0300 123 9 123** (office hours)

www.financial-ombudsman.org.uk

This factsheet for consumers is only a general guide. It is not legal advice. We look at each case on its own individual facts and merits. We will always give you the chance to query anything you don't understand or agree with.

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