DRN-3330321

The complaint

Mr N complains that Aviva Life & Pensions UK Limited has unreasonably refused his critical illness claim, instead voiding his policy altogether on the grounds of misrepresentation.

What happened

Mr N applied for a Friends Life Critical Illness with Life Cover policy through an independent financial adviser alongside his partner, Miss W, in November 2015. Aviva is now responsible for the operation of the policy, and I will hereafter refer to the business as Aviva.

The application was discussed during a call with the IFA, but Mr N says he wasn't able to complete all of the details without relevant information before him. The application was submitted but Mr N agreed with the IFA that he would send amendments to Aviva.

On 10 November 2015, Aviva sent Mr N and Miss W a copy of the policy application. Mr N says they both sent their amendments to Aviva on 14 November 2015.

On 12 November 2015, the IFA called Aviva to note the policy start date should be 13 November 2015. Mr N and Miss W's existing policy would be cancelled later that month. He also amended the sum assured down from £233,500 to £232,500 and added that Mr N had been diagnosed with high blood pressure in 2010.

The IFA told Mr N and Miss W he had confirmed with Aviva that the policy had begun on 13 November 2015.

In March 2021, Mr N made a claim to Aviva for critical illness benefit, after he sadly suffered a heart attack and underwent surgery the previous month. Aviva therefore wrote to Mr N's treating consultant for more information.

On receipt of the report from Mr N's consultant, Aviva noted a number of points about Mr N's medical history which were not consistent with the policy application from November 2015. It therefore sought additional medical evidence from Mr N's GP.

On 1 July 2021, Aviva offered Mr N £250 for the time it was taking to provide an outcome on the claim.

On 13 July 2021, it refused his claim. It said Mr N had answered "*no*" to a number of questions on his policy application, including questions about smoking, drinking, having certain conditions in the last five years and attending a hospital in the last five years.

Aviva also said Mr N had also incorrectly answered subset questions about blood pressure ('*BP*') treatment in the last twelve months and medical confirmation that it was under control.

It said it understood Mr N had sent back the proposal confirmation of 10 November 2015 with amended answers, but it never received it. And even looking at the amended answers he referred to now, there was information missing that was set out in his medical records.

Aviva told Mr N that it accepted his actions were not deliberate. But, he had not given it accurate information in 2015. If he had done so, the application would have been postponed until all investigations were complete and the results known. Following this, Mr N would have been required to reapply by submitting a fresh application. Because of that, it couldn't now accept a claim. Instead the right outcome was to void the policy from the outset and refund Mr N's policy premiums.

Mr N appealed the decision. He said:

- in October 2015 he was prescribed omeprazole – a type of treatment for heartburn;
- though Aviva claimed otherwise, he had no tests or treatments outstanding in November 2015 when they commenced the policy;
- the incident of March 2015 was a side effect to colchicine, a gout medication – not anything to do with his blood pressure;
- he has discussed his medical records with his GP surgery and it has told him that at no time was he recorded as a user of tobacco;
- he therefore answered Aviva's question correctly;
- had Aviva conducted its investigation in a fair and proper manner, the results would clearly show that - with the exception of episodes of gout - all the information he provided at application stage and during the claim process was correct.

In the interim, Mr N brought his complaint about the claim refusal to this service, supplying extensive submissions on several different occasions.

Mr N also complained about the application process, and this was dealt with as a separate complaint.

I recognise Mr N has gone into considerable written detail regarding each policy question and his view on his health at the time he sought the policy. Though I will not set the full submissions out here, I have read them in full. In summary, Mr N said:

- throughout the process Aviva has told him that the main reason for the investigation was because of smoking habits and gout;
- however, the claims handler later said that Aviva would have adjusted a final claim payment for gout as it may have only increased the policy premium marginally;
- Aviva had otherwise said that his BP wasn't a relevant factor – but it is now relying on it;
- he does not believe Aviva has acted with integrity;
- it is unfairly tying unrelated BP, dizziness and chest pain incidents together along with an allergic reaction to medication taken for gout as a combination of factors to suggest he wasn't insurable;
- the only misrepresentation that can be considered on his part, was missing the question about gout;
- he missed it because it was grouped in with other ailments;
- in any event, he does not believe Aviva would have sought his medical records solely for gout as a minor medical ailment;
- he says this because in a previous policy application he disclosed his BP and a GP report was not sought;
- in this policy he had disclosed BP and asthma and no report was sought;
- he does not accept that gout would be the minor condition which altered that decision;
- his chest pain was down to suffering with heartburn, not any other reason;

- Aviva is trying to imply that he saw his GP in March 2015 for BP reasons but this was untrue – he was dizzy and unwell with a brief impact on his BP reading because he had a side effect to gout medication prescribed earlier that month;
- he believes that claims handler is being untruthful about their discussions;
- it has transpired that Aviva always intended to refuse his claim by whatever means;
- having looked at information from the Association of British Insurers, his actions are best described as 'innocent';
- Aviva, on the other hand, has not complied with any of the professional values principles as set out by the ABI.

Mr N then supplied further submissions from a legal representative, Mr R. Again, I will not be repeating these arguments in full here. In summary, Mr R said:

- Aviva has moved its goalposts as it told Mr N that it was looking into his smoking and gout history;
- in any event, the medical records confirm there is no evidence to suggest Mr N smoked tobacco and the later history confirmed he did not smoke tobacco;
- Mr N's condition of gout was under control at time of the application, having been given Allopurinol effective 1 July 2015;
- Mr N's GP has since retired but has nonetheless supplied a written account supporting his position;
- if the underwriter had written to the GP in November 2015, she would have explained that there was no evidence to suggest that Mr N was a tobacco/nicotine smoker;
- Mr N was never given alcohol cessation advice – he was specifically told to not drink red wine (in favour of other alcoholic drinks) as advice about gout;
- the one minor dizzy spell was in relation to a reaction to the gout medication;
- Mr N did not have another episode of gout after being prescribed the medication in July 2015;
- the one hospital visit in 2015 was confirmed as reflux/heartburn;
- Mr N disclosed he had high BP so no attempt was made to mislead Aviva about that;
- it is not correct to say that tests were awaited at the time of the application;
- the records do show that Mr N had been advised to attend a blood glucose test on 23 June 2015 but the same doctor postponed the test on seeing Mr N on 1 July 2015;
- Aviva has taken a particularly unfair amount of time to reply to the file requests from the Financial Ombudsman Service and it should be held to account for this;
- there is relevant commercial court case law relating to innocent non-disclosure that should apply to Mr N;
- this is specifically in the case of the only missing disclosure of gout – which would not, of itself, result in declinature of insurance terms.

An investigator reviewed the complaint, and he felt that the complaint should succeed. In his view, though Aviva had never received Mr N's amendments, he did not think Mr N had made any material misrepresentations on the application bar one question, which didn't alter the underwriting decision of Aviva.

Specifically in respect of questions about smoking, drinking and gout, our investigator noted that Mr N hadn't made any qualifying misrepresentation under relevant legislation applying to consumer disclosures.

He also noted that another question regarding medical attention at hospital hadn't been answered incorrectly as the medical evidence showed how, at the time of the application, Mr N didn't have any outstanding investigations or awaiting results of any tests.

Finally, he said Mr N's policy application did answer positively to a question about BP, but

one of two subsets questions was answered incorrectly. However, he said Aviva hadn't shown this would have affected its decision to provide the cover. As such, he took the view that Aviva should reinstate the policy and reconsider Mr N's claim.

Mr N accepted the investigator's view.

Aviva disagreed. It said, in summary:

- though it remained of the view that cessation advice wouldn't be offered outside of tobacco use, it agreed that there was contradictory information about Mr N's smoking history so it agreed to disregard this;
- it was also prepared to accept there was no misrepresentation around alcohol use;
- however, it still maintains that there was significant misrepresentation around chest pain, gout, numbness of limbs, and most importantly BP control;
- these matters would have led Aviva to seek a GP report and postpone Mr N's policy application;
- it is therefore unfair to suggest a claim ought to be considered now since it would not have insured Mr N on those policy terms;
- Aviva does not accept that Mr N's GP told him that he was happy that there was a consistent normal and well controlled level of BP or that there had been no requirement to make a change to his treatment;
- the evidence shows record of high BP readings and Mr N was required to increase his treatment regime just eight months prior to completion of his application;
- if Aviva's underwriters had known about this, they would have sought the aforementioned GP report;
- accordingly Aviva would then have become aware of Mr N suffering with erratic BP levels, numbness down the arms and episodes of chest pain;
- and so, Aviva would not have been in a position to offer cover at that time.

Aviva therefore asked for the complaint to be referred to an ombudsman.

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, I agree this is a complaint that ought to be upheld. Whilst I do believe that there were misrepresentations on the application that Aviva used to provide Mr N's insurance, I don't consider any of these to amount to qualifying misrepresentations which would permit Aviva to avoid the policy altogether now. I'll explain my reasons below.

When applying for insurance, if an applicant doesn't tell his or her insurer relevant information in response to a clear question it's known as 'misrepresentation'.

Industry guidance and relevant law on consumer disclosures in insurance contracts allows an insurer to consider if any misrepresentation occurred from the outset of a policy. If the circumstances around a claim prompt an insurer to believe a misrepresentation may have occurred within an application, it's entitled to consider what ought to have happened at that time. That is what Aviva has done.

When it was obtaining information from specialists treating Mr N, it was noted that he was an ex-smoker with a past medical history of hypertension, chest pain and gout. Since three of these matters were not disclosed on the application, Aviva rightfully sent a targeted medical report to Mrs N's GP, covering the relevant period preceding the policy application.

I realise that Mr N and Miss W say they made amendments to the IFA's first submission of the application on 10 November, and I have seen the written notes they made on the proposal summary documents they each received which carries a date of 14 November 2015 – the day after the IFA emailed them that the policy had begun.

Be that as it may, Aviva did not receive these handwritten amendments from either Mr N or Miss W. The cover began without any amendments. The arguments around this are the subject of a separate complaint, so I won't be looking at that here. In any event, the amendments I have seen do not change any of the answers to the questions disputed by Aviva now.

I will look at the information Aviva did have at the time the cover went on risk, because that forms the material disclosures relevant to its insurance decision at that time – and the potential to amend its decision under relevant law if there has been a misrepresentation.

It therefore falls to me to look at what Mr N was asked, and determine if I think he made a misrepresentation, upon which Aviva could amend the terms it offered and/or avoid the policy. The correct position is to decide what ought to have happened at the time of the application. That means looking at what was asked against the relevant evidence (including the medical records) up to the date of the application submitted by the IFA.

The matters of Mr N's alcohol intake and smoking (non-tobacco) are understood by both parties to no longer be in dispute. So, I won't be looking at that further. However, in respect of various other questions, Aviva says it could not have offered insurance terms in 2015.

Mr N was asked:

> "*In the last five years have you had any of the following:*
>
> - *epilepsy, dizziness or blackouts?*
> - *arthritis or any muscle, bone or joint disorder (including sciatica, back, shoulder or knee pain, RSI or gout)?"*
> - *received any form of medical attention at a hospital as an inpatient or outpatient?*

Mr N answered "no" to all of the above questions. He was also asked:

> "*In the last five years have you had any chest pain, irregular heartbeat, raised blood pressure or raised cholesterol?*"

Because Mr N said "*yes*" to the above question and disclosed his high BP, he was asked a number of further questions. Aviva says two of these were wrongly answered:

- "*Has your treatment changed in the last 12 months? and*
- *Has your medical practitioner told you that your blood pressure is now consistently normal and well controlled?*"

I believe that Mr N did make material misrepresentations to all five of the above questions. Notwithstanding that amendments were not made, and I will come on to address Mr N's reasons for his answers, but as a finding of fact I believe all of the five bulleted questions above should have been answered positively.

Under relevant law (applying from 2013 and so at the time Mr N and Miss W sought their

cover), each and any of the misrepresentations above are a 'qualifying' misrepresentation if they affect the terms an insurer could have offered or if it can be shown that the insurer would not have entered into the contract at all. Following this, qualifying misrepresentations are categorised in one of two ways – either, as deliberate/reckless or otherwise as careless (the law does not provide for an innocent category, as Mr N's representative suggested).

However, though I believe misrepresentations to have occurred, I do not think any of them are qualifying such that Aviva has the right to void the policy. That is because it has not shown any objective evidence that the application would have been entered into on different terms or avoided altogether.

Aviva's retrospective underwriting view was that a medical report and postponement would be needed because before terms could be considered, the underwriter needed to know:

- the cause of the dizzy episode with numbness in the arms in March 2015;
- confirmation of the outcome of investigations for the ECG and blood sugar results because of chest pain;
- evidence about consistently well controlled BP.

If Aviva had been able to obtain this information in November 2015, I believe it would have offered Mr N cover without any rating – because there is no relevant underwriting guidance supplied to this service in respect of the various disclosures that shows otherwise.

Mr N's medical records confirm that he had one spell of dizziness on 16 March 2015. In his submission to us, he said he believed he included it on his application, but either way it was not in the context of epilepsy or any wider issue.

The underwriting guidance Aviva has referred to in respect of this relates to vertigo. I do not consider it appropriate to use that guidance as the medical records are clear that the cause was Mr N's gout medication – and this was stopped immediately with no further issue. Aviva has highlighted on that guidance that postponement applies – but that is where the matter is 'not investigated'. That doesn't apply to Mr N – his issue was investigated and found to be a reaction to medication which was not repeated.

It is clear that Mr N did not disclose gout – and should have done so. However, Aviva has stated above that gout was not one of the conditions which it would have awaited further information about; and it has not provided any objective evidence that the disclosure would have affected the terms offered to Mr N.

In terms of Mr N suffering from chest pain and attending hospital, his medical records show he attended on one occasion on 24 February 2015, reporting chest pain which worsened when lying flat. However, the medical records from the discharge confirm "*bloods were unremarkable and ECG's revealed no abnormalities. He was considered to have reflux*".

It was for this reason that when attending the GP the following day, Mr N was given medication for heartburn. By 16 March 2015, this was confirmed as resolved, with the GP setting out that Mr N no longer had chest pain.

Aviva confirms that it would have needed to know the ECG results in relation to chest pain and blood sugar results. However, these were satisfied in the discharge summary of February 2015. In respect of the blood sugar test, Mr N's GP has confirmed that the tests were ordered on 23 June 2015 after a routine visit. However, she also confirmed that "*on 1 Jul 15, the same doctor postponed these tests, his doctor being satisfied with [Mr N's] condition*". There was no further outcome awaited at the time of the application.

This was also expressly confirmed in writing by the GP in her letter of 28 July 2021, where she confirmed "*Mr [N] had no tests or treatment outstanding in November 2015*".

Finally, the GP has also set out in her response to the representative that "*Mr [N}' blood pressure shows to be under control from Feb 15 after retaking the drug Amlodipine with his additional medication Ramipril*".

I know Mr N feels the question infers being placed on *new* medication – and he didn't undergo a new treatment programme in February 2015; he was asked to restart medication he'd already been prescribed. But I take the view that this was still a change. However, I do not believe this would have altered Aviva's decision to insure Mr N.

It says as another drug was added, its underwriters would have written to the GP. And the GP has confirmed that the change was a reinstruction following which Mr N's BP was under control.

The medical records show as such – Amlodipine was actually first prescribed to Mr N one year prior, in February 2014. The entry of February 2015 explains that Mr N "*did not continue to take Amlodipine when issued in 2014 as was not aware he needed to keep taking it*." Aside from the episode of the reaction to the gout medicine the following month, the readings are shown as being 130/80. Mr N did not otherwise return to the GP regarding his BP before the policy application. In the underwriting information supplied by Aviva, there has been no suggestion that this would affect the terms it could offer Mr N.

I therefore believe that the policy should not have been voided since there were no qualifying misrepresentations to allow for that. Instead, a claim should have been considered.

Putting things right

Aviva should reinstate the policy without delay. It is unclear what has happened with Miss W's cover, but this should include Miss W if she has also been left without cover.

Mr N (and Miss W if applicable) will not be required to pay missed premiums since the policy was voided. This is because the redress should place Mr N in the position he would have been in but for the action Aviva took in cancelling the cover. Since I believe Aviva didn't reach a reasonable conclusion in determining it was allowed to end the policy, I do not believe missed premiums should be made up by Mr N (or Miss W).

Aviva must process Mr N's claim for critical illness benefit. If a claim is payable, it will be entitled to deduct the premium refund it has previously issued to Mr N from the claim value and the policy will then end.

If a claim is not payable and Mr N (and/or Miss W) wish to continue with the cover, they will need to pay the policy premiums going forward after the claim outcome has been confirmed in order to continue the policy. They will also need to return the refund of premiums up to the time the policy was voided. I consider twelve months is a reasonable timescale to return that payment if incremental payment is required, as it is unclear if Mr N has retained those funds.

I make no other award.

My final decision

I uphold this complaint. Aviva Life & Pensions UK Limited must follow the redress I've set out above – principally, reinstating the policy and considering Mr N's critical illness claim.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr N to accept or reject my decision before 5 May 2022.

Jo Storey
Ombudsman