DRN-3541603

The complaint

Ms K complains about the decision by Liverpool Victoria Financial Services Limited ('LV') to decline her income protection claim that was in payment and cancel her policy from the start.

What happened

In September 2016, Ms K took out the policy through a financial adviser. The aim of the policy was to pay a monthly benefit of £800 in the event Ms K couldn't work in her occupation due to illness or injury. She also took out waiver of premium cover.

Ms K made a claim in January 2018. She'd stopped work between 11 January 2018 and 25 January 2018 because of neck and back problems following a road traffic accident. LV accepted the claim.

Then in June 2018, Ms K made another claim after having an accident at work. She stopped work because of pain in her back and neck. LV accepted the claim.

Ms K continued to remain off work. In November 2019, LV started reviewing the claim. It received Ms K's medical records in July 2020. After considering this information, LV thought Ms K had misrepresented relevant information about her health when taking out the policy. LV said that if it had known the relevant information, it would've applied an exclusion for back and neck pain from the outset. It asked Ms K to return the claim payments she had received, which totalled £21,099.42.

LV thought that Ms K's misrepresentation had been deliberate/reckless, and so it also cancelled her policy from the start. Unhappy with LV's actions, Ms K brought a complaint to this service.

I issued a provisional decision on 16 May 2022. Here's what I said:

"As this complaint concerns misrepresentation, I need to consider the case in accordance with the principles set out under the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract.

LV thinks Ms K failed to take reasonable care when answering the below application question.

> *"In the last 5 years have you had any of the following: (This is regardless of whether or not you have seen your doctor or required treatment.)*
>
> - *Any back or neck condition, including pain, sciatica or whiplash?"*

I'm satisfied this question was clear. Ms K answered 'no'.

Ms K's GP records show that on 14 November 2016 (around two months after applying for

the policy), Ms K reported ongoing pain in her right upper back since an accident in February 2016. The GP said that Ms K had declined physio then, but now wanted to be referred.

I agree with LV that this evidence supports that when Ms K applied for the policy in September 2016, she had apparently been experiencing back pain for several months. It appears that Ms K had also sought advice from her GP around the time of the accident (as she was offered a referral to physio at the time), but she chose not to go ahead with this. I think Ms K ought to have disclosed this information in response to the question asked.

Ms K did disclose some medical problems in response to other questions asked. She explained that she had a muscle strain which she had experienced in the previous year. Our investigator thought this may have been the reason that Ms K had been offered a physio referral by her GP previously. However, I see that LV asked Ms K for more information about her muscle strain after receiving her application. Ms K completed a questionnaire and explained that she had pain and swelling in her right lower leg following a road traffic accident in February 2016. It's therefore apparent that Ms K's disclosure in respect of her muscle strain wasn't related to her back pain.

I therefore agree with LV that Ms K failed to take reasonable care when answering the above question relating to back pain, and so there was misrepresentation.

LV has provided evidence, by way of its underwriting guide, to show that if it had known of Ms K's ongoing back pain at the time of the application, it would've applied the following exclusion:

> *"We will not pay any claim for any disease or disorder of the back, neck or spine including the supporting muscles, ligaments, joints or discs of the spinal column or related nerves including sciatica."*

I'm satisfied that LV has shown that Ms K's misrepresentation was qualifying, according to CIDRA. In other words, if LV had known the relevant information, it would've entered into the contract on different terms.

LV thought Ms K's misrepresentation was deliberate/reckless, and so it cancelled her policy from the start.

CIDRA says a qualifying misrepresentation is deliberate or reckless if the consumer: -

a) *Knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and*
b) *Knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether it was relevant to the insurer.*

It's for LV to show that the misrepresentation was deliberate or reckless. On balance, I don't think it has done so. I'll explain why.

Ms K explains that her injuries from her accident in February 2016 weren't severe, and she didn't think to mention them when taking out the policy. I think this is supported by Ms K continuing to work in her manual role after her accident, and not needing to seek medical help until November 2016. Also, the GP record from November 2016 doesn't comment on the severity of the pain, or how often it occurred. So I don't think I can reasonably conclude that Ms K knew her response to the question was untrue or misleading or didn't care that it was untrue or misleading. I also note that Ms K did take care to answer other medical questions asked in the application form.

I think Ms K's misrepresentation was careless. Under CIDRA that means LV was entitled to apply the exclusion relating to back and neck pain retrospectively to the cover, but it shouldn't have cancelled the policy.

I recognise that Ms K will be disappointed with my decision in this respect, but given that both her claims related to back and neck pain (and so would've fallen under the exclusion), I think LV was entitled to ask Ms K to return the payments it had made under those claims. I note that LV offered to arrange a repayment plan for Ms K, which I think was fair.

However, I intend to require LV to reinstate Ms K's policy if she wants it to do so. Though she would need to pay the backdated premiums due since LV cancelled her cover, and I appreciate Ms K may not want to do this.

Ms K has questioned why it took LV so long to obtain her medical records.

I see that LV obtained a report from Ms K's GP before accepting her first claim from January 2018. This didn't mention anything about her previous back pain. Then after LV received Ms K's second claim in June 2018, it obtained her medical records. Again, these didn't mention anything about her previous back pain as the information was dated after February 2018. It was only after LV reviewed the claim in 2019/2020 that the misrepresentation came to light when it received Ms K's updated GP records which also included the November 2016 note.

It's unfortunate that the medical records provided to LV in 2018 didn't include the November 2016 note. If they had done, then LV wouldn't have paid the claim, and Ms K wouldn't need to now pay the money back. However, when assessing a claim, an insurer is required to only request information relevant to the claim. Ms K's claims in 2018 both related to injuries she'd experienced following accidents. So I don't think LV had any reason to ask for information relating to Ms K's health prior to those accidents. I'm satisfied that LV legitimately discovered Ms K's misrepresentation when assessing her claim in 2019/2020.

After LV started reviewing the claim in 2019, I note there were delays obtaining Ms K's updated medical records due to the impact of the Covid-19 pandemic in early 2020. I therefore don't find that LV caused unnecessary delays here.

Ms K has also raised some concerns about her financial adviser who arranged the policy on her behalf. She should raise those concerns directly with her financial adviser in the first instance."

I asked both parties to provide me with any further comments they wished to make before I made a final decision.

Ms K responded to say she disagreed with my provisional findings, and made the following main points:

- Her financial adviser had all the information about her medical history, and this ought to have been passed to LV. She says if she said no to the relevant question, it might be because the adviser asked her the question in a different way (as it needed to be translated from English). She also made the point that a friend of hers is in the same situation, who used the same financial adviser.
- LV had her permission to check her medical records, and so the information could've been checked with her GP.
- LV made payments to her for over two years, and she can't afford to repay LV.

LV responded to say it has noted my intention to require it to reinstate the cover. However, it says this remedy doesn't follow the ABI code of practice for misrepresentation. It says if the misrepresentation is careless and the exclusion relates to the claimed condition, it should decline the claim and refund premiums.

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.

Ms K has said that she gave her financial adviser the relevant information about her medical history. However, Ms K's financial adviser acted on her behalf and didn't work for LV. That means that Ms K would need to raise her concerns directly with her financial adviser.

Ms K has also made the point that she gave LV consent to check her medical records, and thinks it ought to have checked the information with her GP. However, it's not practical to expect an insurer to check that information it has been given is correct whenever it receives an application. Under CIDRA, a consumer should take reasonable care not to misrepresent information.

I've noted Ms K's comments about LV paying the claim for so long before discovering the misrepresentation. However, I've addressed this in my provisional decision, so I won't repeat my findings about that here. I do sympathise with Ms K's situation, as LV is asking her to repay the benefit payments she received, though as I've said, LV has offered to arrange a repayment plan for her which I think is fair. Ms K should get in touch with LV about this directly.

LV says my intention to require it to reinstate the cover doesn't follow the ABI code of practice for misrepresentation. I disagree. The code of practice (which takes CIDRA into account) says an insurer must apply a proportionate remedy where the misrepresentation is careless. And the outcome will depend on what the underwriting decision would have been had the misrepresentation not occurred. In Ms K's case, an exclusion would have been applied. It says in such circumstances, the insurer will assess the claim as though the exclusion had been applied when the cover started, and if the exclusion applies to the claim, then no payment will be made.

As the exclusion which LV would have applied (had there not been misrepresentation) related to the claim, I remain satisfied it was appropriate for LV to turn down the claim. However, the code of practice/CIDRA doesn't then allow LV to cancel the policy and refund the premiums. That remedy would only be available to LV if it would have declined the application completely had it known the relevant information, rather than applied an exclusion. Therefore, the appropriate outcome is for LV to reinstate the policy if Ms K wants this.

However, it may be the case (given Ms K's financial situation) that she won't want to reinstate the policy and pay the backdated premiums due. Therefore, if LV wants to give Ms K the option of having her policy cancelled and deducting the premiums that she paid from the amount she owes it, then it can do so.

My final decision

My final decision is that I uphold this complaint in part. I require Liverpool Victoria Financial Services Limited to reinstate Ms K's policy if she wishes it to do so (subject to her repaying the outstanding premiums due since the cover was cancelled).

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms K to accept or reject my decision before 22 July 2022.

Chantelle Hurn-Ryan
Ombudsman