DRN-3560512

The complaint

Ms C and Mr H complain that First Complete Ltd failed to set up their life and critical illness assurance policy promptly. And that this led to the insurer declining Mr H's claim as they considered he'd misrepresented his health.

Where I refer to First Complete, this includes their appointed representatives.

What happened

The background to this complaint is well known to both parties and so I'll only refer to some key events here.

Ms C and Mr H were recommended a life and critical illness assurance policy by First Complete. The application for cover was submitted on 7 November 2017 and included £201,400 of decreasing cover over a 34-year term. It also included income protection cover for Ms C.

The insurer required medical information from Ms C's GP as part of their underwriting of the policy. They obtained consent from Ms C to obtain this information on 6 December 2017 and requested it from the GP the next day.

Ms C emailed First Complete's adviser, who I'll refer to as 'R', on 30 January 2018 asking for an update as she hadn't heard anything since returning the medical consent form to the insurer. A response wasn't provided but, on the same day, R contacted the insurer asking for an update. The insurer contacted the GP surgery and were told their request wasn't received, so it was resent.

Ms C emailed R for an update on 8 February 2018 but, again, a response wasn't received.

An invoice from the GP surgery was received by the insurer on 9 February 2018, which they paid on 17 February 2018.

Ms C emailed R for an update for a third time on 25 February 2018. First Complete contacted Ms C the next day and told her R was no longer working for the firm. But, having spoken with the insurer, the medical information from the GP was still outstanding (although the surgery had confirmed it was done but awaiting the doctor's signature). First Complete advised Ms C that it may help if she chased her doctor.

The GP report was received by the insurer on 12 March 2018 and they informed First Complete, on 15 March 2018, that cover had been accepted on standard terms. The next day First Complete got confirmation from Ms C to proceed with the application. As the policy couldn't continue under R's log in details, due to him leaving First Complete, it had to be resubmitted as a new application. Cover started on 19 March 2018.

Mr H received a multiple sclerosis diagnosis in December 2019 and so made a claim under the policy. The insurer declined the claim as they said Mr H had misrepresented his health by not disclosing symptoms he experienced, and sought advice for, in February 2018 – which was prior to cover being put on risk.

Ms C and Mr H complained to First Complete in March 2021. In short, they said:

- They weren't told R had left the firm until 26 February 2018, when they received a

response to their third email asking for an update. Nor were they informed that their application needed to be resubmitted and only became aware of this when the claim was declined.

- There was a period of 19 weeks between submitting the application and cover being put in place. They believe their application was mishandled during this time and that they were misled.
- Had the application been handled correctly, cover should've been in place before Mr H displayed his first symptoms. Further, had they been informed the resubmittal of the application may have implications on the validity of cover, then they would've had the opportunity to rectify the issues the delay had on their eventual claim.
- Based on the information provided by First Complete, they were led to believe the insurer had received medical reports post 26 February 2018 (when Mr H saw a GP about his symptoms) and issued cover based on up to date medical information.
- They feel they were lied to and weren't provided with qualified financial advice after their application was submitted which directly impacted their claim. This has affected them financially at an already worrying and stressful time following Mr H's diagnosis.

First Complete didn't uphold the complaint. They said they were satisfied the policy was correctly recommended and dealt with. But that, due to the absence of R, it was necessary to submit the policy application again. The insurer sent Ms C and Mr H a copy of the application on 19 March 2018 and, had there been a change in medical history before cover was accepted (16 March 2018), they were obligated to inform the insurer of this. This didn't happen.

The matter was referred to the Financial Ombudsman Service. Our investigator upheld the complaint in part. In short, she said:

- Although Mr H didn't receive his multiple sclerosis diagnosis until December 2019, information from his consultant evidenced that he started experiencing symptoms in August 2017 – before the application was submitted. Therefore, even if the policy had been put in place quicker, Mr H wouldn't have had a successful claim.
- Mr H also saw his GP in February 2018 about persisting symptoms of pins an needles, as well as numbers in his fingers that had spread to his lower legs and back. This information wasn't disclosed to the insurer even though Mr H had an ongoing duty of disclosure until the policy went live.
- First Complete made several customer service failings. Those being, they ought to have let Ms C and Mr H know the policy application had to be resubmitted. They didn't respond to the first two emails sent to R asking for an update on their application. And First Complete could've advised Ms C or Mr H the GP report was outstanding due to it requiring a GP signature at an earlier opportunity – as the emails from Ms C requesting updates ought to have prompted this.
- The level of service fell below what would reasonably be expected, particularly around communication. And so, she recommended £250 compensation be paid.

Ms C provided a letter from Mr H's consultant that confirmed he only started experiencing symptoms in February 2018 as opposed to 2017. In light of this, Ms C and Mr H maintained their position that cover would've been in place before the first symptoms were experienced had the application been handled correctly.

Our investigator considered this but her position remained the same. In short, she added:

- She accepted the consultant's correction to the patient notes by confirming Mr H's symptoms only commenced in February 2018. But she wasn't persuaded cover would've been in place prior to these symptoms occurring.

- This is because the insurer requested the GP report on 7 December 2017 – after receiving the relevant consent from Ms C – due to a freckle being disclosed on the application. First Complete chased the insurer for an update on 30 January 2018, most likely because of Ms C's first email, and were told the GP hadn't received a copy of the insurer's request (prompting it to be resent). Although it's disappointing First Complete didn't update Ms C and Mr H about this, she was satisfied they contacted the insurer for an update which resulted in them chasing the GP surgery.
- First Complete also advised Ms C and Mr H to chase the GP surgery on 26 February 2018 which she thought was appropriate as it isn't unusual for customers to contact their GP to try and speed things up. Although it's possible Ms C and Mr H could've been advised of this earlier, she accounted for this in the £250 compensation.
- She didn't think the delay in the GP report requiring a signature could fairly be attributed to First Complete, or the insurer. Instead it was more to do with the GP surgery. In any case, the report wasn't received until 12 March 2018.
- So, although First Complete made customer service failings she couldn't safely say, had it not been for these, the policy would've been in place prior to Mr H experiencing his first symptoms.

First Complete accepted our investigator's recommendation to pay £250 compensation.

Ms C and Mr H disagreed and so the matter has been passed to me to decide.

Before I go on to explain the reasons for the decision I've reached, I want to clarify that I'm only looking at the actions of First Complete here. So, I won't be commenting on the insurer's decision to decline the claim – which I understand has been dealt with by the Financial Ombudsman Service as a separate complaint.

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.

I want to firstly reassure Ms C and Mr H that I've given careful consideration to everything they've said. I also don't underestimate the impact Mr H's diagnosis has had on them or the financial implications of the claim being declined. But what I must consider here is whether First Complete is responsible for the misrepresentation that the insurer relied upon in declining the claim. I know this won't be the outcome Ms C and Mr H are hoping for but, for similar reasons to our investigations, I don't think they are. I'll explain why.

Ms C and Mr H's application was submitted on 7 November 2017 and, considering the consultant's letter provided, I accept Mr H hadn't experienced any multiple sclerosis symptoms at that time. The policy summary document provided by the insurer said:

> *"**What do I need to do?***
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> - *You must answer all of our application questions completely, truthfully and accurately. If you don't, we may amend or cancel your policy, or we may not pay a claim.*
> - *You need to tell us if any of the information you've given us changes between completing your application and us confirming when your policy will start."*

This meant that Ms C and Mr H had an ongoing duty to inform the insurer if their health changed before cover commenced if it affected the answers they'd provided in the application.

Before the insurer could offer terms, they required information from Ms C's GP. After receiving Ms C's consent, the insurer requested it from the GP on 7 December 2018. The

application process during this time was therefore outside of First Complete's control as it was the insurer's requirement for medical information.

Ms C asked R for an update on 30 January 2018 but she didn't receive a response. It seems however that this prompted First Complete to contact the insurer about the status of the application, as they did so the same day. The insurer, after contacting the GP surgery, informed First Complete that their initial request hadn't been received so it had to be resent. Although I understand Ms C and Mr H's frustration at not receiving a response to their email, I'm satisfied First Complete took reasonable steps to ensure their application was being progressed by contacting the insurer.

I also don't think First Complete can reasonably be held responsible for any delay relating to the GP surgery not receiving the insurer's initial request. This is because, as I've said, it was the insurer's requirement for this information and so First Complete weren't involved in requesting it. And even if First Complete had responded to Ms C's email, I don't think it would've sped up the application process as the insurer had to resend their request – which they did.

The GP surgery received the insurer's request but required an invoice payment before the information could be provided. This was paid by the insurer on 17 February 2018. I understand Ms C sent another email on 8 February 2018 – prior to the invoice being received and paid by the insurer – asking for an update. Again, although this wasn't responded to, I likewise don't think First Complete were able to influence this part of the application process either. The requirement for payment lay between the GP surgery and the insurer – and I don't think it took an unusually long time either.

After this, Ms C sent a third email to R on 25 February 2018 asking, yet again, for an update. This was responded to by First Complete the next day and they explained R had left their firm. First Complete also said the insurer was still awaiting the medical information from the GP and so advised Ms C that it may help if she chased the surgery. Given the invoice had only been paid about nine days earlier, I don't think First Complete could do much more at that time but I consider the advice they gave Ms C was appropriate – as sometimes, the patient chasing the surgery can speed things up.

The GP report was received by the insurer on 12 March 2018. Mr H's medical records show that he first contacted the NHS on 25 February 2018 about his symptoms and then saw a GP about them the next day. So, the symptoms he experienced and sought medical advice for happened prior to the insurer receiving Ms C's medical information and before cover commenced.

It's unfortunate that there were delays in the insurer obtaining the medical information from Ms C's GP surgery to allow them to underwrite the policy. I understand this was also partly due to the report awaiting a GP signature. Although I sympathise with Ms C and Mr H's situation, these types of GP surgery delays aren't uncommon. And, for the above reasons, I don't think the delays can fairly be attributed to First Complete. I think they acted appropriately by contacting the insurer on 30 January 2018 and by advising Ms C to chase her GP surgery on 26 February 2018.

Due to R leaving the firm, the application had to be resubmitted once the insurer had agreed to offer cover. I understand Ms C and Mr H weren't informed of this by First Complete. So, I understand their frustration at later finding this out when they tried to claim. Nevertheless, I don't think the misrepresentation relied upon by the insurer can be attributed simply to resubmittal of the application. This is because, as I earlier explained, Ms C and Mr H had a duty to inform the insurer if their health changed before cover commenced if it affected the answers they'd provided in the application. In Mr H's case, it had and they didn't inform the insurer about it.

I appreciate Ms C and Mr H have pointed out that cover was put in place quickly after someone picked up their application following their third email. And so, they consider that it

would've been in place before 25 February 2018 – when Mr H first contacted the NHS about his symptoms – had it been picked up sooner. Although I've considered this, I'm not persuaded that it was a lack of action on First Complete's part that led to the delay in the policy being set up. I think this was largely due to the insurer's initial request for information not being received and the delay in the GP signing the report. I also think it's relevant to add that, at the point of Ms C's third email, the GP invoice had been received and paid – which was, at least, partly due to First Complete's actions in chasing the insurer on 30 January 2018. I therefore don't think it would be reasonable to say First Complete only picked up Ms C and Mr H's application after their third email.

It follows that I don't think First Complete are responsible for Mr H's claim being declined by the insurer.

I have however considered the service issues Ms C and Mr H experienced during the setting up of their policy. And I agree with our investigator that First Complete failed to communicate with Ms C and Mr H appropriately. I think First Complete ought to have let them know R had left the firm when he did, responded to their first two emails, kept them updated on the progress of their application and also let them know that their application had to be resubmitted. This lack of communication caused avoidable trouble and upset to Ms C and Mr H. I've given this careful thought and I consider the £250 recommended by our investigator to be a reasonable figure in recognition of this.

I realise Ms C and Mr H will be disappointed by this outcome given the impact the declined claim has had on their lives following Mr H's diagnosis. But, for the above reasons, I think £250 compensation is fair.

My final decision

My final decision is that I uphold this complaint. I direct First Complete Ltd to pay Ms C and Mr H £250.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C and Mr H to accept or reject my decision before 7 November 2022.

Daniel O'Dell
Ombudsman