DRN-3576671

The complaint

Mr M complains that an appointed representative of TenetLime Ltd ('*Tenet*') failed to accurately record medical disclosures he made when applying for two protection policies with a third party insurer. As a result, the policies were set up incorrectly.

To resolve his complaint, he wants Tenet to obtain policies from a specialist broker with cover on the same basis as the policies he had, with Tenet to pay the difference in the cost. He also seeks compensation for his lost time, emotional distress, and a possible critical illness claim he may currently have paid out, but for his policy being wrongly instituted.

Finally, Mr M believes Tenet ought to have its regulatory activities suspended until an investigation about potentially void policies has been undertaken.

What happened

Mr M made an online query about taking out term assurance policies, for both life and critical illness cover. This was because he was considering mortgage lending in the near future. He was contacted by an adviser from Protect Line Ltd who explained that it could assist Mr M on a non-advised basis. Tenet takes responsibility for the actions of Protect Line.

During a call on 15 February 2021, Mr M queried his eligibility for insurance because he suffered from of a type of immune system disorder, a type of connective tissue disorder and a type of mental health condition. The adviser assured Mr M this would not be an issue and transferred him to a colleague to provide quotes. These were then emailed to Mr M.

On 18 February 2021, a different adviser called Mr M to discuss the prospective cover. During this call Mr M reiterated his health circumstances, clarifying the length of time he had suffered from each disorder. The adviser told Mr M that before any applications were made he wanted to check the quotes with a manager. This was to ascertain the prospect of likely acceptance for insurance for someone with Mr M's medical circumstances.

On 25 February 2021, Mr M spoke with a third adviser who obtained quotes for the two policies. One offered £200,000 of life cover for a 53-year term and the other £200,000 of critical illness and life cover for a 43-year term. In that call, Mr M disclosed two conditions in relation to questions he was asked on the insurer's application(s). In relation to the immune system disorder, no relevant question was asked, but the adviser told Mr M he would have to submit that condition separately to the insurer on his behalf, for underwriting consideration.

On 1 March 2021, Mr M was called by another adviser from Protect Line who confirmed that the policies had been accepted without the need for a GP report at the sum assured and terms requested. The policies had premiums of £20.89 and £74.52 respectively.

On 10 March 2021, Mr M contacted Protect Line as he had discovered on receipt of the insurer's paperwork that only one of the three medical issues he told it about had been confirmed in the applications; his two disorders had not been disclosed as promised. The adviser said that the insurer would have been made aware, but Mr M asked for evidence that he was covered on that basis because this conflicted with the insurer's documentation.

The policies went on risk on 15 March 2021. Mr M sent further emails chasing Protect Line on 22 March, 20 April and 29 April 2021 – in the latter he also included a subject access request and that email was also taken as his grounds of complaint.

On 30 April 2021, Protect Line's complaint handler had received confirmation from the insurer (as Mr M had suggested) that the two missing medical conditions had not been detailed within or after the policy application(s). It had therefore liaised with Mr M and the insurer to arrange disclosure of the conditions retrospectively. A GP report was requested on 11 May 2021 but this was subject to Mr M's approval.

On 23 June 2021, Tenet issued a response to the complaint. It set out a summary of the complaint history and noted that at the time of writing to Mr M, the insurer was waiting for him to return his consent for access to his medical records for the purposes of the retrospective underwriting which would expire 90 days after 11 May 2021.

It also said that as Protect Line did not notify the insurer of the medical conditions Mr M disclosed during the application or deal with the matter in a timely manner, his complaint against Protect Line Ltd had been upheld.

In order to resolve the complaint, Tenet offered to return Mr M's premiums from March to May 2021 along with simple interest and a payment of £50 to reflect the upset he had been caused. This totalled £338.61.

Mr M said he remained unhappy and so Tenet undertook a senior management review of the complaint. It agreed to increase Mr M's compensation to £500 from £50 and asked him to sign settlement terms. It appears that Mr M did not do so.

As an aside it also told Mr M that the insurer stated that it had not yet received Mr M's Access to Medical Reports (AMRA) form to request a GP report, which was first issued on 11 May 2021. Tenet said the insurer could not continue its investigations without it; should it not be provided by Mr M the policy would be cancelled within 90 days as previously advised.

In July 2021, Mr M brought his complaint to this service. He said he worked in the legal profession and he understood the implications of non-disclosure for insurance policies. It was for this reason that he took great lengths to ensure Protect Line recorded and acknowledged his medical conditions. He also said he was surprised when the first adviser said he would be able to be insured without any particular issues.

He also said that both Protect Line and Tenet had ignored him, lied to him, misled him and taken no proper steps to put the matter right. He explained that it was reprehensible of the first adviser to tell him he would be insured – if he had relied on this, he could have paid for cover for years, which may well have been cancelled at the time of any claim by himself or his family.

Mr M explained that he now suffers with long-COVID as a consequence of a severe reaction to a vaccination in April 2021. Protect Line/Tenet's actions meant that he could not make any critical illness claim about that. Nor could he consider claims for degenerative conditions should he have had children in the future, and this situation has affected that choice. Mr M explained how his upset at losing his insurance cover could not be underestimated – he used to have protection through a previous employer and had cancelled it in favour of the policies arranged by Protect Line.

Mr M said he had also complained to the insurer and received a written response. The complaint about the insurer was therefore also set up, and dealt with separately.

Mr M explained that the insurer had cancelled his policies and now he was in a position where he had no appropriate term assurance cover. He also said that having undertaken a subject access request with the insurer, it was quite apparent to him that both parties put the business of securing an insurance referral ahead of his interests as the policyholder.

He said Tenet had told the insurer it could not speak to him and the insurer hadn't told him what Tenet had said and he feels that both parties kept everything hushed up.

Mr M reiterated that he felt Tenet ought to be liable for the additional cost of insuring him, which may be anywhere from £400 to £900 per month more than had been suggested previously.

An investigator from this service considered the complaint. She did not think Tenet needed to take further steps. She agreed it had mistakenly failed to record Mr M's medical information when submitting his application to the insurer. But she felt its offer to put matters right was fair in the circumstances and Tenet should not be required to do anything more.

Mr M said he disagreed and wanted the complaint to be passed to an ombudsman. He said this was because:

- the proposed level of compensation did not reflect the level of culpability of Tenet nor the loss he has suffered;
- it also did not encourage Tenet to change its practices, systems or behaviour;
- he is disabled and Tenet ought to have made reasonable adjustments for him;
- Tenet owed a duty of care to customers especially those in vulnerable positions;
- £500 did not begin to represent the 50 hours of time he spent applying for the policy, investigating and following up on the complaint;
- if proper compensation is not awarded for this type of behaviour then Tenet may continue to mis-sell policies, collect commission and ignore complaints;
- he also remains of the view that Tenet has colluded with the insurer;
- Tenet did not properly respond to his subject access request;
- he still believes that it did provide the medical information to the insurer and the difference in documentation without proper subject access evidence supports that collusion took place.

Our investigator was not persuaded to change her view on the complaint. She remained persuaded that Tenet's offer to resolve the matter was reasonable. She did not believe that collusion had taken place and noted that Tenet accepted full responsibility for the failure to disclosure Mr M's full medical circumstances.

Mr M reiterated that he wanted an ombudsman to review the complaint because he believed £500 was an inappropriate offer of compensation.

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 appreciate how strongly Mr M feels about the complaint and the separate complaint about the insurer. However, my view is that it cannot succeed. That is because I believe Tenet has correctly upheld the complaint and offered reasonable compensation to Mr M. Consequently Tenet shouldn't be required to do anything more than it has already offered. I'll explain my

reasons for reaching this conclusion below.

I also cannot provide findings on any suggestion of systematic failings by advisers at Protect Line Ltd. That is because we are not a regulator; that duty falls to the Financial Conduct Authority and Mr M is free to contact the FCA if he requires. We are an informal dispute resolution service and my role is to reach a fair outcome based on the evidence before me.

Similarly, if Mr M has outstanding concerns about subject access and data protection, that is a matter for the Information Commissioner's Office.

It is important for me to set out that this complaint rests against Tenet as the broker which facilitated Mr M's insurance applications. It is separate and independent from the insurer of the policies. Mr M has pursued a distinct complaint about the insurer so I will not be making findings about the insurer's actions here. However, the background to the complaints and some of the content will be similar as they arise from the same set of adjoined circumstances.

I do not accept the suggestion that there has been collusion or complicity between Tenet and the insurer. I realise Mr M's opinion differs on that, but I have seen no clear evidence which suggests that the two businesses would have arranged to cover Mr M without correct medical disclosure. The insurer sent Mr M a copy of his application answers as a means of checking to ensure accurate disclosures. That system would negate any grounds for a cover up on the basis Mr M has suggested, since the applicant could review the answers for accuracy, just as Mr M did.

That was also followed up by correspondence sent to Mr M by Protect Line, which said:

> "*Check your details*
>
> *As requested please find the quotation(s) for your life insurance policy. With no advice offered by ourselves and from the options we have provided for you, you have chosen to apply for a policy fitting your criteria with [insurer]. Further details can be seen on the quotation attached to this letter. Please note that it is your responsibility to ensure that the policy you have applied for is suitable to your needs.*
>
> *During the application you answered the health and lifestyle questions in order for us to submit this information to the insurance company. Failure to have answered these questions correctly or missing out any related information may result in any claims being affected or not paid. You will shortly receive a copy of the application from the insurance company, please check through this carefully. If any details are incorrect or require additional information, please amend and initial prior to returning that form to the insurer, which must be returned as soon as possible*."

This step is in place as a failsafe – because as Mr M is aware, insurers have the ability to assess whether misrepresentations on insurance policies occurred from the outset in accordance with relevant insurance law on consumer disclosures and representations. In this case, the insurer was pointed to errors in the application once Mr M checked his policies. So, the policies were only in force a matter of months before they were then correctly underwritten – which led to the insurer withdrawing terms.

It is manifestly clear that the advisers from Protect Line (for which Tenet takes responsibility) made errors which meant that the insurer was not informed of Mr M's correct health circumstances. This is accepted and agreed by both parties. Protect Line did not convey the complete medical information Mr M had told it to the insurer when it should have done so.

What remains in dispute is the correct redress for the mistakes which prevented disclosure of the two medical conditions. I disagree with Mr M's assessment of how matters should be put right. Notwithstanding the upset Mr M has been placed under, the correct response to mistakes on the part of a business is to put a consumer in the position they would have been in, but for the mistake(s).

Following that through, Protect Line's advisers should have passed on the correct information about Mr M's two disorders to the insurer. It would have then sought the GP report with Mr M's consent and refused the applications. Sadly, Mr M would not be able to obtain insurance with the specified company, even if Protect Line had done everything as it should have. So, I cannot order it to set up policies that would never have existed. Nor do I accept or agree it is liable to make up premiums for a policy it never quoted for or compensate Mr M on that basis.

Protect Line did not advise Mr M, it acted as an intermediary and a representative. Its relationship with Mr M was one of sourcing and assisting in the administration of arranging protection policies. I have not seen evidence it told Mr M to cancel other cover in favour of prospective policies and nor should it have done. Similarly, it is not liable for Mr M's loss of the ability to make a claim (if he suffered from a listed critical illness on the insurance terms) because no policy would or should have begun with the insurer – and that was known before any circumstances pertaining to a claim arose.

Matters could (theoretically) have been different if Mr M had lost the opportunity to make a valid claim, because that may have been a consequential loss flowing from Protect Line's mistakes for which Tenet would be liable. Be that as it may, the argument is hypothetical, because it did not happen. The matter Mr M complains of relating to vaccination took place the month after he noticed the inaccuracies on the insurer's documentation. And, long-COVID is not a listed critical illness in the policy wording in any event.

Putting things right

The compensation which applies here is consideration of the upset and distress Mr M has been caused in believing he could be insured, and then for realising the insurance was not instituted correctly because the insurer did not have the accurate position of his linked disabilities. I can see how concerned and distressed Mr M has been about that.

Our awards are not punitive; we do not award compensation to discipline businesses. Instead, we make limited compensatory awards which account for the impact of any upset caused. Mr M can review our website for guidance around awards if he requires. Tenet has already suggested an award in the range of what would be considered reasonable if I had made that direction myself in circumstances where a matter has caused Mr M considerable trouble, disappointment and taken some months to resolve. I therefore do not believe it should do anything more besides sending the payment to Mr M if it remains outstanding.

My final decision

I uphold this complaint, insofar as I agree that the appointed representative business acting for TenetLime Ltd failed to properly complete policy applications for Mr M to his chosen insurer. This caused Mr M upset, distress and inconvenience when those applications were wrongly accepted and later withdrawn.

If TenetLime Ltd has paid Mr M the redress already offered in its letter of 30 June 2021, then no further redress is due. If it has not, then it must pay that redress if Mr M accepts my decision – without the requirement of a settlement agreement. From the original calculation,

Tenet is entitled to deduct the previously calculated premiums (to June 2021) since these have now been returned to Mr M by the insurer, though I leave that open for Tenet to determine and I do not make a direction on that basis.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 22 August 2022.

Jo Storey
Ombudsman