DRN-3632817

The complaint

The estate of Mr C has complained that that AIG Life Limited unfairly declined a claim and voided Mr C's policy. The estate has also complained about the handling of the claim.

What happened

Mr C applied for a term assurance policy with critical illness cover in through a financial adviser in 2018. The application was accepted and cover commenced on policy on 12 July 2018.

In March 2021 Mr C submitted a claim following a diagnosis of cancer. Very sadly Mr C died in April 2022.

Having assessed the claim AIG said that Mr C hadn't answered the questions correctly and if he had done, he would not have been offered a policy. AIG voided the policy and refunded Mr C the premiums he had paid. However it accepted that the service Mr C had received fell below its usual standards and that this had caused delays. It offered Mr C £200 in compensation.

Our investigator didn't think that AIG had been wrong to decline Mr C's claim, but she felt the service provided to Mr C merited compensation of £450. AIG agreed to this. The representative of Mr C's estate didn't. He said that AIG should be responsible for the agent, as the agent was aware of Mr C's medical history. He felt that the offer of £450 was not enough for the poor service received.

As no agreement has been reached the matter has been passed to me to decide.

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.

Firstly, I would like to offer my sincere condolences to Mr C's family. It's clear that this has been a very traumatic time both for Mr C before he died and for the family.

The relevant law in this case is 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 (a policy). The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation the insurer has to show it would have offered the policy on different terms or not at all if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

AIG has said that Mr C failed to take reasonable care not to make a misrepresentation. It has relied on the answers he gave to questions about his medical history on the application form. He answered 'no' to the following questions:

- *Have you received or been advised to have any medical investigations, scans or blood tests in the last* 5 *years? (You do not need to tell us about common colds, contraception prescriptions, cold sores, ear syringing , hayfever, holiday jabs, ingrowing toenails, influenza, tonsillitis, wisdom teeth or regular well-man/wman checks where the results were all normal. You also do not need to tell us about normal pregnancies and childbirth, but must let us know about pregnancies with complications including but not limited to high blood pressure and sugar and/or protein in your urine.)*

- *Have you been referred to, or been to see, any medical practitioner other than your GP in the last* 5 *years? (Examples can include but are not limited to all visits to a hospital doctor, consultant, psychiatrist, therapist or other visit to a clinic or Accident and Emergency.)*

- *Have you had any disorder of the digestive system, including bowel, stomach, liver (including fatty liver or hepatitis), pancreas or recurrent indigestion or heartburn in the last* 5 *years? Please include ulcers, Crohn's disease , ulcerative colitis and bowel polyps. (Examples can include, but are not limited to, gastric or duodenal ulcers, hepatitis and Crohn's disease)*

When assessing Mr C's claim AIG received his medical notes from his GP and treating specialist. It became aware that he had suffered from a small bowel obstruction in June 2015 and again in September 2017 and had been admitted to hospital. This was confirmed as having been close to the site of a previous anastomosis, said to have been performed in 2000 due to Crohn's disease. Mr C was under the hospital for this condition.

I find that the questions asked were clear and in the light of the medical evidence it was reasonable of AIG to conclude that Mr C failed to answer the questions correctly and to treat the misrepresentations as qualifying ones under CIDRA.

Further questions were asked, including:

- *Have you had any kidney, bladder or other urinary disorders in the last* 5 *years? This includes blood or protein in the urine and urinary tract infections (Examples can include, but are not limited, to difficulty passing urine, kidney stones, kidney infections and nephropathy)*

- *When was your blood pressure last checked by a medical professional? Options - Within the last 12 months 13 to 18 months ago, More than 18 months ago*

Mr C answered that his blood pressure check by a medical professional was within the last 12 months. He did disclose that he had high blood pressure but the medical evidence shows

the last check was in fact in September 2016 – more than 18 months previous to the application being completed. At this time Mr C's blood pressure was raised and an echocardiogram of his heart revealed he had left ventricular hypertrophy. He also underwent other investigations due to having blood and protein the urine.

AIG concluded that both the above two questions had been answered incorrectly. I find that was a fair conclusion based on the medical evidence. AIG has shown that had the correct answers been given to the medical questions asked, Mr C wouldn't have been offered a policy.

Mr C's representative argues that Mr C disclosed his full medical history to the financial adviser who sold him the policy. He says that he was advised to answer 'no' to the questions asked. However, in this decision I am looking only at the actions of AIG. AIG isn't responsible for the actions of the financial adviser – he wasn't AIG's agent.

What is not in dispute is the answers given to the questions above on the application form were incorrect. AIG sent Mr C a copy of the answers given and asked him to make sure that the information given was accurate and complete. He did not advise AIG that there were any inaccuracies. In all the circumstances I don't find AIG was wrong to conclude that Mr C had made a careless misrepresentation. It has shown that this did make a difference – that is if it had been aware of Mr C's full medical history it wouldn't have offered a policy.

I understand there is some dispute as to the entry of Crohns disease in the medical records. For completeness I would say that having seen the underwriting guidance it is apparent that AIG would have declined cover for the history of bowel issues (whether Crohns disease, ulcerative colitis or bowel obstruction). In line with CIDRA it was entitled to void the policy and refund the premiums paid, which it did. Whilst I can understand how disappointing this was, I'm satisfied that AIG has acted fairly and reasonably in the circumstances by avoiding the policy and declining the claim.

Service

AIG agree that the service it offered fell below the standards that Mr C could have expected. Although I can see that AIG needed to wait for medical information, I agree that the claims process could have been more efficient. In total it took five months to give Mr C a claims decision, and I accept that this would have been an extremely worrying time for him. Mr C and Mrs C called on numerous occasions explaining the difficulties that they were facing, however Mr C wasn't regularly updated. In August 2021 Mr C asked for his representative to deal with the matter and AIG agreed to this. Nevertheless a call declining the claim was made directly to Mr C, ignoring this instruction.

I've carefully looked at what happened here and agree that compensation is merited for the distress caused to Mr C. I find the original offer of £200 was low, but I'm satisfied that £450 is fair in all the circumstances.

My final decision

My final decision is that I uphold this complaint in part.

For the reasons given above AIG Life Limited should pay the estate of Mr C a total of £450.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mr C to accept or reject my decision before 8 November 2022.

Lindsey Woloski
Ombudsman