

The complaint

Miss D complains that 1.618 Advisory Services UK Limited (1.618) mis-sold her a life and serious illness assurance policy by failing to accurately record her health in the application. Because of this, Miss D considers 1.618 responsible for the policy being avoided and her serious illness claim being declined by the insurer due to misrepresentation.

What happened

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

In August 2019 1.618 sold Miss D a life and serious illness assurance policy. It provided £68,000 of cover for monthly premiums of about £113. Upon this being set up, Miss D cancelled an existing policy (policy 2) that she set up in 2003 and provided life cover only – which had a sum assured of £180,000 and a 25-year term.

Miss D sadly suffered a stroke in July 2020 and so contacted the insurer to make a claim under her policy. The insurer declined the claim as they considered Miss D misrepresented her health when she applied. So, they avoided the policy and return the premiums Miss D had paid.

Miss D complained to 1.618 about the sale of the policy as she said, having told them about her health history, they failed to accurately include it in the application. And that, even though she contacted 1.618 about being unable to access the insurer's member zone online, she received no response. This meant she was unable to check or update the information submitted in the application. Miss D considered 1.618 responsible for her claim being declined by the insurer and so, she wanted them to pay her the £68,000.

1.618 considered there had been no errors on their part and that the misrepresentations within the application were due to Miss D not disclosing all material information. They said their advisers are required to follow a predefined process where the client is requested to answer various questions in respect of their health – with each answer recorded by the adviser as specifically provided by the client. And it is absurd to contend that their adviser failed to record health issues – as, had they been disclosed, the adviser would've recorded them as they did with the raised blood pressure (which was brought to the adviser's attention).

1.618 further explained that, had Miss D disclosed all material health issues in the application, the insurer wouldn't have offered cover. And so, it's possible Miss D was aware cover wouldn't have been offered and so chose to intentionally withhold such information to obtain cover. They considered Miss D to be a very hands-on client with many interactions on her policy, and acutely aware of what was covered – having reviewed the policy documents which were available to her on the insurer's website, along with a hard copy sent in the post. So, there was no doubt Miss D was aware she needed to disclose all health conditions and the importance of this was stressed by both them and the insurer.

The complaint was considered by one of our Investigators. She thought 1.618 was responsible for Miss D's health not being accurately presented to the insurer in the application, and so mis-sold the policy. When considering how to put things right however, she noted the insurer wouldn't have offered cover had they been aware of Miss D's true health. And that the insurer for policy 2 likewise confirmed they wouldn't have offered cover for Miss D at that time, had a new application been made. Because of this, our Investigator thought it most likely Miss D wouldn't been able to obtain serious illness cover in August 2019. She therefore thought Miss D would've likely retained policy 2, which only provided life cover.

Our investigator therefore didn't think it would be reasonable for 1.618 to pay the £68,000 as, based on her health in August 2019, Miss D likely wouldn't have been able to obtain serious illness cover with any insurer. But considering Miss D had lost the benefit of retaining policy 2, she put forward three options (with the first being the preferred):

- 1.618 search the market to find a life assurance policy offering the same level of cover as policy 2 – that being £180,000 of cover up to May 2028.
- 1.618 indemnify the £180,000 sum assured up to May 2028. So, if Miss D dies during this period then 1.618 would pay this sum to her estate/beneficiary(s).
- Both parties agree to a significant payment now but less than the sum assured (perhaps 50%).

1.618 disagreed as they considered the three proposals admitted liability or fault on their part, which they denied. They remained of the view that there was a clear material non-disclosure of all relevant facts by Miss D at policy inception. And they said had it not been for this non-disclosure, policy 2 would remain in force.

Miss D also disagreed. She explained that she didn't need or want life cover as she didn't have children and so wouldn't be leaving money to any beneficiary(s). Instead, she needs to have benefit of the money while she is still alive – which is what the insurance was meant to provide. Miss D further added, had 1.618 done things correctly, she would've been paid in 2020 and that she doesn't have until May 2028 to live. So, she thought the £180,000 payment should be made now or, alternatively, the £68,000 plus medical expenses and trials she had to pay (and so she would be happy with £120,000).

Our investigator considered the complaint further and, while she remained of the view the complaint should be upheld, she felt to put things right 1.618 should pay Miss D £1,500. This was because she'd previously put forward the three options under the assumption Miss D would've retained policy 2 (had she known in August 2019 she wasn't able to obtain serious illness cover). However, considering Miss D's comments about not requiring life cover, she thought it was more likely she would've cancelled policy 2 regardless of whether she was able to obtain serious illness cover or not – as this simply wasn't the cover she wanted. Because of this, Miss D has suffered a loss of expectation as she thought she had the benefit of serious illness cover in place when she didn't. So, our investigator thought appropriate redress would be an award for the distress caused by the loss of expectation. And she considered £1,500 a fair amount to recognise that Miss D expected to receive a significant sum of money, only to discover she wasn't entitled to it.

Miss D disagreed and, in summary, she added:

- She didn't think £1,500 was fair compensation as, at the very least, she thought 1.618 should pay £68,000 plus additional compensation.

- She was assured she was covered under the policy by 1.618 and all premiums were paid. She couldn't access the insurer's online member zone and raised this on several occasions. And when she had the stroke, she called 1.618 and was told she was covered.
- The outcome reached by the Investigator is biased and her last email suggested it should be upheld, with suggestions of £180,000 being paid to beneficiaries when she died. She questions why it would change from £180,000 to £1,500.
- The outcome changed without good reason – it is unjust, unfair and not impartial.
- There should also be compensation for the time this has taken as well as the suffering she is going through – including stress and lack of sleep.

The complaint has been passed to me to decide. At which point, I'd like to note that I'm not considering the insurer's decision to avoid Miss D's policy and decline her claim as part of this decision. I'm only considering the actions of 1.618 in setting up the policy, whether they're responsible for the misrepresentation and – if so – how to fairly put things right.

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'm sorry to hear of Miss D's ill health and the impact this has had on her. I also appreciate that not receiving the £68,000 has affected Miss D significantly at a very difficult time. And so, I want to reassure Miss D that I've taken everything she's said into consideration when reaching my decision. I know this will come as a disappointment to Miss D but, for similar reasons as our Investigator, I've come to the same outcome.

It isn't in dispute that the application submitted to the insurer didn't accurately reflect Miss D's health history at the time. Both parties however consider each other responsible for the non-disclosures that led to the insurer's decision to avoid the policy and decline the claim due to misrepresentation. As I wasn't present when the application was completed, I can't be sure whether 1.618 asked Miss D the relevant questions, or if Miss D failed to answer them accurately and honestly. I've therefore thought about what I think is most likely to have happened here. Having done so, I think it's more likely that 1.618 is responsible for Miss D's health not being accurately recorded in the application. This is because:

- Miss D's raised blood pressure was recorded in the application. It didn't however include that Miss D was taking medication, or that she was awaiting further investigations for the condition. I consider it unlikely Miss D would've disclosed a condition, but only in part, if she was deliberately trying to mislead the insurer.
- Miss D's weight, amongst other application questions, also wasn't recorded correctly in the application – it should've been 54kg, not 62kg. This is a significant difference and I think it's unlikely Miss D would've overestimated her weight. And based on NHS guidelines this would've been considered a healthy weight for a person of Miss D's height. So, I likewise see no reason for Miss D to have not disclosed her weight accurately or that she could reasonably have been that inaccurate.
- The fact find completed by 1.618 recorded that Miss D didn't have any existing policies in place at the time. I can see no reason or benefit for Miss D not to tell 1.618 about policy 2 - particularly given she was replacing it with the cover being applied

for. This, in my view, supports the likelihood of errors made by 1.618 in the application process.

- I've seen various emails Miss D sent 1.618 shortly after the policy was set up in which she explained, after successfully logging into the insurer's member zone on one occasion to start checking the policy documentation, she was now unable to. And that 1.618 hadn't responded to her about the problem even though she'd raised it several times. From this, I'm satisfied Miss D was unable to check the policy documentation, including the answers to the application questions.
- Miss D has also provided emails, sent shortly after the policy was set up, in which she raised concerns about the premium cost but also uncertainty about what cover was provided. I consider this lack of understanding on Miss D's part suggests the conversation between her and the adviser – at the point of application – wasn't as thorough as it ought to have been. This therefore supports Miss D's testimony – which I've found consistent throughout the complaint process – that the adviser didn't ask her the specific application questions.

I therefore consider the misrepresentation of Miss D's health in the policy application was most likely caused by 1.618. It follows that I think the policy was mis-sold.

I've given careful thought about what compensation is fair to put things right, and I've looked at what would've happened had the policy not been mis-sold. In Miss D's case, two major insurers have confirmed – based on her health in August 2019 – they wouldn't have been able to offer life or serious illness cover. So, even if it had not been for 1.618's error, I think it's unlikely Miss D would've been able to obtain the serious illness cover she wanted. Miss D therefore wouldn't have been able to claim for the stroke she suffered. Because of this, I can't fairly conclude that Miss D has suffered the £68,000 loss. So, I don't think I can reasonably direct 1.618 to pay this.

Miss D did however cancel policy 2 upon being accepted for the life and serious illness policy. Our Investigator initially put forward three remedies under the assumption Miss D would've retained policy 2, had Miss D known she couldn't obtain the serious illness cover she wanted. Miss D has however since confirmed that she has no need for life cover as she won't be leaving money to any beneficiary. Considering this, I think it's reasonable to assume that – had correct advice been given by 1.618 – Miss D would've cancelled policy 2 in August 2019 as she had no need for this type of cover.

I appreciate Miss D believed she had serious illness cover in place and was financially protected when she had the stroke. But, as I've explained, I don't think Miss D could've obtained this cover had her health been accurately disclosed to insurers. And it seems most likely she would've cancelled policy 2 had her protection requirements been reviewed properly. It follows that Miss D would've been in the position she now sadly finds herself in even if it hadn't been for the policy being mis-sold. That said, I do think Miss D has suffered a loss of expectation by finding out she wasn't covered for the stroke she suffered and so not entitled to the £68,000.

In addition to this, I think there were service failings by 1.618 following the policy being set up as it seems they didn't respond to Miss D's emails – about the policy cost/benefits and being unable to access the insurer's online member zone – appropriately. Taking everything into consideration, I think £1,500 is a reasonable amount to recognise the service issues and the loss of expectation Miss D experienced.

I'm sympathetic to Miss D's circumstances and I realise £1,500 is significantly less than the £68,000 sum assured she was expecting. But, for the above reasons, I think it is fair in the circumstances.

My final decision

My final decision is that I uphold this complaint in part. I direct 1.618 Advisory Services UK Limited to pay Miss D £1,500 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 28 April 2023.

Daniel O'Dell
Ombudsman