

## The complaint

Mrs A complains that The Royal London Mutual Insurance Society Limited trading as Scottish Provident has unfairly refused her critical illness claim. Instead, it has voided the policy on the grounds of misrepresentation.

To resolve her complaint, Mrs A wants Scottish Provident to pay her the outstanding claim value. She says it is using loopholes to avoid paying out on a genuine claim.

## What happened

Mrs A applied for a Scottish Provident Self Assurance policy through a third party financial adviser in May 2001. On 12 June 2021, Scottish Provident confirmed to the adviser and Mrs A that the policy had begun on 8 June 2001. It offered Mrs A level life cover of £40,000 as well as level death, terminal illness or earlier critical illness benefit of a further £40,000. It had other additional benefits including premium protection benefit and total and permanent disability benefit. The policy was set up for a 25-year term, to June 2026.

In April 2021, Mrs A made a claim to Scottish Provident for critical illness benefit, as she had sadly been diagnosed with Multiple Sclerosis ('MS').

Scottish Provident thereafter wrote out to Mrs A's GP and her treating consultant for further information in May 2021. It says it had to chase for medical information several times. In June 2021, it asked Mrs A's GP for additional information as the report it had supplied was insufficient to validate the claim.

Further report requests were sent to the GP in July 2021, August 2021, September 2021, and October 2021.

On 2 December 2021, Scottish Provident wrote to Mrs A to ask her view on three policy questions she had answered on 29 May 2001 in relation to smoking, her history of kidney disease and whether she had consulted a doctor or undergone diagnostic tests in the three years preceding the policy application.

Mrs A explained that she found it upsetting to be questioned by Scottish Provident over things that she could not remember. She said, in summary:

- she agrees she signed the application, but it wasn't completed in her handwriting;
- she had taken the policy out because it was a provision of lending to purchase her local authority home at the time;
- she was very young and inexperienced at that time, and placed faith in the adviser;
- she may have smoked very occasionally on a social basis but she had never considered herself a smoker;
- she had disclosed that she suffered from asthma when completing the application;
- she would not consider a childhood ailment relating to her kidneys was relevant, because it was a minor matter;
- the condition was never described as kidney disease;

- her recent MS diagnosis now takes a huge toll on her health and the process of the claim has made matters worse;
- she had paid the cover consistently for over 20 years and now feels she is being treated unfairly;
- her GP was frustrated with having to deal with multiple requests for information.

Her reply was treated as a complaint by Scottish Provident.

On 17 February 2022, Scottish Provident rejected the complaint. It said though it had to undergo several attempts to seek medical evidence, it was satisfied that its requests for information from Mrs A's GP had been appropriate. It was required to examine Mrs A's relevant medical records in detail, in order to fairly assess her claim.

Scottish Provident apologised for upsetting Mrs A, and confirmed that was not its intention. However, it said the medical information it received differed to that of Mrs A's policy application, and for that reason it had written to allow her the opportunity for an explanation.

Scottish Provident told Mrs A it was still considering the evidence alongside her response and its claims team would confirm an outcome in due course.

On the same date by separate cover, Scottish Provident rejected Mrs A's claim. It said the medical evidence that it had received showed that she was attending renal clinic reviews within the three years prior to policy application, the most recent being three months prior.

It explained how its underwriters could not have offered Mrs A the same cover for the same price in 2001. In fact, it could only have provided her life cover for a greater cost.

It therefore gave Mrs A two options – she could either reduce the death benefit to £20,690 and keep the death, terminal illness or earlier critical illness benefit at £40,000 with a reduced monthly premium of £8.34 because of the removal of all but the death benefit. This would entitle her to a partial refund of £1,579.02. Or she could have all the premiums she'd paid from the outset returned to her, totalling £3,859.41. If Mrs A did not choose an option, the latter would apply by default.

On 20 March 2022, Mr and Mrs A wrote to Scottish Provident complaining that neither option was acceptable to them. They also noted Mrs A hadn't agreed to amend her policy. They said their concerns should be treated as a formalisation of their complaint.

On 18 May 2022, Scottish Provident upheld the complaint in part. It said its claim decision had been correct. But it accepted that it had told Mrs A it would amend her policy without her consent, and that this would have been additionally upsetting for her. Though it had rightly given her two correct options to move forward or cancel the policy, it should not have assumed any option and it felt that its actions would have caused Mrs A distress. It therefore issued her a cheque for £150 compensation.

In July 2022, Scottish Provident told Mrs A it still hadn't received a reply as to her decision about the policy going forwards. So, it said if it did not hear from her further within 14 days, it would cancel the cover and return all the premiums she had paid. Consequently, Scottish Provident told Mrs A on 8 September 2022 that it had cancelled the policy, as advised.

Mrs A brought the complaint to this service. She explained that she consented for this service to also speak with her husband, Mr A, as a representative.

She said Scottish Provident had strung out the claim for over a year and sent continued, unnecessary correspondence to her doctors. She felt Scottish Provident was looking for any

excuse to avoid the claim and cancel the policy; it was now alleging that it could not honour the payment based on vague details that she 'may' have smoked 20 years ago – yet she was a non-smoker. Mrs A explained how she was suffering both emotionally and financially due to Scottish Provident's actions.

Scottish Provident said it hadn't refused the claim because of smoking – this had since been disregarded. The reason it had reached a belief that there had been a misrepresentation was because Mrs A hadn't answered the question about consulting a doctor in the last three years correctly. If it had known about Mrs A's renal clinic appointment three months before the policy started, it would have insured her for life cover at a higher cost but refused critical illness, total permanent disability, disability income and premium payment benefits.

An investigator from this service reviewed the complaint, but she did not think it should succeed. She said she felt the question Mrs A had been asked was clear, and she needed to tell Scottish Provident about her review at the renal clinic which would lead to disclosure of her kidney condition.

If she had done so, Scottish Provident couldn't insure her on the same terms. So it was fair for it to amend the policy now to remove the benefits it couldn't offer and reduce the life cover sum assured based on the premiums Mrs A had paid.

Mr A said he and Mrs A did not accept the investigator's findings. They asked for the complaint to be passed to an ombudsman.

Mrs A also replied directly and said that if Scottish Provident will not pay out and instead only return her premiums, she questioned if it should be liable for interest on that refund. She also explained she was upset by the refusal to uphold her complaint.

Scottish Provident did not make any further comments. The complaint has now been passed to me.

### **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 was sorry to learn of Mrs A's diagnosis and how difficult things have been for her. I know my decision will be disappointing but I'm unable to direct Scottish Provident to pay her claim. Though I agree it should have paid compensation in respect of the upset it has caused, I otherwise do not believe it has acted unfairly. I'll explain why I've reached this view below.

When applying for insurance, if an applicant doesn't tell his or her insurer relevant information in response to a clear question it's known as 'misrepresentation'. If the circumstances around a claim prompt an insurer to believe a misrepresentation may have occurred within an application, it will consider what ought to have happened at that time. That is what Scottish Provident has done.

When it received information from Mrs A's consultant regarding the claim, it was noted on the recent clinic documentation from April 2021 that her consultant had written to another renal consultant for a view on Mrs A, regarding an incidental finding of haematuria. In that letter it was confirmed how from the age of 11, Mrs A had suffered with glomerulonephritis, following an episode of glandular fever. From that point on, she had annual renal check-ups.

On this basis, Scottish Provident was prompted to seek additional information about this matter. A further neurology letter from 10 September 2019 (where it was suspected Mrs A

may have MS) also referred to her previous history as chronic kidney disease, following glandular fever in childhood.

Once it had reviewed Mrs A's medical records relating to glomerulonephritis, Scottish Provident said its underwriting rules meant it couldn't have offered Mrs A any critical illness cover at all. Because of this, it can't pay her claim for MS now.

It therefore falls to me to look at what Mrs A was asked, and determine if I think she made a misrepresentation, upon which Scottish Provident could amend the terms it offered and/or avoid the policy. The correct position is to decide what ought to have happened at the time of the application. That means looking at what was asked of Mrs A, against the relevant medical records up to the date the policy started on 8 June 2001.

Though I know Mrs A has contended otherwise, Scottish Provident has not gone further to rely on misrepresentation over any history of smoking – and it is not the reason the claim was refused. It was raised by Scottish Provident because Mrs A's records from the years preceding the policy do mention her being an occasional or social smoker. Since it has not been considered in relation to the claim, I have not looked at this issue further.

In the policy application, Mrs A was asked:

*“Have you consulted your doctor or any other doctor, or been advised to have an operation, x-ray, check-up or investigation in the past 3 years?”*

She answered “no” to this question. However, the medical records show that Mrs A had visited a number of consultants between June 1998 and June 2001 for conditions including Raynaud's syndrome and glomerulonephritis. For the latter she undertaken annual reviews, since her condition had begun following the episode of glandular fever as a child.

These renal clinic reviews were increased on occasion because Mrs A also suffered from haematuria and proteinuria – so, where required, this was monitored through urine tests. In the months preceding the policy application, Mrs A had seen the renal clinic in December 2000. The clinic then wrote to her GP to ask it to obtain urine samples from Mrs A in February 2001, as the clinic had required a four-month follow up depending on the results.

As it was, Mrs A was seen at the renal clinic again in July 2001 – after the policy began, because the GP sent a letter dated 19 February 2001 noting her urea and creatinine levels had returned to normal. At that time, the consultant had noted Mrs A *“required no specific treatment of her renal disease”*.

I therefore appreciate why Mrs A felt that she may have had nothing of consequence to tell Scottish Provident about; since she wasn't being actively treated for her kidney condition. But I must be fair to both parties, and the duty on an applicant is to answer a question to the best of their knowledge or belief, providing it is neither unclear nor ambiguous.

This question was clear; it asked Mrs A if she'd consulted a doctor in the last three years or been advised to have a check-up. And she had undergone tests – routine or otherwise – as well as being seen on several occasions by her GP and renal clinic. It wasn't for Mrs A to decide if the matter was insignificant or not. Scottish Provident needed to know an accurate medical history upon which it could decide if it offered Mrs A insurance, and on what terms.

I am also mindful that while Mrs A may not have written on her application, she had signed a declaration which said:

*"I declare that to the best of my knowledge and belief the statements made in this application and in any document delivered pursuant to it, whether in my handwriting or not, are true and complete and that I have not concealed any material fact. (Material facts are those likely to influence the company's assessment and acceptance of the application).*

*I confirm my understanding that failure to disclose a material fact may lead to the avoidance of the plan applied for, or a rejection of any claim thereunder."*

So, I do think, on balance, that it was likely that the need to answer the questions carefully was put to Mrs A at the time of the application; though sadly, she did not do so.

I therefore believe there was a misrepresentation. Mrs A needed to show more care in answering the question put to her, rather than substituting her own view for what was asked. The application process was designed to trigger the requirement for medical reports based on the information disclosed. Because Mrs A did not answer the question positively, the cover was offered on standard terms without further underwriting.

In these circumstances, Scottish Provident has acted fairly and reasonably in applying a proportionate remedy. This means the claim outcome will depend on what the underwriting decision would have been had the misrepresentation not occurred at the time. If insurance could have been offered under different terms or for a different cost, an insurer may amend the contract to reflect this. If it couldn't have offered cover at all, the insurer can void the policy and return the premiums paid from the outset.

Scottish Provident hasn't had the opportunity to underwrite the policy in 2001 as it would have, if it had known about Mrs A's correct circumstances. It is therefore fair and in accordance with the policy terms for it to amend the cover now to reflect the terms it could actually have offered. That means I can't ask it to pay Mrs A's claim in full, because Scottish Provident would not have been in a position to provide Mrs A with any critical illness benefit at all, had it known of her accurate medical history.

I note that Mrs A has decided not to accept the policy amendments and by default received a premium refund. I believe this a fair and reasonable response in the circumstances.

The only remaining point is that Mrs A has questioned why, after she did not contest the return of premiums in full, interest hasn't been added to the refund. Firstly, I should note that I agree Mrs A was caused upset by the manner in which Scottish Provident amended the policy going forwards without first seeking her consent; and I believe that a payment of £150 was appropriate in the circumstances for the distress that she suffered. Otherwise, I do not agree that any interest ought to be awarded.

If an award had been made by this service whereby we uphold a complaint about a refused claim and direct a payment to be made, we may include additional interest when redressing a loss a consumer has suffered. This separate interest award (in most cases, simple interest of 8% after April 1993) is intended to compensate a consumer for being 'deprived' of money that he or she would otherwise have been able to use elsewhere, but for the business having made a mistake of some kind.

A return of premiums would not routinely attract an award of interest in the event of voiding a policy on the grounds of misrepresentation unless a business has unreasonably delayed the refund or unfairly retained the money for some reason. That is because the requirement to void the policy arises once a misrepresentation has been confirmed, based on the evidence. Therefore, a business has not unreasonably deprived the consumer of his or her funds.

Scottish Provident offered Mrs A the refund option at the time of the decision on misrepresentation. Because Mrs A complained about the actions with amending the policy, Scottish Provident waited for her instruction as to how she wished to proceed. It only voided the policy and made the premium refund as a default after it had given Mrs A appropriate notice. As it couldn't have made the refund sooner, no payment of interest was required.

### **My final decision**

Though I appreciate this will be disappointing for Mrs A, I do not believe The Royal London Mutual Insurance Society Limited trading as Scottish Provident needs to do anything further. It has rightly compensated her for the upset it caused and otherwise correctly voided her policy on the grounds of misrepresentation, accordingly returning Mrs A's policy premiums.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs A to accept or reject my decision before 17 January 2023.

Jo Storey  
**Ombudsman**