DRN-3868484

The complaint

Mr W is unhappy that Legal and General Assurance Society Limited ('L&G') declined an income protection claim and cancelled the income protection element of a suite of policies he'd taken out including life and critical illness insurance ('the policies'). He's also unhappy with the service received by L&G.

Although Mr W is being represented in this complaint, I've referred to him throughout as he is the policyholder.

What happened

Mr W applied for the policies in or around April 2020 through a broker. When doing so, he was asked a number of questions – including about his health and medical history. L&G agreed cover and the policies commenced.

In early 2022, Mr W made claims on the income protection policy in relation to time off for a hip operation, and for sepsis ('the claim'). L & G requested medical information. And upon receipt, and consideration, of the same, the claim was declined. It concluded that Mr W had made a qualifying misrepresentation when answering certain questions when applying for the policies. L&G said that had Mr W declared a problem with his hip, it would've still offered him income protection but would've applied an exclusion to the policy. However, because it also concluded that Mr W had answered certain questions without any care as to whether the answers given were right it cancelled the income protection policy from the date it started but refunded the premiums paid for it.

Unhappy, Mr W complained to our service. Our investigator looked into what happened and didn't uphold his complaint. Mr W disagreed so his complaint 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.

Declining the claim and cancelling the income protection policy

When considering this issue, I've taken into account The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I think it's relevant here. CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. The standard of care is that of a reasonable consumer.

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 (in this case L&G) 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.

L&G says Mr W failed to take reasonable care not to make a misrepresentation when answering medical questions about whether he'd ever had arthritis or joint trouble when applying for the policies – and had received treatment over a continuous period of 4 weeks or more, during the past 12 months.

Overall, I think L&G has acted fairly and reasonably by declining Mr W's claim under the income protection policy. And also cancelling this policy and refunding premiums back to the start date. I've set out my reasons below.

When first applying for the policies, Mr W was asked a number of questions about his medical history including:

> *Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for:*
>
> - *Lupus, fibromyalgia, gout or any type of arthritis, neck, back, spine or joint trouble, for example rheumatoid arthritis, sciatica?*

I'll refer to it as the 'medical question' and the parties agree that Mr W answered 'no'.

I'm satisfied that the medical question is clear, and I don't agree that there were shortcomings in the question as Mr W says.

When L&G reviewed Mr W's claim, it concluded that he'd answered the medical question incorrectly. That's because in April 2020 – so around six months before applying for the policy – Mr W had attended a telephone triage appointment with a doctor. His GP notes reflect that this was due to "known hip OA" and he wanted the doctor to prescribe him with an anti-inflammatory painkiller which he'd run out of because he didn't find paracetamol or codeine effective.

Further, at the end of December 2022 – so a couple of months after applying for the policies – his GP notes reflect that he had ongoing hip pain. It's also reflected that Mr W thought his mobility had become progressively worse in the last 12 months. There's mention of Mr W wanting a steroid injection and being advised many years before that he may need a hip replacement later in life. I think this further supports that the reason Mr W consulted with his doctor in April 2020 was due to his hip.

Given Mr W's medical records, I'm satisfied that L&G has fairly and reasonably concluded that he answered the medical question incorrectly.

Mr W says he answered 'no' to the medical question because it had been over five years since he'd last seen a doctor in relation to his arthritis. However, I'm satisfied that L&G has reasonably concluded that the telephone appointment which took place in April 2020 related to his arthritis (or at the very least 'joint trouble'). He wanted the doctor to prescribe medication to help him manage the pain. And I'm satisfied that a reasonable person would reasonably interpret this appointment as having seen a doctor. So, I don't agree with Mr W that there wasn't a doctor's visit to declare.

I think the medical question clearly asks whether Mr W had seen a doctor or other medical professional. I don't think a reasonable person would conclude that the question was limited to an 'in person' appointment – particularly as the application was made shortly after the

emergence of the Covid-19 pandemic where it was common to have medical appointments by telephone or, otherwise, virtually.

I'm satisfied L&G has fairly concluded that Mr W made a qualifying misrepresentation under CIDRA. And that it's fairly concluded that Mr W's misrepresentation was deliberately or recklessly made.

Taking into account Mr W's explanations about why he answered questions in the way he did, I don't think he's given a credible explanation supported by the facts for the misrepresentation having occurred when considered against the medical evidence, summarised above. Nor do I think there are any credible mitigating circumstances to explain why he answered certain questions about his health in the way that he did.

Given the nature of the medical evidence – particularly the GP note from April 2020 - I think L&G has fairly concluded on the balance of probabilities that Mr W knew, or must have known, that the information given was incorrect or misleading (or – at the very least - acted without any reasonable care as to whether the information was correct or misleading). And as the medical question was asked before agreeing to insure Mr W, I think he ought to have known that the question being asked was relevant to L&G – or he didn't care about whether or not it was relevant to it.

L&G has provided underwriting guidance showing that if Mr W had answered the medical question correctly – and it had been aware of his hip problem/arthritis – it would've added an exclusion. So, I think the answer to the medical question mattered to L&G and was directly relevant to its decision to offer Mr W the policies – including income protection cover – on the terms it did.

I've looked at the actions L&G can take in line with CIDRA when it's concluded a deliberate or reckless misrepresentation has taken place. Under the legislation it's entitled to cancel the policy and retain the premiums. And it doesn't have to pay any claims made on the income protection policy as it can treat the policy as if it never existed.

That's what L&G has done here, albeit it's agreed to refund the premiums paid for the policy to the start date. I think that's more than it was reasonably required to do, and I think it's acted fairly and reasonably.

It's important to add that L&G also concluded that Mr W had incorrectly answered 'no' to another question when applying for the policy about whether (during the last 12 months) he'd had any medical condition, illness or injury for which he'd received treatment over a continuous period of 4 weeks or more. I don't think I need to make a finding about whether Mr W had answered this question incorrectly based on the medical evidence – and whether he'd made a qualifying misrepresentation (deliberate, reckless or careless). That's because even if he hadn't made a qualifying misrepresentation when answering this question, for the reasons set out above, I think L&G has reasonably concluded that he'd (at the very least) answered the medical question without any reasonable care as to whether the information was correct or misleading.

L&G has also redrawn the remainder of the suite of policies in line with its underwriting guidance on the basis that the income protection policy was optional and, so, a severable benefit. L&G offered Mr W the opportunity to cancel the remaining cancel cover and refund the premiums paid to the start date if he didn't wish to proceed with the revision of the policy terms. I think that's fair and reasonable in the circumstances.

Delays

Whilst the claim was being assessed by L&G, Mr W complained about the way in which the claim was being handled including delays. L&G has an obligation to handle complaints fairly and promptly.

After the complaint was brought to our service, when providing its response, L&G told us that it agrees that it caused some avoidable delays with the management of the claim and offered £400 compensation in recognition of the impact this had on him.

I can see that this was a worrying time for Mr W, which would've been exacerbated by the delays caused by L&G assessing the claim. And he spent time chasing L&G for an answer which I accept would be frustrating. I'm satisfied £400 compensation fairly reflects the distress and inconvenience caused to him.

Putting things right

L&G should pay Mr W £400 compensation for distress and inconvenience.

My final decision

I partially uphold Mr W's complaint but only in respect of his concerns about the service he received after claiming on the income protection policy. I direct Legal and General Assurance Society Limited to pay him £400 compensation for distress and inconvenience.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr W to accept or reject my decision before 14 April 2023.

David Curtis-Johnson
Ombudsman