DRN-3937419

The complaint

Mrs C complains that The Royal London Mutual Insurance Society Limited ('*Royal London*') has unreasonably refused her claim for death benefit under her joint life assurance policy. Instead, it has voided the policy on the grounds of misrepresentation. Mrs C believes no misrepresentation has occurred and Royal London should pay out her claim.

What happened

On 13 August 2019, Mrs C applied for a life assurance policy alongside her husband, Mr H. The policy had a level sum assured of £4,000 and a term of 18 years. The application for the policy was completed through an independent financial adviser ('*IFA*') and conducted via telephone with Mrs C and Mr H.

The policy was thereafter accepted by Royal London on standard terms for both Mrs C and Mr H, for a £23.29 monthly premium. It went on risk on 12 September 2019.

In April 2021, Mr H sadly passed away due to a type of cancer. On his death certificate, it was also set out that he had chronic obstructive pulmonary disease ('*COPD*') which had contributed to Mr H's death but was unrelated to his cancer.

Mrs C thereafter made a claim to Royal London. However, it noted COPD was set out on Mr H's death certificate, yet it had not been disclosed within his policy application. In May 2021, Royal London sought further medical evidence from Mr H's GP about his medical history, specifically relating to COPD and if this condition had been present before 13 August 2019. It provided the GP with a targeted medical report to complete and return to Royal London.

The GP initially replied in May 2021; however, it did not provide complete medical evidence. So, Royal London sent a further letter of 11 May 2021 seeking confirmation around the date of Mr H's COPD diagnosis and his subsequent treatment.

In July 2021, Mrs C complained. She felt Royal London was unfairly penalising her when she had not been responsible for the actions of the IFA incorrectly recording COPD as asthma on the application form. She also believed Royal London wasn't fairly handling the claim.

In August 2021, Royal London explained to Mrs C that it was not seeking to be obstructive; however, when it is presented with new information at the time of a claim, it will need to ask further questions to establish what information it ought to have been given at the time the application was made. To do this, it needed additional medical evidence.

Royal London also told Mrs C that it believed the IFA had ceased trading, and if she wished to pursue a complaint about its actions, she'd need to refer her concerns to the Financial Services Compensation Scheme ('*FSCS*').

In September 2021, Royal London received the relevant medical records. It then wrote to Mrs C on 27 September 2021 asking for more information about Mr H's circumstances at the time of the application in August 2019. Specifically, it was noted that Mr H had suffered from a type of peripheral vascular disease ('*PVD*') which was diagnosed in 2018 and COPD from

2010. Neither of these conditions had been disclosed to Royal London.

In October 2021, Royal London rejected the claim. It said that it remained of the view that Mr H had answered two questions incorrectly, whereby he ought to have told Royal London that he had PVD and COPD. Instead, a disclosure of asthma was incorrectly made. Had he done so, Royal London said it couldn't have insured him at all. This meant it couldn't accept Mrs C's claim now, and it instead voided the policy, returning the premiums to Mrs C.

In November 2021, Royal London rejected the complaint. It said it had been right to refuse Mrs C's claim and void the policy on the grounds of misrepresentation based on the medical evidence it had seen. Therefore, it would not overturn the decision nor uphold the complaint.

It explained that when Mrs C and Mr H sought their cover, they were sent a copy of their applications to check thoroughly. That correspondence told them the importance of accurate answers and how failure to provide them could lead to loss of the cover at the time of a claim.

Whilst it remained sympathetic to the circumstances of Mr H's death, Royal London said it could not pay a claim because the full facts of his medical history were not disclosed on the application. The law applying to consumer disclosure for insurance policies and relevant industry guidance allowed Royal London to amend the policy at the time of a claim. Had it known of Mr H's medical circumstances, it wouldn't have offered him any insurance at all.

In January 2022, Mrs C's son (Mr C) referred her complaint to this service. He said that Mrs C had never been supported by Royal London in any way, such as through being offered its bereavement service. He also set out that their key complaint was that the claim was refused.

Mr C also said:

- he believed the policy was taken out through a broker acting for Royal London;
- the application was undertaken by telephone as Mrs C and Mr H were not computer literate;
- it was this means of communication that caused issues because the adviser did not understand the medical information that Mr H disclosed to him;
- it was made clear several times that Mrs C had asthma and Mr H had COPD – but this was still incorrectly recorded;
- they do not feel this should be deemed Mrs C's fault merely because she isn't able to complete an online application;
- the telephone conversation covered the issue of COPD several times as he repeatedly asked Mrs C if COPD was actually asthma, to which she confirmed "*no*";
- however, Royal London has not provided a copy of the call to verify this;
- the policy was taken in good faith and all existing medical issues were declared;
- all requested payments and premiums were paid;
- despite this, Royal London merely decided irrationally not to pay out Mrs C's claim;
- Mrs C thought the policy would provide her funds to pay for Mr H's funeral, and to be left without any claim proceeds at all has caused her considerable upset at a very traumatic time.

An investigator reviewed the complaint and concluded that it ought to succeed. He believed that whilst Royal London had rightly concluded that a 'careless' misrepresentation took place, it had wrongly determined that it couldn't have insured Mr H and Mrs C altogether. He believed that the underwriting guidance showed Mr H would have been able to be insured, with ratings for both PVD and COPD. So, he felt that Royal London ought to retrospectively

apply those ratings to the joint policy to see if Mrs C could have had a claim paid at a proportionate value greater than the premium refund she'd already received.

Though Royal London indicated it would seek further information from its reinsurers, it did not provide any additional comment or evidence. Mr C also didn't have any further submissions to make. The complaint has now been passed to me for review.

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 thank the parties for their patience whilst this matter has been pursued at this service. Having looked at everything before me, I also believe this complaint should be upheld, on the same basis that was put forward by our investigator. I'll explain my reasons below.

I appreciate that Mrs C and Mr C are unhappy about the IFA's actions when recording Mrs C and Mr H's medical information. But I cannot consider that here, as this complaint is set up against Royal London as the insurer of the policy. Royal London is not linked to the IFA and was not party to the sale of the policy, so it hasn't got access to the sales call that Mr C asked for. Instead, its duty was to offer and administer the insurance taken out in 2019.

Though Mr C has suggested otherwise on bringing the complaint here, the IFA was not a broker or appointed representative of Royal London at the time of the sale. As it has set out previously, Royal London is not responsible for the advice, actions, or inactions of the IFA.

Any concerns about the IFA would form the subject of a separate complaint. However, I can see Mrs C has already been informed by Royal London about directing any complaint concerning the IFA to the FSCS. That is the appropriate course of action for businesses that may have ceased trading; under our rules (as determined by the Financial Conduct Authority Handbook), this service cannot set up complaints against a business that is in default.

I have therefore gone on to look at the claim and complaint as it stands against Royal London.

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's entitled to consider what ought to have happened at that time. That is what Royal London has done.

It is not in dispute that Mr H sadly passed away from a type of cancer which was unrelated to COPD or PVD. And he did not have this condition when he and Mrs C sought their cover. However, when it received the medical information to process Mrs C's claim, it noted COPD was recorded as having contributed to his death; this had not been disclosed in the policy application two years prior. Given the longstanding nature of COPD, it therefore sought targeted medical information for a period preceding the policy application.

So, it was the circumstances of the claim which gave rise to the need to review the policy application questions. That's not because Mr H went on to suffer with cancer, but because at the time of the claim, it became apparent that some questions may not have been answered consistently with Mr H's health at the time of completing the form. I believe Royal London was reasonable in reaching that conclusion based on the evidence it had seen.

Once Royal London had sight of Mr H's medical records, it became clear that he had suffered with COPD for many years, and more recently, he had been diagnosed with PVD.

In reviewing what was set out on the application, Royal London acted in accordance with relevant law on consumer disclosures. The law says expressly that an insurer has a remedy against a consumer if a misrepresentation was made by the consumer before an insurance contract was entered into. For that reason, Royal London was reasonable in trying to ascertain what should have happened in August and September 2019.

So, it falls to me to look at what Mr H was asked and determine if I think he made a misrepresentation or not. Royal London says two questions on the application had been wrongly answered. They were:

> "*HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE, ANY OF THE FOLLOWING?*
>
> *Heart disease or disorder, circulatory disease or diabetes?*
> *Including: Angina or heart attack, Disease of, or surgery to, your heart or arteries, Cardiomyopathy, Heart valve or heart structure abnormalities, Irregular or rapid heartbeat, Aortic aneurysm, Peripheral vascular disease, Heart Murmur, Deep vein thrombosis (DVT)?*"

Mr H's answer was given as "*no*" to this question. He was also asked:

> "*APART FROM ANYTHING YOU'VE ALREADY TOLD US ABOUT, DURING THE LAST 5 YEARS HAVE YOU HAD, OR DO YOU CURRENTLY HAVE, ANY OF THE FOLLOWING:*
>
> *Asthma, bronchitis, or any other disorder affecting your lungs or breathing? Including: Sleep apnoea, Sarcoidosis, Emphysema, Pneumonia*
> *You don't need to tell us about:*
> *Common colds or flu, One off chest infections that you've fully recovered from*"

Mr H's answer was "*yes*", which then provided a new subset question asking, "*which conditions have you had?*" to which "*asthma*" was given as the answer.

When she was asked to clarify Mr H's health with Royal London in September 2021, Mrs C explained that Mr H had merely been told that he suffered from leg cramps in 2018.

However, Mr H's GP records go further to give a diagnosis of PVD as a cause for a ten-week history of leg cramps. On 22 May 2018, the GP diagnosed PVD and duly referred Mr H to a vascular surgeon where diagnostic testing took place in July 2018. It wasn't clear at this stage what was the underlying cause for his leg pain (claudication).

Upon the results of the tests in August 2018, it was confirmed by a different vascular consultant that Mr H had significant left arterial disease, which was responsible for his leg pain. Angioplasty of the leg artery was recommended, but only if Mr H was able to cease smoking during the next six months. The matter was therefore left under review.

At the time of applying for the cover, the situation remained unresolved; Mr H hadn't attended his two most recent vascular clinic appointments of April and August 2019.

In my view, Mr H should have answered "*yes*" to the first question. Even if he was unsure about PVD, Mr H had been told in writing on 9 August 2018 that he had arterial disease, which was awaiting surgery. The question asked about both PVD and arterial disease.

Notwithstanding Mrs C's concerns about the actions of the IFA (which I'll address below), insurers can expect customers to answer clear questions carefully, accurately and to the best of their knowledge and belief. Royal London needed to know about Mr H's particular medical history. The question was clear and relevant to Royal London and so he ought to have answered "*yes*" to it, and given further details.

I can see that in respect of COPD, Mrs C does not dispute that Mr H suffered with the condition and that he did disclose it in response to the above question. She says Mr H told the IFA in clear terms about the condition – but the IFA wrongly recorded it as asthma.

But Royal London isn't responsible for the actions of the IFA. It is for this reason that it sends a copy of the application to applicants directly, to ensure that what is recorded actually reflects what was told to the adviser. This is since an applicant's medical history is best known by themselves, not a third party.

For this reason, Royal London wrote to Mrs C and Mr H on 14 August 2019, where it said:

> "*Dear [Mrs C and Mr H],*
>
> *I am delighted to enclose your pack telling you about your protection plan with Royal London.*
>
> *You should have received a copy of the application containing the information given to us. It is vitally important you both check that the information we have is complete and accurate, and return the confirmation form to us by 14 October 2019.*
>
> *If any of the information in the application is incorrect or incomplete, and you don't tell us and give us the correct and complete information; or if there has been a change to any of the answers given to the questions in the application form or any other information provided between the date the answers or information were provided and the date we assume risk on your plan and you don't tell us, it could mean we won't pay a claim. If you tell us about any such changes after the date we assume risk on your plan and those changes would have affected the terms we offered you, we'll amend the terms to take account of the changes.*"

Mrs C and Mr H didn't return their confirmation form to Royal London. So, the policy began with the mistakes on the disclosures relating to COPD and Mr H's history of arterial disease. Though there may be concerns regarding the IFA's behaviour, I've already explained that Royal London isn't linked or affiliated with the IFA. So, it placed reliance on what it was told on the application – and neither Mr H nor Mrs C amended the answers given by the IFA.

Though I recognise Mrs C has a credible and fair explanation for what has gone on, it is nonetheless clear that a misrepresentation took place as relevant information was withheld from Royal London about Mr H's two notable health conditions.

And once that's been established, relevant law on disclosure in consumer insurance contracts says that it should be classed as 'deliberate/reckless' or otherwise as 'careless'. The types of categorisations allow for different types of outcomes.

I consider the categorisation was careless, as defined by the Association of British Insurers ('*ABI*') within its Code of Practice on Misrepresentation and Treating Customers Fairly and the relevant law on consumer misrepresentations. Careless misrepresentation includes anything from an understandable oversight to serious negligence, and I think Mr H's actions

sit within that range of responses. I note that Royal London also reached this same conclusion on categorising the type of misrepresentation.

In the event of careless misrepresentation, an insurer should consider a proportionate remedy. This means the 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 can amend the contract to reflect this. If it could not have offered cover at all, the insurer can void the policy and return the premiums paid by the customer from the outset.

Royal London has provided us with copies of its underwriting information that it would have used in 2019, had it received accurate disclosure of Mr H's health conditions.

For Mr H's COPD, it correctly used the medical evidence of Mr H's annual COPD checks showing his forced expiratory volume ('*FEV*') percentages. He had been recorded as 60% in 2018, 66% in 2017, 64% in 2016 and before that, 65% in 2013. On Royal London's scale this placed Mr H at mild/moderate COPD with a rating of +175. I believe Royal London fairly interpreted Mr H's COPD severity in line with its own guidance.

For the PVD, Royal London said it would have declined life cover because it believed the medical evidence showed Mr H was in the 'severe' stage (stage III) of its PVD classification. This grading is defined as having a "*pain-free walking distance less than 50m*".

I disagree with that interpretation. The most recent evidence from the vascular clinic in August 2018 (the last time Mr H attended an appointment), said that his walking distance was 50m to 100m. This evidence carries the most weight as it was observed by the vascular consultant, and it is the most proximate to the policy application of August 2019.

Royal London has argued that as Mr H could walk 50 -100m he could not have been pain-free beyond 50m, as it infers he experienced pain when walking beyond that distance. But that is not what its underwriting says. The previous severity stage for PVD (stage II-b) is described as "*pain-free walking distance less than 200m*". It does not qualify what distance within 200m ought to be satisfied, rather, that it must be below that distance. Therefore, it ought reasonably to be the case that if a patient can exceed 50m (as that is the constraint of grade III) then grade II-b has been met.

The reasonable interpretation of Royal London's underwriting guidance placed Mr H at stage II-b, which was 'moderate' PVD. That same guidance confirms how, for an applicant in Mr H's age bracket, the rating for moderate PVD was +100.

I therefore agree with our investigator that Mr H could have been offered life insurance, but for a notably increased cost. If Royal London had known about Mr H's medical history and it had been able to underwrite his actual circumstances appropriately by applying a combined rating of +275 on the cost of cover to reflect the additional risk of insuring Mr H with his two noted medical conditions. Mrs C and Mr H could have potentially paid more to receive the same amount of cover – but they did not do so, and so the rating should now be used to reduce the sum assured as a proportionate remedy.

The position set out in the ABI guidance is that the policy's £4,000 sum assured should be reduced proportionately to account for what Mrs C and Mr H's policy premium of £23.29 would have bought them if a +275 rating was applied from the outset. A claim could then be paid to Mrs C for the sum assured (which I will address below).

I also do not believe Royal London should have cancelled the policy altogether – as Mrs C was not given any option to continue with the policy by herself when the claim was refused.

There is no suggestion that Mrs C misrepresented her position. If Royal London wished to contend that Mr H would never have been insured, it did not need to void Mrs C's cover, only Mr H's. I therefore believe compensation is warranted for the upset Mrs C has been caused.

Putting things right

For the reasons set out above, I do not believe Royal London fairly cancelled this policy – it should have reached a conclusion of careless misrepresentation and determined the value of the £4,000 sum assured once the +275 rating had been applied. It ought to have then paid any sum assured to Mrs C on settlement of the death claim for Mr H, if this produced a positive figure upon calculation.

It may be that because Mrs C has since received a premium refund (and neither party has confirmed the amount refunded precisely), that no further redress is due to her; this would apply in circumstances where the refund may exceed the value of the rated sum assured. Without sight of the calculations, I cannot conclude this.

To fairly resolve matters, Royal London must supply a calculation of the cover to Mrs C for the correctly rated sum assured (+275) within 30 days of this decision being accepted, if Mrs C chooses to do so. It must then offset the policy premiums already returned to Mrs C from this calculation. If any outstanding payment is due, it must pay this to Mrs C promptly.

To this sum, Royal London must add 8% interest, payable from the date that the claim should have been settled in October 2021 to the date of payment. If Royal London considers it is legally obliged to deduct income tax from the interest paid, it should issue a tax deduction certificate with the payment. Mrs C may be able to reclaim the tax paid from HM Revenue and Customs, if applicable.

Finally, whether the above retrospective calculation produces financial redress or not, Royal London must also pay Mrs C £300 compensation for its actions when voiding the policy in October 2021. It did not explain to Mrs C why it was cancelling the policy altogether, when the misrepresentation related to Mr H; it contended it could not have insured him, but there was no suggestion or direction that Mrs C had misrepresented or was uninsurable based on any of her medical information. As such, Mrs C lost her cover in addition to her inability to claim. That shouldn't have happened. Royal London contended a claim wasn't payable, in which case it should have allowed Mrs C the opportunity to continue with the policy solely.

This failure to explain the circumstances had an impact on Mrs C by causing her avoidable distress at a particularly difficult time of bereavement. This award is distinct from the redress calculation above, and must be paid to Mrs C without delay, should she accept my decision.

My final decision

I uphold this complaint. The Royal London Mutual Insurance Society Limited should not have cancelled Mrs C and the late Mr H's policy altogether upon receipt of a life assurance claim. Instead, it should have applied a rating to the policy and determined if any proportionate financial remedy was due to Mrs C.

I therefore instruct Royal London to undertake that calculation now - as directed above - and pay any redress to Mrs C with interest, if due. It must also pay her £300 for the unnecessary upset she has been caused as a distinct payment, irrespective of any claim value.

I make no other award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C to accept or

reject my decision before 17 April 2023.

Jo Storey
Ombudsman