DRN-4024732

The complaint

Mr G has made three complaints regarding The Prudential Assurance Company Limited's dealing with his Serious Illness Cover policy.

All references to Prudential include its agents.

What happened

The three complaints concern the decline of a claim and cancellation of his Life Cover and Serious Illness Cover policies, the handling of a subject access request and the service he received. I'll deal with each in turn.

Mr G disputes that he intentionally answered any of the application questions dishonestly when applying for the policies.

Our investigator didn't recommend that the complaint be upheld. Mrs G appealed on behalf of Mr G.

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

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 aware I've summarised the background to this complaint and some sensitive medical details. No discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. If there's something I haven't mentioned, it isn't because I've ignored it. I've fully reviewed the complete file and considered the representations Mr G made via his representative after our investigator's view. I'm satisfied I don't need to comment on every individual argument to be able to reach what I think is the right outcome.

I recognise that Mr G will be very disappointed my decision and I'm sorry it cdoesn't bring more welcome news. But for the following reasons I agree with the conclusion reached by our investigator:

The claim and cancellation

Prudential assessed Mr G's claim for Total and Permanent Disability under his Serious Illness Cover. It felt that Mr G had answered questions it asked during the application process incorrectly. The application was submitted electronically on 3 February 2015. It considered this to be a reckless qualifying misrepresentation, which entitled it to cancel the policy.

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.

Prudential thinks that Mr G failed to take reasonable care when answering some questions on the application form. He was asked: *Have you smoked or used tobacco products in the past 12 months? This includes cigarettes, cigars or pipes and any nicotine replacement therapy.* Mr G answered 'no' to this question. His medical records note on 6 February 2014 *'he was a secret smoker largely due to habit rather than dependence'.*

Mr G was also asked: *Apart from any condition you have already told us about, have you had any of the following in the last 5 years: Raised blood pressure or raised cholesterol, chest pain, palpitations or irregular heartbeat.* Mr G disclosed high blood pressure and medication for this. Mr G says that he did disclose palpitations and I accept that the question is poorly worded – not asking specifically what the positive answer was referring to. It may also be, as he suggests, that he told his financial adviser. But this complaint is against Prudential.

Mr G was asked whether, apart from anything he's already told Prudential about, he'd had anaemia or blood disorders in the last 5 years. He answered 'no' although his medical records show he'd had liver function testing following an elevated liver function test and tests for anaemia following a diagnosis in 2013. I acknowledge Mr G's comment that he didn't know he had anaemia, but I don't find it was unreasonable of Prudential to conclude he should have answered positively in respect of the liver function tests.

Additionally Mr G was asked two further questions that would have given him the opportunity to disclose the blood tests he was undergoing. He was asked whether within the last two years he'd had any medical condition, illness or injury that he had received treatment for over a continuous period of two weeks or more. He was also asked whether in the last two years he had undergone any investigations such as blood test, scan or biopsies. Mr G thought the tests for anaemia were for a virus – but again he didn't mention the blood tests he had been having in answer to either question.

Prudential has shown by underwriting evidence that had these questions been answered 'yes' it wouldn't have offered cover on standard terms. I note that Mr G's representative was given information at the claims stage by claims advisers that she feels are at odds with this. But having made further enquiries, and although I can't share the details due to their commercial sensitivity, I'm satisfied that the underwriting evidence is correct. Accordingly I'm satisfied that the misrepresentation is qualifying. Prudential has said that the misrepresentation was reckless. I have not disregarded the submission on Mr G's behalf that he had not deliberately held back information or answered the questions dishonestly.

I've looked at the all the questions Mr G was asked and taken into account the Association of British Insurers Code of Practice. Lifestyle questions, which are familiar and easier for customers to understand, and Mr G's ongoing tests in particular. I don't find it was

unreasonable for Prudential to conclude that he must have known the information given was both incorrect and relevant to the insurer, or that he acted without any care as to whether it was relevant or not. In the circumstances I don't find that Prudential's classification as 'reckless' was unfair. It follows that Prudential was entitled to cancel all Mr G's policies and retain the premiums – that is in line with the legislation. However I note that premiums were returned, which I find was reasonable.

For completeness I note the submissions made about the 'mood exclusion' that Prudential says it would have added had the relevant question been answered correctly. This has been challenged on behalf of Mr G and a medical report submitted. I don't need to make a finding in this regard. This is because the qualifying misrepresentations referred to above alone were sufficient for Prudential to show it would only have entered the contract on different terms.

Subject access request

Mr G has complained via Mrs G that a subject access request was not responded to within the time limit set by the statutory regulations. As our investigator explained it is not for this service to determine whether there has been a regulatory breach – that is the role of the Information Commissioner's Office. I don't find it was unreasonable for Prudential to require the request to come from Mr G rather than Mrs G, as it concerned his personal data. Neither do I find it was unreasonable for Prudential to answer Mr G's appeal when it was in a position to do so. It wasn't obliged to wait for further submissions.

Service

Mr G, via Mrs G, complained that Prudential didn't take reasonable care when assessing Mr G's claim. She would like Prudential to be 'held to account'. This service doesn't regulate or punish insurers, rather we consider if there has been any error or omissions and look at the effect his has had on the consumer. I note that the claim process was slow, but I'm satisfied that it was necessary to request medical records and make full enquiries. Overall, I don't find that the process was delayed unnecessarily, although I do accept that waiting for a response would have been distressing for Mr G and his family. It is most unfortunate that Mrs G heard an uncourteous response on one occasion when she called, but I'm considering the complaint by Mr G who is the eligible complainant – rather than Mrs G as his representative.

The relevant rules and industry guidelines say that Prudential had a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. I don't find there is evidence to show that these rules or guidelines were breached or that Prudential treated Mr G unfair or contrary to his policy terms.

My final decision

For the reasons given my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 12 October 2023.

Lindsey Woloski
Ombudsman