DRN-4338736

The complaint

Miss H is unhappy that Legal and General Assurance Society Limited has declined a claim she made on her critical illness insurance policy.

What happened

Miss H applied for a critical illness policy in 2014. During the application process she was asked questions about her medical history. In 2022 Miss H was diagnosed with breast cancer and claimed on the policy.

The claim was declined because Legal and General said that Miss H hadn't answered the medical questions correctly when she applied for the policy. They said she hadn't disclosed a lump on her breast which had been investigated in 2012 and, if that had been disclosed, they would have applied an exclusion to the policy for breast cancer. They redrew the policy to reflect this.

Miss H complained but Legal and General maintained their decision to decline the claim and apply an exclusion was fair. They issued a number of final response letters. £350 compensation was offered for delays and a lack of call backs in November 2022. A further final response was issued in December 2022 offering £300 for other errors and claims handling issues. Unhappy, Miss H complained to the Financial Ombudsman Service.

Our investigator looked into what happened. She thought Legal and General had acted fairly, bearing in mind the relevant legislation and that the compensation offered was fair.

She highlighted that any concerns about the sale of the policy would need to be addressed with the seller of the policy. Miss H didn't agree and asked an ombudsman to review her complaint. She raised several additional points, but these didn't change the investigator's thoughts about the outcome of the complaint.

I asked our investigator to clarify the amount of compensation which was offered. Legal and General confirmed it was offering a total of £650 compensation

In August 2023 I issued a provisional decision. I said:

> 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 the circumstances surrounding Miss H's claim. Understandably, it is an upsetting and difficult time for Miss H and her family. And, I can understand and empathise with the disappointment and frustration they feel about the claim being declined when they were dealing with the impact of Miss H's diagnosis and treatment.
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> At the outset I acknowledge I've summarised this complaint in far less detail than the parties have, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are

the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to reach what I think is a fair and reasonable outcome in the circumstances of this case.

I also want to make it clear that my decision focuses on whether Legal and General have acted fairly. I can't comment, as part of this complaint, on the seller of the policy. Miss H has raised concerns about the way in which information was gathered and the documentation she had sight of during the sale. Those are issues which would need to be addressed with the business responsible for the sale of the policy.

The decision to decline the claim and add an exclusion

The relevant rules and industry guidelines say that Legal and General have a responsibility to handle claims promptly and fairly. And, they shouldn't reject a claim unreasonably.

Legal and General say that Miss H didn't answer the questions in the application correctly. This means the law set out in the Consumer Insurance (Disclosures and Representations) Act 2012 ("CIDRA") is also relevant and I think it's fair and reasonable to apply these principles to the circumstances of this case. I've also taken into account the relevant Code of Practice issued by the Association of British Insurers.

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.

A qualifying misrepresentation is when a consumer fails to take reasonable care not to misrepresent facts which an insurer has asked about. The standard of care required is that of a reasonable consumer. One of the factors to be considered when deciding whether a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

In the application the questionnaire asked:

> When answering the following questions if you're unsure whether to tell us about a medical condition please tell us anyway.
>
> 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 a growth, lump, polyp or tumour of any kind?

I think the question was adequately clear and specific. The answer recorded on the form is 'No'. Legal and General say Miss H ought to have answered 'yes' to that question because she ought to have disclosed her medical appointments relating to a breast lump. I think the answer to that question should have been 'yes' because Miss H had been investigated for a breast lump within the time frame set out in the question.

Legal and General has provided evidence which shows that if Miss H had answered 'yes' to that question they'd have applied an exclusion for breast cancer. This means I'm satisfied Miss H's misrepresentation was a qualifying one.

Legal and General has said Miss H's misrepresentation was careless, not deliberate or reckless. I agree it was a careless misrepresentation because I don't think Miss H was trying to mislead or deceive Legal and General. I appreciate that she's said there were lots of questions, but she still needed to make sure the answers were correct and accurately reflected her medical history.

As I'm satisfied the misrepresentation should be treated as 'careless' I've looked at the actions Legal and General can take in accordance with CIDRA. This says that they can add the exclusion to the policy from the point of misrepresentation and then assess any claim in line with this additional exclusion. That's what Legal and General have done.

I've taken into account Miss H's representations about the Confirming Your Details form (CYD). The declaration says:

> 'By signing and dating the form you declare that to the best of your knowledge and belief the information provided on your application and, where necessary, on this form is true and complete. You agree the answers provided form part of the legal relationship between you and us. Please sign even if the details are incorrect or if your policy has started'.

Miss H says, in summary, there was an instruction to sign even if the details are incorrect or if your policy has started. The representations about the declaration haven't changed my thoughts about the outcome of the complaint. The form also says:

> If the answers on your application are not correct, are incomplete, or are out of date it may mean that a claim will be declined and the policy or policies cancelled. In the event of a claim we may request a report from your doctor to support your application answers. Please tell us straight away if you need to change any of your answers before your policy starts. Please read the 'personal details' document carefully'.

But there is also a question which asks, 'Have we got your details right?'. 'Yes' is selected.

And there are sections on the form which say:

> 'Please make changes to any of your health details here'
>
> 'If you need to tell us about another medical condition please provide the following details….'
>
> 'Please make any changes to any other answers here'.

Miss H confirmed that her details were rights and signed the form. I think the instruction to sign if the details are incorrect or the policy has started needs to be read in the context of the other information on the form. I think the instruction to sign if the details weren't correct applied where further information had to be provided.

In Miss H's case this was an opportunity to select 'no' and give more information about her health in 2012 that wasn't captured in the application form. I don't agree that the form encouraged her to sign when there was incorrect information in the way she's suggested. I think it was an opportunity to review the medical information, check it was right and complete the sections of the form, before signing it. The section she's highlighted was, I think, intended to address situations where the details weren't correct, and more information had to be provided. As I outlined above if Miss H has concerns about the sale of the policy, they'll need to be addressed with the business responsible.

Taking all of this into account I think it is fair and reasonable for Legal and General to add the exclusion and decline the claim because it relates to breast cancer.

The redrawn policy and payments

I don't think it was unreasonable for Legal and General to redraw the policy. They've explained that their systems don't allow them to amend a policy. So, the existing policy had to be cancelled and a new one issued to reflect the updated terms. But, effectively it was the same policy, with the exclusion added. I think that's a reasonable explanation. It's not uncommon for insurers to have to take such action particularly where the policy has been in force for some time.

There has been no break in cover and this was a practical way to ensure Miss H's policy reflected the outcome of the claim investigation. I'm not persuaded Miss H has experienced any detriment as a result of Legal and General having to take this action. I've not seen evidence to suggest that the terms of the policy are more financially advantageous to Legal and General. If Miss H believes that to be the case, she's entitled to ask Legal and General for an updated copy of her policy terms and complain to them if she's unhappy with any changes she identifies.

Miss H doesn't think it was right that Legal and General continued to take premiums following the changes I've outlined above. I don't think that was unreasonable in the circumstances of this particular case, given the circumstances which led to the changes to the policy. And, in any event, there's no compelling evidence which confirms Miss H's assertion that she's paying for a fundamentally different product to the one she took out, other than the presence of the exclusion due to the qualifying misrepresentation.

Refund of premiums

I don't think it's fair and reasonable to direct Legal and General to refund the premiums.

Even if I accepted that Miss H was told she'd receive a refund I don't think that leads to a fair outcome in the circumstances of this case. That's because, as I've outlined above, Legal and General have applied the appropriate remedy in line with CIDRA.

In any event, Miss H has also had the benefit of cover since the policy was taken out. Legal and General have carried the risk of her making a claim. That includes the risk of making a claim for lots of other conditions which would have been covered by the

policy.

Unfortunately, she's unable to claim for this particular condition but she's still had the benefit of cover.

Customer service

In their final response letters Legal and General have acknowledged that there were issues with the customer service Miss H received. That includes delays, lack of call backs and other errors made.

Legal and General has offered a total of £650 compensation in two of their final response letters. I think that fairly reflects the distress and inconvenience caused.

Putting things right

Legal and General has already made an offer to pay £650 to settle the complaint and I think this offer is fair in all the circumstances.

So, my provisional decision is that Legal and General should pay Miss H £650.

Miss H responded to my provisional decision. She said that she fundamentally disagreed with the interpretation of events but accepted the conclusions. In summary, she said the policy wasn't redrawn, it was cancelled. She didn't want a brand-new policy from Legal and General and told them they didn't have permission to take the money. Miss H doubted the legality of this.

Miss H also highlighted that she'd spent 15 months of precious time trying to achieve a fair outcome in this case and the devastating impact that Legal and General's actions had on her family. She also raised concerns about whether Legal and General would make payment.

Legal and General confirmed that they had no further comments to add.

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.

Miss H accepted my findings but did make some further comments. So, I've taken into account the further points she's made.

I remain persuaded that the way in which Legal and General handled the redrawing of the policy was reasonable and that they've provided a reasonable explanation for what happened when the policy was redrawn.

As I explained in my provisional decision Legal and General explained that their systems don't allow them to amend a policy. So, the existing policy had to be cancelled and a new one issued to reflect the updated terms. But effectively it was the same policy, with the exclusion added. I can understand Miss H's frustrations on this point, but I remain persuaded this was reasonable in the circumstances of this case.

When reaching a decision about the compensation to award I have taken into account everything that Miss H has said about the impact of dealing with this issue throughout her diagnosis and treatment. I don't doubt what she's told me about the devastating impact on both her and her family. I'm very sorry to disappoint Miss H and her family after everything they've been through over the last year and a half but I do think the £650 compensation is fair for the reasons I explained in my provisional decision.

Miss H expressed concern that Legal and General won't pay the compensation. Legal and General are expected to make payment within 28 days of the Financial Ombudsman Service confirming that the decision is accepted by Miss H. If the final decision is accepted by Miss H and she doesn't receive payment she can get in touch with our investigator and, ultimately, can enforce the decision in court.

Putting things right

Legal and General should pay Miss H £650 compensation.

My final decision

Legal and General Assurance Society Limited has already made an offer to pay £650 to settle the complaint and I think this offer is fair in all the circumstances.

So, my decision is that Legal and General Assurance Society Limited should pay Miss H £650.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss H to accept or reject my decision before 9 October 2023.

Anna Wilshaw
Ombudsman