DRN-4668549

The complaint

Miss H, as trustee, complains that Legal and General Assurance Society Limited avoided her father's life insurance policy and refused to pay a claim.

What happened

The background to this complaint is well known to the parties, so I won't repeat it in detail here. In brief summary, Mr H applied for cover in April 2018. Very sadly, Mr H died in December 2021.

Miss H subsequently claimed on her father's policy, but L&G declined the claim, saying Mr H hadn't given full and accurate information during the application process.

L&G considered this to be a qualifying misrepresentation. It said that, had Mr H answered correctly, it would not have offered cover at all. So L&G refused to pay the claim, cancelled the policy and refunded the premiums paid.

Miss H complained but L&G maintained its stance, so Miss H brought the complaint to the Financial Ombudsman Service, saying her father had answered the application questions correctly. But our investigator didn't uphold the complaint, so Miss H asked for an ombudsman to review everything and issue a final decision.

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.

Having done so, I'm not upholding this complaint. I know this will be disappointing news for Miss H and I'm sorry about that. I'll explain my reasons, focusing on the points and evidence I think is material to the outcome of the complaint. So if I don't mention something specifically, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

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.

When applying for the policy, L&G said Mr H failed to take reasonable care not to make a misrepresentation when he answered no to the following questions:

> *Have you ever been told by a health professional that you should reduce the amount of alcohol you have because you were drinking too much?*
>
> *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 raised blood pressure, raised cholesterol or condition affecting blood or blood vessels, for example anaemia, excess sugar in the blood, blood clot, deep vein thrombosis?*
>
> *Apart from anything you've already told us about in this application, do you have any medical condition or symptom that your doctor or nurse told you to see them about during the next 3 weeks?*

L&G relied on entries in Mr H's GP record which it said indicated he should've answered the questions positively. I've reviewed the medical evidence provided.

I'm aware Miss H has referred to a bereavement claim medical information report, completed by Mr H's GP in April 2022. In response to a question about concerns regarding the patient's alcohol intake, history or misuse or any advice/referral in respect of alcohol, it refers to a consultation in September 2019, notably *after* Mr H took out the policy. Miss H argues that this supports her assertion that her father answered the alcohol question correctly. However, the report also notes that the details of all consultations that refer to alcohol are attached. And it's these extracts from the GP record which pre-date the application for the policy that are central to this complaint.

In April 2018, the day before he applied for the policy, Mr H saw his GP for abdominal pain. On examination is blood pressure was noted to be 174/90 mmHG. The record states, *'as bp up needs rechecked 2 weeks.'* The entry also comments, *'patient advised about alcohol'* and Mr H's alcohol consumption is recorded as 40 units per week.

Two further entries make reference to advice about alcohol. In July 2012, Mr H's alcohol consumption is noted as 60 units per week and the entry records, *'lifestyle advice regarding alcohol.'* In May 2011, alcohol consumption is noted as 30 units per week and the entry records, *'patient advised about alcohol.'*

I acknowledge Miss H's view that the GP records don't specifically state that Mr H was advised to reduce his drinking. But on balance, I'm satisfied the records demonstrate such advice was given, noting that all of the recorded consumption levels are above recommended health guidance, and that the 2012 record refers to a discussion with Mr H about *'high MCV, likely alcohol related and recent prolonged binge [abroad].'*

I accept there's some ambiguity regarding the raised blood pressure question, as Mr H was, in April 2018, seeing his GP for abdominal pain. However, during that consultation his blood pressure was taken and was noted to be raised (*'bp up'*). He was told to return in two weeks for a recheck.

So I think, when Mr H applied for the policy, he should've answered yes to the alcohol question and the question regarding a symptom he'd been told to see a doctor or nurse about. I acknowledge Miss H's reliance on the bereavement claim medical information

report, where the GP has ticked *no* in relation to the question, *'has your patient suffered any related or linked conditions?'* I accept Mr H was not diagnosed with raised or high blood pressure. Rather, his blood pressure was raised and he was asked to return for rechecking. But on balance, I don't think L&G acted unfairly in concluding that the blood pressure reading and 'bp up' note was a symptom about which Mr H had been told to see his doctor or nurse.

Mr H was responsible for answering questions accurately. He was sent a copy of his personal details and asked to check it carefully and let L&G know if any answers needed changing. The cover letter also refers to the potential consequences of not providing correct and complete information. I've seen that Mr H signed a declaration confirming that to the best of his knowledge and belief the information provided on his application was true and complete. I think L&G's questions are clear. So I'm satisfied Mr H failed to take reasonable care when taking out the policy.

L&G has provided information about its underwriting criteria to show what would have happened, had Mr H answered the questions accurately. This shows that full medical disclosure would've made a difference to L&G's underwriting decision, so I'm satisfied Mr H's misrepresentation was a qualifying one. In relation to the blood pressure reading of April 2018, L&G would've charged a higher premium for the policy. But in relation to alcohol, had Mr H disclosed fully, he would not have been offered cover at all.

In its final response letter, L&G didn't specify whether it considered Mr H's misrepresentation to be careless, or deliberate or reckless, saying the outcome would be the same for either category. CIDRA sets out the actions an insurer can take in cases of misrepresentation. As no cover would've been offered at all, L&G was entitled to cancel the policy. However, it's refunded the premiums paid. The action L&G's taken is in line with CIDRA, so I think it's acted fairly. Given this, I don't think L&G needs to do anything more in respect of this complaint.

My final decision

For the reasons given above, my final decision is that I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss H as trustee of the I H Trust to accept or reject my decision before 18 April 2024.

Jo Chilvers
Ombudsman