DRN-4695074

The complaint

Miss W complains that Scottish Equitable Plc, trading as Aegon, unfairly declined an insurance claim she made and cancelled all her cover.

What happened

The history of events is well known to the parties, so I won't repeat the detail here. In brief summary, Miss W applied for critical illness family income benefit with Aegon in 2017. This policy included total and permanent disability (TPD) benefit and waiver of premium (WP) benefit. In 2019 Miss W also applied for life cover. Both policies were bought via independent financial advisors.

Unfortunately, in July 2023, following deteriorating health, Miss W made a claim for TPD and WP benefits. But in January 2024, Aegon declined the claim. It said Miss W hadn't accurately answered questions asked during the application process about her health. It considered this to be a deliberate or reckless qualifying misrepresentation and said that, had it been aware of Miss W's full medical history at the time of application, it would not have offered cover.

In light of this decision, Aegon reviewed Miss W's life insurance policy. And it said that had full disclosure been made, it wouldn't have offered cover when Miss W applied in 2019.

Given this, Aegon cancelled Miss W's policies and declined her claim. However, it said it would refund the premiums Miss W had paid towards the policies.

Miss W complained, but Aegon maintained its position. So she brought the complaint to the Financial Ombudsman Service. Our investigator didn't think it should be upheld. She agreed there'd been a qualifying misrepresentation and was satisfied Aegon had shown that, had Miss W fully disclosed, it wouldn't have offered cover at all. She thought Aegon had acted fairly in avoiding Miss W's policies but saying it would refund the premiums paid.

Miss W didn't accept the investigator's view. Amongst other things, she said the questions were ambiguous. She maintained she'd taken reasonable care when completing the application forms.

Miss W requested an ombudsman's decision, so her complaint has come to me for 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 carefully reviewed everything, I'm not upholding this complaint. I know this will be very unwelcome news for Miss W. So I'd like to explain my reasoning, focusing on the points and evidence I consider material to my decision. If I don't refer to a particular point or piece

of evidence, it's not because I haven't thought about it. Rather, I don't consider it changes the outcome of the complaint.

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.

Aegon says Miss W failed to take reasonable care not to make a misrepresentation when she answered '*no*' to the following questions on her application form:

> *'Do you now have, or have you ever had, any of the following:*
>
> > *'Chest pain, palpitations, heart murmur or any disease or abnormality of your heart, pulse, veins or arteries?'*
>
> *'Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for any of the following:*
>
> > *'Numbness, tingling, tremor, temporary loss of muscle power, or loss of balance or co-ordination?*
> >
> > *'Anxiety, depression, stress, fatigue or any form of nervous or mental disorder, including work-related stress?*
> >
> > *'Do you have any other information to give us about any medical investigation, test or consultation, advice, counselling, operation, medication or treatment that you've had or been advised to have or are currently having, but haven't already told us about?'*

As well as the questions above, in relation to Miss W's 2019 policy, Aegon also said Miss W had failed to answer correctly this additional question from the 'last five years' section:

> *'Any arthritis, gout, joint or muscle problems, including the knee(s), shoulder(s), neck, back or spine?'*

Miss W's medical records show a substantial history of health issues over many years, detailing numerous complaints and symptoms. The records are extensive. I'll highlight some key entries here.

I can see that Miss W was referred to cardiology in September 2015, for investigation regarding waking each night with palpitations since March 2014. Miss W underwent a number of investigations, including blood tests, thyroid function test, echocardiogram, exercises ECG and 24 hour Holter monitor. In a post-clinic letter from the cardiology department to Miss W's GP, dated November 2015, Dr C noted a history of *'troublesome*

intermittent palpitations' and reported that Miss W's heart was '*structurally normal'* with '*no evidence of any arrhythmia.'* Dr C commented that there was *'no correlation between symptoms and any arrhythmias.'* Miss W was discharged from the clinic, but Dr C suggested that if symptoms continued to be especially bothersome, a longer period of monitoring could be considered.

Miss W's GP records show that between 2012 and 2019 there were multiple consultations about symptoms of tiredness and fatigue, left-sided weakness, poor balance, headaches, dizziness and joint pains, leading to various investigations and interventions. Miss W had diagnoses of chronic fatigue syndrome and hemiplegic migraine.

Two days before Miss W applied for her policy in 2017, she attended a clinic appointment with consultant neurologist Dr W. In reporting back to her GP afterwards, Dr W said:

> *'In the last few years, she has had attacks with left-sided weakness and has been admitted. She now has an almost constant feeling of weakness of the left side and on top of this two or three times a week she comes [sic] more unwell with photophobia, phonophobia, vertigo, nausea, worsening weakness and a headache that can occur anywhere on her head.'*

Dr W said Miss W's history was consistent with sporadic hemiplegic migraine. He proposed new medication and said he would review Miss W in three months.

In September 2018, Miss W saw her GP to request a neuro-physiotherapy referral as she was suffering with left-sided weakness due to her migraine attacks and lower back pain with left-sided radiating pain. Investigation took place and she was subsequently diagnosed with scoliosis.

I've considered whether Miss W took reasonable care to answer Aegon's questions correctly. Miss W says the questions were ambiguous and she understood Aegon would obtain her medical records. The application form emphasises the importance of answering the questions fully and accurately. It also says, '*you must not assume we'll write to your doctor,'* and warns that cover may be cancelled and a claim not paid if there is missing information. It was Miss W's responsibility to tell Aegon about her health circumstances. I'm satisfied the questions were clear and, consequently, that Miss W failed to take reasonable care when applying for cover.

I now need to consider whether the misrepresentation was a qualifying one under CIDRA, that is, would Aegon have come to a different decision about cover had it been given correct information.

Aegon has provided evidence from its underwriting guidance. This shows that, had Miss W declared her symptoms, most notably, her diagnoses of chronic fatigue syndrome and hemiplegic migraines, Aegon would have sought further information from her GP. Upon receipt of full information, it would not have offered any cover at all for either of Miss W's policies. So I'm satisfied Miss W's misrepresentation was a qualifying one.

Aegon considered the misrepresentation to be deliberate or reckless, meaning the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. Aegon said that, based on Miss W's medical history, it was difficult to see how the information had been overlooked. I agree it's difficult to reconcile Miss W's longstanding and complex health difficulties with the lack of any disclosure. So I think this was a fair assessment.

CIDRA sets out the actions an insurer can take where a misrepresentation is deliberate or reckless. This categorisation would entitle Aegon to avoid Miss W's policies, decline to pay her claim, and retain any premiums paid. However, Aegon has said it will refund Miss W the money she's paid in premiums. I think this is reasonable as it's more than is required under CIDRA.

Miss W hasn't accepted the premium refund, preferring to wait until the outcome of her complaint to this service. Her complaint is now at an end, so Aegon should refund her the premiums paid.

My final decision

For the reasons set out above, Scottish Equitable Plc, trading as Aegon, should now refund Miss W the premiums she paid towards her policies.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss W to accept or reject my decision before 10 May 2024.

Jo Chilvers
Ombudsman