DRN-4717174

The complaint

Mr R has complained that AIG Life Limited declined a claim under a joint life term assurance policy. He has also complained about the service he received.

What happened

The background to this complaint is well known to the parties so I won't set it out in detail here. In summary Mr and Mrs H took out a term assurance policy in March 2014. It would pay a lump sum if one of the policy owners died. Tragically Mrs H passed away in 2022 and Mr H made a claim under the policy.

AIG didn't meet the claim – it said that had Mrs H answered the medical questions correctly at the application stage it wouldn't have offered her a policy. It refunded the premiums paid and offered Mr H £100 for the poor service he had experienced.

Our investigator didn't recommend that the complaint be upheld. They didn't find that AIG had done anything wrong. Mr H appealed.

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 file and considered the representations Mr H made after our investigator's assessment. I'm very sorry to read of the circumstances that led to this claim. However I agree with the conclusion reached by our investigator. I'll explain why.

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.

AIG declined Mr H's claim because it felt that Mrs H had failed to take reasonable care not to

make a representation when the policy was taken out.

I've looked at the questions she was asked, for completeness I'll set the relevant questions out again here:

Q - Have you received or been advised to have any medical investigations, scans or blood tests in the last 5 years?

(You do not need to tell us about common colds, contraception prescriptions, cold sores, ear syringing, haemorrhoids, hayfever, holiday jabs, ingrowing toenails, influenza, tonsillitis, wisdom teeth or regular well-man/woman checks where the results were all normal. You also do not need to tell us about normal pregnancies and childbirth, but must let us know about pregnancies with complications including but not limited to high blood pressure and sugar and/or protein in your urine.)

Mr H says, and I accept, that Mrs H's condition didn't affect her quality of life or ability to live it to the full. She was able to travel and was holding down a full-time job. Nevertheless her medical records show that this question should have been answered positively. She had received regular reviews, tests, and investigations, including blood tests and MRI and EEG scans in the 5 years before the policy was taken out.

Q - Have you been referred to, or been to see, any medical practitioner other than your GP in the last 5 years?

(Examples can include but are not limited to all visits to a hospital doctor, consultant, psychiatrist, therapist or other visit to a clinic or Accident and Emergency.)

Mr H says that although Mrs H had been under the care of the neurologist team for over 10 years, she hadn't been referred to a *new* consultant in the last five years. He feels that the question was ambiguous for Mrs H. I do understand the point Mr H makes about Mrs H's honesty, but I struggle to see that the question could be interpreted as referring to only new referrals. In any event I note that Mrs H had been referred to a neuropsychiatrist only months before the policy commenced.

Mrs H was also asked:

Q - Are you under routine medical review or awaiting a consultation with a specialist for any medical condition?

(Examples can include but are not limited to all expected visits to your GP, a hospital doctor, consultant, psychiatrist, therapist or other visit to a clinic.)

The medical evidence shows Mrs H was under routine medical review for her condition.

I haven't disregarded Mr H's contention that the questions aren't clear – but I'm afraid I don't agree. Additionally, I've seen nothing to indicate that Mrs H wouldn't have understood the questions being asked when completing the form. It follows that I find that AIG's conclusion that Mrs H should have answered the questions positively was fair.

I've seen underwriting evidence that AIG has shared which shows that had the questions been answered correctly it would have asked further questions. I'm afraid I can't share the commercially sensitive information, but I'm satisfied from this evidence that having considered the details of Mrs H's condition and the frequency of her attacks, AIG wouldn't have offered her cover. This means I'm satisfied that the misrepresentation was a qualifying one under the relevant law.

AIG has refunded the premium paid for the policy. Avoiding the policy and refunding premiums accords with the remedy available to AIG under CIDRA for careless misrepresentation, where no policy would have been offered. As CIDRA reflects our longstanding approach in misrepresentation cases I don't find that AIG treated Mr H unfairly or unreasonably in the circumstances here. It follows that there is no basis for me to require AIG to reinstate the policy and pay Mr H's claim. I'm very sorry that the decision doesn't bring Mr H more welcome news.

Mr H has also complained about the service he received. AIG has conceded that whilst if was waiting for information from Mrs H's surgery, it failed to update Mr H as to what was happening. I agree that AIG should still have kept Mr H in the loop, even if just to say it was awaiting information. By not doing so, Mr H was caused unnecessary stress and inconvenience. I'm pleased to note that AIG has apologised and offered £100 by way of compensation. I find that sum is fair in all the circumstances. I don't require AIG to make any further payment.

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 H to accept or reject my decision before 10 May 2024.

Lindsey Woloski
Ombudsman