DRN-4734585

The complaint

Mrs W complains that Legal and General Assurance Society Limited avoided her life and critical illness insurance policies 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, in December 2019, Mrs W contacted L&G to update her protection arrangements, in connection with moving house. She took out two new policies. Very sadly, in December 2022, Mrs W was diagnosed with bowel cancer.

Mrs W subsequently claimed on her critical illness policy, but L&G declined the claim, saying she hadn't given full and accurate information during the application process.

L&G considered this to be a qualifying misrepresentation. It said that, had Mrs W answered correctly, it would have postponed offering cover for at least six months, pending results of a follow-up test for a previously identified health concern. For understandable reasons, Mrs W didn't have a follow-up test until September 2021. But in any event, as the initial postponement was for more than three months, L&G would've required Mrs W to reapply, so treated the original application as an automatic decline. L&G refused to pay the claim, cancelled the policies and refunded the premiums paid.

Mrs W complained, but L&G maintained its stance, so Mrs W brought the complaint to the Financial Ombudsman Service. She said she didn't answer the application questions in a deceitful manner and that it was human error at a time when she was stressed with her house move. But our investigator didn't uphold the complaint, so Mrs W 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 and unwelcome news for Mrs W and I'm very 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 Mrs W failed to take reasonable care not to make a misrepresentation when she answered no to the following questions:

> *'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:*
>
> > *'any gynaecological condition for which you've not yet been discharged from follow up, or a cervical smear requiring further investigations?*
> >
> > *'Please ignore routine cervical smears if the results have been normal.'*
>
> *'Apart from anything you've already told us about in this application, during the last 12 months have you:*
>
> > *'been referred to or had any investigations in hospital, for example, biopsy, scan, ECG?*
> >
> > *'Please ignore investigations related to pregnancy or infertility where the results have been confirmed as normal.'*

L&G relied on entries in Mrs W's medical record which indicated she should've answered these questions positively. It's standard practice for an insurer to obtain medical evidence when a claim is made and from what I've seen, I think L&G acted fairly in making these enquiries.

I've reviewed the medical evidence provided. I can see that in September 2019, Mrs W was recalled following an abnormal smear test. She attended a colposcopy clinic in October 2019, the result of which confirmed the presence of abnormal cells. Mrs W was diagnosed with CIN 3. In November 2019, she attended for a loop biopsy to remove the abnormal cells.

I've also seen a follow-up letter sent to Mrs W in December 2019, confirming her previous diagnosis and explaining that it's not expected she'll need any further treatment but it is important that she attends her GP for a further smear test in six months. I've noted Mrs W says she moved house the day after the letter was sent and doesn't recall receiving it.

I've also listened carefully to the call recordings Mrs W sent us. In the main sales call, I've heard that the questions were asked as set out on the application form. I acknowledge the sales representative groups some conditions and symptoms together. But he also tells Mrs W at the outset that he'll read through the health questions and if anything applies, she should stop him straight away. Mrs W confirms that's ok. The representative also tells Mrs W if she's unsure about whether to tell him about a medical condition, she should tell him anyway. And he pauses regularly and gives Mrs W opportunities to confirm her answers.

I appreciate Mrs W says she didn't review her documents on the day of the sale. During the sales call, the representative explains to Mrs W that she can log into her online account to

check her application and make any amendments necessary. And towards the end of the call, the representative reminds Mrs W to keep an eye out for the email to log in online and check all her policy documents. I think it was made clear to her how she could check her documents and review her answers. And ultimately, Mrs W was responsible for answering questions accurately.

I'm satisfied the questions asked were clear and unambiguous. And that when Mrs W applied for the policy, she should've disclosed her recent abnormal smear test and subsequent hospital investigations and biopsies. So I'm satisfied Mrs W 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 Mrs W answered the questions accurately. It would've postponed offering cover for at least six months. This shows that full medical disclosure would've made a difference to L&G's underwriting decision, so I'm satisfied Mrs W's misrepresentation was a qualifying one.

L&G considered Mrs W's 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. In view of the proximity of Mrs W's abnormal smear test and hospital attendance to her taking out cover, I think this was a fair categorisation.

CIDRA sets out the actions an insurer can take in cases of misrepresentation. In the circumstances of Mrs W's misrepresentation, where no cover would've been offered at all, L&G was entitled to cancel the policy and keep the premiums. However, I'm aware it has refunded Mrs W the premiums she paid. The action L&G's taken is more than is required under CIDRA, so I think L&G has acted fairly here. 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 Mrs W to accept or reject my decision before 22 May 2024.

Jo Chilvers
Ombudsman