DRN-4753313

The complaint

Mr A complains that Legal and General Assurance Society Limited ('*L&G*') unfairly cancelled his term assurance policy, which he took out in May 2023 to replace an existing policy.

To resolve his complaint, Mr A wants L&G to reinstate the new policy and pay him appropriate compensation for the upset he has suffered.

What happened

Mr A took out his first policy on 25 October 2021. It offered £80,000 of life assurance for a 44-year term. In May 2023, he sought a new policy with L&G as he wished to increase the sum assured to £250,000 for the remaining 42-year term.

The policy was accepted on 23 May 2023. As Mr A had told L&G on his application that the second policy was replacement cover, it cancelled the first policy as requested.

As part of the policy application, L&G sought a GP report. It received this back from Mr A's GP on 6 July 2023. Based on the content of the report, it cancelled Mr A's policy. In a letter of 10 July 2023, L&G explained that if Mr A had disclosed his alcohol consumption and liver function testing at a hospital Accident and Emergency ('*A&E*') department in November 2021, it could not have offered to insure him. It therefore cancelled the policy and returned Mr A's premiums to him.

Mr A complained. He spoke with L&G by telephone on 17 July 2023 to confirm that he disputed the content of the medical record. However, in a letter of 9 August 2023, it rejected the complaint. It explained that its underwriting guidance showed it couldn't offer cover to an applicant with Mr A's recorded medical history relating to alcohol use and liver function testing.

L&G noted Mr A had said the GP record was disputed – so it wrote to the GP again about that on 18 July 2023 and again on 9 August 2023. However, the GP did not reply further.

Mr A therefore brought the complaint to this service. An investigator reviewed the complaint, but he did not think it ought to succeed. He noted that Mr A disputed the content in his GP record relating to his liver function and alcohol intake. However, the GP had not amended the record and the investigator did not think L&G had been unreasonable in relying upon it.

Since the content of Mr A's medical records affected answers given on both applications for insurance, the investigator believed L&G had behaved fairly in the circumstances by cancelling the 2023 policy. He therefore did not believe it should do anything further to resolve the complaint.

Mr A disagreed with the investigator. He made further written submissions which he said comprised four points:

1. L&G took two weeks to check the application then breached the contractual agreement to insure him in 2023. He had only applied for further cover as he needed to increase the sum assured.
2. He didn't incorrectly answer all questions on his applications – for example, he declared having been hospitalised overseas with hepatitis many year prior.
3. He only attended the hospital in relation to Covid 19 symptoms in November 2021 – it was nothing to do with his liver or alcohol use. He feels that L&G is allowing the fact that English is not his first language against him, as the conversation would likely have been incorrectly relayed into his GP records.
4. L&G told our investigator that Mr A accepted on a telephone call that he needed to reduce his daily beer consumption from two to one per day – but this did not happen. His view is that these matters have been fabricated. There is no evidence of any abnormal liver function test on his medical records at all. He works over 60 hours per week and is fit and healthy.

Mr A said that our investigator had relied unfairly on L&G's evidence and reached an incorrect decision. He therefore wanted his complaint to be passed to an ombudsman.

Mr A then made some further comments via email. In these comments he reiterated that there was no clear evidence of abnormal liver function such that L&G could refuse to insure him now – and he deemed its actions breach of contract. He also queried the return of premiums as these had only been provided from the first policy.

Our investigator reviewed the additional points but was not willing to change his view on the complaint. He said, in summary:

- L&G was reasonably entitled to seek a medical report for the 2023 application, and its terms allowed it to do so.
- Mr A had answered a question in the 2023 application negatively, and he should have answered differently given the content of his GP records.
- He remained of the view that L&G was entitled to place reliance on the GP record and he saw no reason why it ought to disregard the content.
- He understands there is no record of failed or abnormal liver function testing but this doesn't mean L&G has to disregard the November 2021 entry in Mr A's medical records.

Mr A asked for the complaint to be passed to an ombudsman. In a further series of emails he made additional comments, noting:

- The doctors in A&E told him that the liver results were a little bit high but within a 'normal' range.
- People that have hepatitis in their past can suffer liver damage – but L&G has ignored this.
- He remains steadfast in his view that his GP record is simply a copied entry that has not been verified.
- He feels this service ought to supply evidence that he has an abnormal liver function.
- He also doesn't understand how L&G can rely on evidence if there aren't blood test results.
- If he had an abnormal liver, he would be in receipt of medication.

L&G had no other comments to make. The complaint has now been referred to me.

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 realise Mr A feels very strongly about this matter, and I'm sorry that my decision won't be what he has hoped for. However, for the reasons I'll set out below, I do not believe L&G has acted unfairly in cancelling the new policy based on the medical evidence it received from the GP. I cannot therefore ask it to reinstate the cover.

I think it may help Mr A to understand my role in this complaint. I realise he feels this service ought to verify the medical information, but we cannot do that.

We are not a regulator; that role falls to the Financial Conduct Authority ('FCA'). So, I won't be making findings on how L&G ought to have approached the underwriting process. The way in which L&G decides to process medical evidence isn't a matter for me to determine, aside from being mindful of regulatory requirements such as the duty to handle matters promptly and fairly. My remit is to decide whether a business has acted fairly and reasonably in all of the circumstances. And as I've said above, I do find L&G's actions here to be fair.

Mr A confirmed in his second application that the policy he sought was replacement cover, which permitted L&G to cancel the first policy with his consent at the time the second one began. It is for this reason that it cannot refund the premiums paid for that first policy, because it wasn't cancelled for misrepresentation but rather, it ended with Mr A's agreement as it was replaced by a new policy.

To explain for Mr A, when premiums are refunded because an insurer cancels a contract of insurance on the grounds of misrepresentation, the premiums are usually refunded because it restores the position for the parties – so, treating the contract as if it had never started. However, the first policy Mr A paid for did not have issues of misrepresentation, and so it was merely cancelled at the point the new cover began. The premiums were paid for the event a claim needed to be made between 2021 and 2023, though this did not happen.

Unfortunately, though the new policy had begun, L&G was otherwise entitled to review it in respect of updated medical evidence. In his application, Mr A consented to a GP report being sought, with a confirmation from L&G which set out how "'*around one in ten applications will be checked by obtaining information from your doctor, either before or shortly after your policy has started*'".

When applying for personal term assurance cover, an insurer will ask a detailed set of medical questions to establish an accurate picture of an applicant's medical circumstances. The reason for this is that relevant insurance law allows an insurer to consider at the point of a claim whether any 'misrepresentation' has taken place at the application stage. I'll explain misrepresentation further in this decision below.

Consequentially, an insurer is only liable to provide cover for circumstances that are reasonably disclosed to it, upon asking an applicant clear, fair, and unambiguous questions.

Periodic guidance is issued by the Association of British Insurers ('*ABI*') on this basis. Its 'Code of Practice: Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products' provides guidance to insurers about offering these policies. It principally covers fair treatment of claims for UK individual and group life assurance, critical illness, income protection and other long-term protection insurance contracts. It does this in light of evolving industry practice, FCA regulations, the treating customers fairly ('*TCF*')

regime, the approach of this service, and the relevant law on consumer disclosures and representations.

The reason I've set this out is to explain to Mr A that an insurer such as L&G ought to obtain as much clear and relevant medical information as it can at the outset, rather than retrospectively underwriting insurance if a policyholder (or their beneficiaries) needs to make a claim in the future. It is for this reason that it sent out a targeted report to Mr A's GP.

When applying for insurance, if an applicant doesn't tell his or her insurer relevant information in response to a clear question it's known as 'misrepresentation'. If the circumstances around a claim prompt an insurer to believe a misrepresentation may have occurred within an application, it's entitled to consider what ought to have happened – and if the application should have been answered differently. That is what L&G has done.

When it received the information to process Mr A's claim, L&G was prompted to review his medical records, because in the report sent to L&G from the GP, it was set out that Mr A (in 2021) was recorded as having drunk to excess and had liver function which was abnormal. Mr A reported this to his GP, noting he had been told to reduce his alcohol intake.

Given this predated both the policy application and policy start date, it was therefore reasonable that L&G reviewed what Mr A was asked on the May 2023 policy application. Two specific questions asked:

> "*Apart from anything you've already told us about in this application, during the last 2 years have you been in contact with a doctor, nurse or other health professional for any condition affecting your gall bladder, liver or pancreas, for example hepatitis, fatty liver?*'
>
> and
>
> "*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?*
>
> *[You may ignore being told by a health professional that you should reduce the amount of alcohol you have because you were drinking too much, provided it was only on one occasion and before age 25]"*

Mr A answered "*no*" to both questions.

L&G says that in the call of 17 July 2023 with its underwriter, Mr A agreed he was told to reduce his alcohol intake. I've reviewed that call, and I can see there was a discussion had with Mr A about reducing his intake from two beers to one on occasions. However, I disagree with L&G that this call is clear objective evidence of advice from a health professional. As Mr A has explained, his first language is not English and it appears that he and the L&G underwriter were at times talking at crossed purposes. I am not persuaded that the reflective content of this call – without any other medical evidence – is of itself sufficient to determine Mr A misrepresented his answer to the second question above.

However, I do otherwise believe that in his application to L&G, Mr A needed to answer the questions differently. I say that because his medical record from 11 November 2021 says:

> "***History*** *Drinks copious amounts of alcohol but has since stopped on being told liver FT abnormal in A&E - I'm unable to see those bloods*
> ***History*** *Now has anxiety around liver problem and has stopped drinking alcohol*

> ***History*** *works long shifts as [job title] and wants to be signed off sick since his liver has problem*"

I can understand that – as Mr A rightly contends – there are no liver function tests to support abnormalities being recorded either from A&E three days prior to the GP visit, or thereafter. However, when Mr A completed the application it said at the very start of the application how "*you must answer the application questions truthfully and accurately. This is to help ensure L&G can pay valid claims*". Mr A was also sent a copy of his application on 25 May 2023 and it reminded him of his duty to have answered all questions accurately, because not every application would be checked alongside an applicant's GP records.

That Mr A's records do not show the amount of any perceived liver function abnormality doesn't mean that L&G ought to disregard the content of the medical record sent to it by the GP. This shows Mr A attended hospital (albeit with issues regarding a type of reflux, anxiety and blood pressure concerns) and was given information about his liver, and cessation advice. Three days later he relayed that to the GP and consequentially ceased drinking.

I cannot see any objective reason why the medical record ought to be disregarded by L&G. It has made reasonable attempts to establish with the GP that the record was accurate. Though Mr A disagrees with this, our investigator has explained how he can seek to have any incorrect record amended directly with the GP if this were the case. Since that hasn't happened, L&G has treated the record as an accurate recording. I find that a fair approach in the circumstances. Accordingly, I think Mr A knew, or ought to have known he had seen a doctor in A&E relating to a liver matter, and that he had been advised to reduce drinking – as his GP record confirms Mr A's account of that taking place on 8 November 2021.

I therefore believe there was a misrepresentation. Under law, it is a 'qualifying' misrepresentation if it affects the terms an insurer could have offered, which L&G has shown is the case here by providing us with a copy of its relevant underwriting guidelines.

Once that's been established, the law on disclosure in consumer insurance contracts says that it should be classed as either deliberate/reckless or careless. The types of categorisations allow for different types of outcomes.

In the event of 'careless' misrepresentation, an insurer should consider a proportionate remedy and this is what L&G has done. This means the outcome will depend on what the underwriting decision would have been had the misrepresentation not occurred at the time. If insurance could have been offered under different terms or for a different cost, an insurer can amend the contract to reflect this.

However, I do not need to go further and determine the type of misrepresentation, because the outcome here is the same – whether the misrepresentation was either 'careless' or 'deliberate or reckless', the underwriting decision would have been to refuse terms. Put simply, if L&G had sought a medical report because Mr A answered "*yes*" to the above questions, it could not offer to insure him based on the GP record from 11 November 2021.

L&G correctly refunded the entire premiums as paid for the May 2023 policy once it became aware of the misrepresentation, and it did this promptly. That was the reasonable outcome in these circumstances, and it has done so in accordance with relevant industry guidance on misrepresentation in insurance policies, as issued by the ABI within its Code of Practice on Misrepresentation and Treating Customers Fairly. It has also complied with its own policy terms which set out how "*if we would not have issued your policy had the accurate information been provided, we are entitled to cancel your policy, however we will refund any premiums you have already paid*". I therefore cannot ask L&G to do anything more.

As an aside, Mr A remains free to return to L&G in the future in the event his medical record is updated in respect of the evidence relating to alcohol use and liver function testing. L&G has already confirmed to Mr A that it is willing to review any amendments to the record.

My final decision

Despite my sympathy for Mr A, I do not uphold this complaint. L&G has reasonably voided the policy upon receipt of medical evidence which determined there was a misrepresentation on the May 2023 policy; this led it to correctly refunding the premiums Mr A paid from the outset. It has therefore behaved fairly in all of the circumstances.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 25 June 2024.

Jo Storey
Ombudsman