DRN-4780940

The complaint

Miss B contacted us on behalf of D and complained that Aviva Life & Pensions UK Limited had declined a claim on one life assurance policy and another life and critical illness policy.

What happened

Miss B's company, D, applied for the policies on 3 July 2019. The policies were accepted on standard rates. On 5 July 2019, Miss B's financial advisor contacted Aviva to inform them of a genetic condition Miss B had been diagnosed with. This was discussed with an underwriter, and it was agreed that the policies could continue on standard rates.

In July 2022, Miss B was sadly diagnosed with cancer. A claim was raised with Aviva. In December 2022, Aviva declined the claim due to a misrepresentation. Aviva said that some of the questions at the point of the application hadn't been answered correctly. Aviva added that had they been provided with the correct information, they wouldn't have offered Miss B either policy. As a result, they declined the claim under the critical illness policy, avoided both policies and refunded Miss B all premiums paid. Miss B brought the complaint to our service.

Our investigator didn't uphold the complaint. They agreed that there had been a misrepresentation. They said that Aviva had followed the remedy for insurers under the relevant legislation.

Both Miss B and her financial advisor responded to our investigator's view. Miss B provided some additional medical information and advised that she didn't need to be on life-long medication as per medical advice. Miss B's financial advisor noted that most of Miss B's medical notes referred to either '*suspected*' or '*thought to be'* and so weren't definitive diagnoses. He also added that a former colleague had recently submitted an application through Aviva for a consumer with a similar medical history to Miss B and it had been accepted with a 25% rating.

Our investigator reviewed the additional information but didn't think it made a difference to their outcome. The complaint was passed to me to decide.

What I provisionally decided – and why

In my provisional decision, I said:

"*I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.*

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether Aviva acted in line with these requirements when it declined to settle Miss B's claim.

Having done so, I've broadly reached the same overall outcome as our investigator, that Aviva hasn't acted unfairly, but for different reasons. So, I'm issuing a provisional decision, to give both parties an opportunity to comment on my provisional findings before I reach my final decision.

Our investigator said that Aviva had acted in line with the relevant law, which he said was the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). However, CIDRA only applies to individual consumer contracts of insurance.

Here though, as Miss B's company, D, were the policy holders, CIDRA doesn't apply. Instead, for commercial consumers and commercial contracts of insurance, the Insurance Act 2015 applies.

In summary, this says that Miss B had to make a fair presentation of risk to the insurer. And this includes disclosing every material circumstance which the insured knows, or ought to know. Failing that, disclosure which gives the insurer sufficient information to put a prudent insurer on notice to make further enquiries for the purpose of revealing those material circumstances.

I first need to decide whether Miss B provided a fair presentation of risk to Aviva. During the application, Miss B was asked the following question:

"Apart from any conditions you've already told us about in this application, within the last two years have you: Been referred to, treated at or had any investigations at a hospital or clinic?"

Miss B answered the above question 'No'. Two days after the application, Miss B's financial advisor phoned Aviva and disclosed a genetic condition. In a conversation with an underwriter, the financial advisor was asked the following question:

"Has the client ever had any symptoms in relation to this condition?"

This question was also answered No.

Having reviewed Miss B's medical records, I've seen the following entries:

- *March 2006 – Suffered from a blood/circulatory condition during pregnancy.*
- *September 2006 – Suffered from a blood/circulatory condition and placed on medication for 12 months.*
- *February 2018 - Attended A&E with chest pain symptoms.*
- *March 2018 - Saw a consultant Haematologist.*
- *2018 – Noted a suspected blood/circulatory condition whilst on holiday.*

Based on the above, I'm satisfied that Miss B, or her advisor who was acting on her behalf, should have told Aviva that she'd been referred/treated/had investigations in hospital within two years of the application. I'm also satisfied that Miss B should have told Aviva that she'd had symptoms in relation to her condition.

I now need to consider whether the misrepresentation was a qualifying breach. This means, if Miss B had told Aviva the correct information above, would they have acted differently in relation to their offer of the insurance contract.

Aviva has provided me evidence from both a named senior underwriter and their chief medical officer. This confirms that had Aviva been aware of the above information, they wouldn't have offered D either policy. So, I'm satisfied that there was a breach.

The Insurance Act 2015 allows Aviva a number of remedies if there has been a qualifying breach. Whilst Aviva has said they believe the breach was deliberate or reckless, by refunding the premiums, they've followed the remedy for a non-deliberate or reckless breach. The remedy for a non-deliberate or reckless breach in the Insurance Act 2015 is as follows:

"If in the absence of the qualifying breach the insurer would not have entered into the contract on any terms, the insurer may avoid the contract and refuse all claims, but must in that event return the premiums paid."

A non-deliberate or reckless breach is the lowest level of breach under the Insurance Act 2015. As Aviva have followed the remedy of the lowest level of breach, I don't think their actions were unreasonable and I don't need to consider Aviva's categorisation of the breach.

In response to the points raised following our investigator's view, I've given these consideration too. Whilst I agree with Miss B's financial advisor that most of Miss B's medical notes referred to 'suspected' or 'thought to be', the questions above didn't ask about where only a definite diagnosis had occurred. This means that the disclosure of the information would still be relevant. In regard to Miss B's advisor's second point, I can only consider the circumstances of this complaint. I only have access to Miss B's medical records and although whilst the medical histories may be similar, they won't be exactly the same.

Whilst I accept that Miss B didn't need to be on life-long medication, this wasn't confirmed until after the policy had been taken out and the misrepresentation had occurred. It also doesn't mean that the questions weren't answered incorrectly.

Whilst I have a lot of empathy for Miss B with her current health, based on what's happened, I'm not able to say that Aviva has acted unfairly."

Therefore, I wasn't minded to direct Aviva to do anything further as I didn't think they'd done anything wrong.

Responses to my provisional decision

Miss B confirmed she didn't agree with my provisional decision. She maintains that the claim should be paid. To summarise, she said:

- She took out the policy in good faith
- Aviva should have looked at her medical history after disclosing her genetic condition
- If she was deliberately trying to avoid answering the questions, she wouldn't have disclosed the genetic condition
- When you have a significant diagnosis, it's impossible to remember or recall things
- She didn't have any confirmed symptoms in the 5 years prior to the application
- Words like suspected aren't confirmed

- Why did Aviva start disputing the claim based on the definition only to decline it for a misrepresentation

- Aviva's application used jargon

- Aviva is basing the outcome on NHS specialists and not the private specialists she got a second opinion from

- Her genetic condition isn't related to her cancer diagnosis

Aviva didn't respond to the provisional decision by the deadline.

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've also thought carefully about the responses to my provisional decision. Having done so, while I appreciate it will come as a disappointment to Miss B, my conclusions remain the same. I'll explain why.

Whilst I accept that Miss B took out the policy in good faith, Aviva provided the policy to Miss B based on the information she supplied. There was no requirement for Aviva to check Miss B's medical records. Based on the answers provided, Aviva were satisfied that no further checks were required and could offer a policy based on their underwriting guidelines.

I don't think the questions Aviva asked contained jargon, were unclear or ambiguous. Miss B wasn't asked if she'd had any symptoms in the last five years, she was asked if she'd ever had any symptoms. Miss B herself has confirmed that she has.

Whilst I appreciate that this was more than 10 years before she took out the policy and I acknowledge what Miss B has said about it being difficult to recall things. However, this doesn't mean that a misrepresentation hasn't taken place. Insurance applications aren't supposed to be a memory test and Miss B could have requested a copy of her medical records if she was having any difficulty in answering the questions accurately.

I agree that Miss B had a suspected and not confirmed symptom in 2018, so I understand the point she makes, but she did have a confirmed symptom in 2006 which did need to be disclosed and wasn't.

Miss B has said that she didn't deliberately answer the questions incorrectly. I agree this is the case. Aviva have also taken the action under the Insurance Act 2015 of a non-deliberate or reckless breach, so I think they also agree it wasn't deliberate.

Insurers will often review the claim whilst investigating any potential misrepresentations. This avoids any potential delays if there doesn't end up being a misrepresentation.

I don't think any specialist's opinion has been considered over any others. The complaint has been reviewed in line with the medical evidence that was available at the time of the application, to decide what Aviva would have done had all the questions been answered correctly.

I also accept that Miss B's cancer diagnosis isn't likely to be related to her genetic condition. However, due to the misrepresentation Aviva wouldn't have offered her a policy. There doesn't have to be a link between a misrepresentation and the condition being

claimed for.

I find that Aviva hasn't done anything wrong in avoiding the policy, declining the claim, and refunding the premiums.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

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

Anthony Mullins
Ombudsman