DRN-4852929

The complaint

Mr R is unhappy that Legal and General Assurance Society Limited declined a claim made on his term assurance policy (which included critical illness cover) ('the policy') for permanent and total disability benefit.

Although Mr R is being represented in this complaint, I've referred to him throughout.

What happened

Mr R applied for the policy in late 2002, and in around 2021 Mr R made a claim under the policy for permanent and total disability.

That claim was ultimately declined by Legal and General. It concluded that when applying for the policy, Mr R didn't accurately declare his medical conditions. If he'd done so, Legal and General says that he would've still been offered the policy with life and critical illness cover but the permanent and total disability cover would've ultimately been removed. So, it declined the claim as cover wouldn't have been in place.

Unhappy with this decision and how long it had taken Legal and General to handle his claim, he made a complaint. Legal and General maintained its decision to decline the claim was fair. However, it did accept that it had caused some unnecessary delays. Legal and General apologised for this and paid £400 compensation to Mr R.

Mr R brought a complaint to the Financial Ombudsman Service.

Our Investigator looked into what happened and didn't uphold Mr R's complaint. Mr R disagreed so this complaint has been passed to me to consider everything afresh to decide.

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.

Legal and General has an obligation to handle claims fairly and promptly. And it mustn't unreasonably decline a claim.

Given the date Mr R applied for the policy, I'm satisfied that the relevant law at the time was the Marine Insurance Act 1906. Mr R had a duty of utmost faith which effectively placed a duty on him as a consumer to disclose all material information which he knew or ought to have known.
Although, The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') was not in force at the time – and so isn't relevant law – I think it would still be fair and reasonable for me to take into account the principles of CIDRA as I think they amounted to good industry practice at the time Mr R applied for the policy.

The decision to decline the claim

When applying for the policy, Mr R was asked a number of questions about his lifestyle and medical history. That included:

> Have you AT ANY TIME had, or been advised to have, any medical investigation or consultation, advice, operation or treatment for any of the following categories of medical conditions in 2a, 2b or 2c?

And included under '2b' is:

> Arthritis, rheumatism, or any form of neck, back or spinal trouble?

I'll refer to this as the 'medical question'.

I think the medical question is clear and it's reflected that Mr R answered it 'no'.

Legal and General concluded that the medical question should've been answered 'yes'. And I'm satisfied that it's acted fairly and reasonably when doing so.

That's because around six weeks before applying for the policy, Mr R's GP records reflect: "cervicalgia – pain in the neck". And that he'd had a recurrence of neck pain after a recent road traffic accident. It's reflected that Mr R was examined and "movements of neck a bit painful".

And a few weeks later (and shortly before applying for the policy), his GP records reflect: "whip lash neck injury". It's also reflected that Mr R was referred for a cervical spine x-ray. So, I'm satisfied Legal and General has reasonably concluded that Mr R misrepresented his answer to the medical question.

When making this finding, I've considered that Mr R says that he didn't understand English very well at the time of applying for the policy, and he didn't fully understand the question. However, Mr R says the application was completed on his behalf by a financial advisor and I think Legal and General are entitled to rely on the answers it received.

Mr R also says Legal and General should've requested his medical records at the time. However, again, I'm satisfied that Legal and General acted fairly by relying on the answers he gave to the questions on the application without requesting medical evidence from his GP. That isn't unusual. And given the answers he provided, Legal and General didn't need to request further medical evidence at the time and before offering the policy to him.

I'm satisfied that Legal and General has fairly and reasonably concluded that Mr R's misrepresentation was careless as opposed to deliberately or recklessly made.

I'm also satisfied that the answer to the medical question mattered to Legal and General as I've seen underwriting information which supports that had Mr R answered 'yes' to this question, it's most likely that it would've postponed including cover for permanent and total disability benefit at the time of the application (and would've subsequently removed this benefit from the policy given that the medical evidence supports that Mr R's symptoms continued).

As I'm persuaded that permanent and total disability benefit wouldn't have been in place had Mr R answered the medical question correctly, I'm satisfied that Legal and General has fairly and reasonably declined the claim as there would've been no cover to claim under.

The handling of the claim

In its final response letter dated July 2023, Legal and General accepts that there were several occasions when its claims team took between four and 12 weeks to progress the claim at different times. It's apologised and paid £400 compensation.

I'm satisfied that unnecessary delays would've been frustrating and upsetting for Mr R particularly given his circumstances at the time. He would've also been put to inconvenience by having to ask a relative to chase for updates. If Legal and General hadn't caused delays, he would've received an outcome to his claim more quickly which would've been helpful. However, ultimately the outcome would've been the same and his claim would've still been declined. So, I think £400 compensation fairly reflects the impact of the delays and not receiving the outcome sooner.

My final decision

I don't uphold Mr R's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R to accept or reject my decision before 26 August 2024.

David Curtis-Johnson
Ombudsman