DRN-4871105

The complaint

Miss C has complained that HSBC Life (UK) Limited has declined her critical illness claim.

What happened

The background to this complaint is well known to the parties so I won't detail it in full here. In summary Miss F took out a critical illness policy in August 2016. The sum assured was £30,00 for a term of 19 years.

Sadly Miss C was diagnosed with cancer in 2022 and called HSBC to make a claim on her policy. In July 2023 HSBC declined Miss C's claim because it said that she had failed to disclose information regarding her medical history in her application. It cancelled the policy and refunded the premiums that she had paid.

Unhappy, Miss C brought her complaint to our service. The investigator felt that the claim had been fairly declined but recommended that compensation of £200 be paid for the time taken to give Miss C an answer.

Miss C appealed. To summarise she said that she couldn't fathom why the answer given to the relevant medical questions was 'no'. She said that she would not have said this had she been completing the document herself.

Miss C also made the point that when she had an ultrasound scan in November 2016 the result was 'essentially unchanged' since the 2015 scan. In April 2017 Miss C was discharged – she needed no treatment, and the issues didn't keep her off work. She sought medical advice because it was the sensible thing to do.

Finally Miss C said that she did receive a welcome letter in April 2016 asking her to inform HSBC of any changes to her health since completing the application form – but she didn't receive a copy of the completed form. Miss C said that had she of done so she would have been able to correct the mistake and gone elsewhere for insurance if HSBC declined to offer cover.

HSBC didn't agree that it didn't provide updates to Miss C. It gave evidence of the updates provided from January to July 2023 which detailed the reasons for the delays in reaching its final response which included waiting for information from Miss C's GP.

As no agreement has been reached the matter has been passed to me to determine.

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 summarised the background to this complaint - 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 reviewed

the file and considered the representations Miss C has made with care. Having done so I agree with the conclusions 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.

HSBC has said that Miss C failed to take reasonable care when answering the following questions on the application form:

Do you currently have, or have you ever had, sought or intend to seek medical advice for…

- *Cancer or any form of tumour, lump, cyst, swelling or growth (including leukaemia, lymphoma and Hodgkin's disease)…*

Other than for the condition listed under Medical Advice…

- *Are you awaiting any medical investigation or referral, or have you any current symptoms or complaint for which you have not yet sought medical advice?*

You do not need to disclose matters related to uncomplicated pregnancy, common cold, influenza, vaccinations, hay fever, infected or extracted wisdom teeth, miscarriage, ingrown toenails, uncomplicated fractures, tonsilitis or infertility treatment'.

Miss C accepts that her 'no' answers to the questions were incorrect. HSBC has said that the following issues should have been disclosed:

- An ultrasound of the uterus in 2008 which revealed fibroids, a cyst and an endometrioma.
- A Gynaecology referral in 2009, after which regular monitoring was recommended.
- A laparoscopy and CT scan in 2012. Mention of "a large fibroid with an ovarian cyst" found on a laparoscopy in the hospital notes.
- A colposcopy in 2015 for intermenstrual bleeding, which revealed a cervical polyp.
- A recommendation of a hysteroscopy and endometrial biopsy with the possibility of moving straight to a hysterectomy in 2015.

I don't find that HSBC's conclusion that the questions asked should have elicited positive answers given Miss C's medical history was unfair. Miss C accepts this too.

I note that Miss C has said that she hasn't seen a recommendation for a hysteroscopy in her medical notes in 2015. However her GP practice confirmed that following the removal of the cervical polyp, she was having increasing menorrhagia and became anaemic was listed for a further hysteroscopy with endometrial biopsy and possibility of moving straight to hysterectomy. I find it is not unreasonable for HSBC to conclude this should have been disclosed.

HSBC has shown that had Miss C answered the questions correctly it wouldn't have offered her cover at that time. So I'm satisfied that the misrepresentation was a qualifying one. It has treated the misrepresentation as careless, rather than deliberate – I find that was fair. There is no suggestion whatsoever that Miss C deliberately failed to answer the questions correctly. HSBC has cancelled her life and critical illness cover and refunded the premiums paid. This is in line with CIDRA.

I do understand Miss C's point that she was discharged in 2017, but I'm satisfied that had the questions been answered correctly she wouldn't have been offered cover in August 2016. Miss C believes that she would have answered the questions correctly and that she had nothing to hide. I accept that the application form was completed by the adviser. However on balance I am not persuaded that having been given correct answers about her gynaecological history the adviser disregarded the answers and ticked 'no' on the form to the above questions. It follows that I'm not persuaded that the error was that of the adviser.

Miss C was then sent a letter in April 2016 asking her to inform HSBC of any changes to her health since her application – she says that she wasn't sent a copy of her answers to check, and if this had been sent, she would have been able to correct the answers. She says that she didn't ask for a copy – having never been through the process before. But I note that Miss C signed a declaration at the time of the sale to confirm that the answers given were accurate and complete. I accept that Miss C didn't later see a copy of the application form, but I find that she did have one opportunity to correct the answers given.

As indicated above Miss C feels that had she been sent a copy of the application form she could have corrected the errors and gone elsewhere for cover. I understand her point and agree that this would have been helpful, but I've seen no evidence that with a full disclosure of her medical history she would have been able to get similar cover elsewhere.

I'm very sorry to disappoint Miss C, but I don't find that HSBC has treated her unfairly or unreasonably by rejecting her claim. For completeness I would add that I'm persuaded HSBC have considered Miss C's complaint on its own facts, as I have. This decision therefore has no general implications for women.

I have also considered the service that Miss C was provided. The relevant regulations provide that insurers must handle claims promptly and fairly. Our investigator felt that the delay from January 2023 to July 2023 after the GP gave a response to the medical enquiries was excessive. In response HSBC has said that updates were provided to Miss C during this time.

I've thought carefully about this. I can see that HSBC needed to refer to its underwriters and reassurers, which added time to the process. I accept that this ensured that the claim was thoroughly investigated before the final response was sent. But I find it would have been reasonable for HSBC to have chased these parties and set parameters for responses. I say this because Miss C had received a worrying cancer diagnosis and waiting for an answer would have been very stressful. She has said that the whole process was traumatic and distressing. Although some brief updates were sent to her, I can see Miss C emailed on more than one occasion for an answer.

In the circumstances it is difficult to conclude that the claim was dealt with promptly – although there is some reasonable explanation as to why. Nevertheless, HSBC was aware that this was a cancer claim, with a policyholder waiting anxiously for a response. In the circumstances I find that some compensation is merited for the time taken to give Miss C an answer. I find that £200 is fair in all the circumstances.

My final decision

My final decision is that I uphold this complaint in part. Whilst I don't uphold the complaint regarding the rejection of Miss C's claim, I do find that compensation is due for the reason given above.

I require HSBC Life (UK) Limited to pay Miss C £200.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss C to accept or reject my decision before 27 September 2024.

Lindsey Woloski
Ombudsman