DRN-5006613

The complaint

Mr F is unhappy that Legal and General Assurance Society Limited have declined a claim he made on his life and critical illness policy.

What happened

Mr F had two life insurance policies with Legal and General, one of which also provided cover for critical illness. The life and critical illness policy was taken out in December 2021. Mr F had a heart attack in late 2022 and made a claim on the policy in February 2023.

Mr F's claim was declined because Legal and General said Mr F hadn't answered questions about his medical history accurately during the application process. They said that had he done so they wouldn't have offered him a policy. They considered Mr F's actions to be deliberate or reckless and so declined the claim and cancelled the policy. However, they agreed to refund the premiums to Mr F. Legal and General also awarded Mr F a total of £900 for delays in handling the claim and customer service issues. Unhappy, Mr F complained to the Financial Ombudsman Service about the claim being declined.

Our investigator looked into what happened. He thought that Mr F hadn't answered the questions accurately, based on the medical information that was available. He thought that the misrepresentation was careless rather than reckless or deliberate. However, he noted that Legal and General had already refunded Mr F's premiums. So, he didn't think they needed to do anything further to put things right.

Mr F asked an ombudsman to review his complaint. In summary, he said the questions were answered to the best of his ability and with care. He didn't agree there had been any misrepresentation and that he'd been very candid during the call with the seller of the policy. He also said that the application form used 'rolled up' questioning which meant some of the questions were ambiguous. So, I need to make a 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.

The relevant rules and industry guidelines say that Legal and General has a responsibility to handle claims promptly and fairly. I have also considered The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I think this is relevant law.

I've also considered the relevant ABI Code of Practice for managing claims for individual and group life, critical illness and income protection insurance products.

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. The standard of care is that of a reasonable consumer. 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 (in this case Legal and General) 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 several 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.

Legal and General say that the qualifying misrepresentation was deliberate or reckless and they wouldn't have offered cover at all if they'd been given the right information during the application process. They've declined the claim, cancelled the policy and refunded the policy premiums.

The application

Mr F applied for a policy via a third party who gathered information about Mr F's health and medical history. I appreciate that Mr F says he was candid with the advisor and gave them lots of information about his health. However, if Mr F is unhappy with the contents of the call, including the discussion about the information captured during the application process, he'll need to raise a complaint with that business. That part of the application process is not something that Legal and General is responsible for.

Mr F was asked a number of questions. That included the following questions

- *Are you waiting for tests or investigations, or are you waiting for a consultation with a hospital doctor or specialist? – Waiting for a routine blood pressure check or routine blood test?"*

  He answered "no" to this question.

- *How long ago was your blood pressure last taken at your GP's surgery by a doctor or nurse or at a hospital?*

  He answered "0 years 6 months".

- *Do you know the result of your latest blood pressure check taken at your GP's surgery or by a doctor or a nurse or at a hospital?*

  He answered "Yes."

- *Please tell us your latest blood pressure reading taken at or provided by you to your GP's surgery? We may need to check the reading you provide with your GP.*

  He answered "Systolic Pressure: 140. Diastolic Pressure 85".

- *Have any of your natural parents, brothers or sisters, before the age of 60, had any of the following? …Cardiomyopathy?*

  He answered "No" to this question.

The medical evidence reflects that:

- Mr F had a blood pressure reading completed approximately two months before the application. The recorded reading was 150/90.

- Mr F was awaiting further blood pressure monitoring which was discussed with him in September 2021 and was scheduled to take place before January 2022.

I think it's reasonable for Legal and General to conclude that Mr F didn't take reasonable care when answering the medical questions, I've outlined above. I'll explain why.

I'm not persuaded by Mr F's representations about 'rolled-up' questions being responsible for his answers in the circumstances of this case. I'm satisfied that it was sufficiently clear that the insurer wanted to know about tests, investigations and consultations (including routine blood pressure checks and blood tests). I'm not persuaded, in the circumstances of this case, that the format of the questions led Mr F to answer them incorrectly.

Mr F did disclose that he had raised blood pressure. However, I don't think he accurately disclosed information about the wider circumstances of this health at the time. Mr F's consultant discussed with him carrying out an ambulatory blood pressure check, which is a test monitoring his blood pressure over a 24 hour period. He says that the ambulatory blood pressure check actually took place in early December 2021 before his application took place. I've seen no evidence to confirm the date this test took place and that's not reflected within the medical history provided.

However, even if the ambulatory blood pressure test took place before the application, I'm not persuaded this is central to the outcome of the complaint. I've considered the consultant's letter of September 2021. It referred to Mr F being reviewed again in 18 to 24 months' time. And, the letter from the consultant who reviewed the blood pressure check was not sent until early January 2022. He said that the results were clearly not an acceptable level of blood pressure control and went on to say that Mr F was being kept under review at clinic and that the consultant was happy to discuss any further blood pressure issues with Mr F's doctor. All this information leads me to the conclusion that, even if Mr F's blood pressure check took place before the application date, it's most likely Mr F was waiting for the results of the checks and/or the next steps from his medical team (including his consultant) until early January 2022. And I think he most likely remained under the care of the consultant or the clinic. So, I still can't fairly conclude his answer to the question relating to tests, investigations or a waiting for a consultation with a specialist was answered correctly.

In any event I've also considered Mr F's answers to the questions about the blood pressure checks completed at his GP surgery and his testimony in relation to the answers he gave. Mr F said he couldn't remember the precise date of his blood test or blood pressure check so he selected a time frame of between zero to six months. But the answer recorded on the application form is '0 years 6 months'. The answer on the form is not correct as Mr F had a blood test around 2 months before the application.

Mr F said that, in line with the question, he provided the result he gave to his GP. He also highlighted that he often has multiple readings during appointments and suffers from 'white coat syndrome'. However, the first relevant questions asks:

> *Do you know the result of your latest blood pressure check taken at your GP's surgery or by a doctor or a nurse or at a hospital?*

I think if Mr F wasn't sure, or didn't know, what the result was he could have answered 'no' to this question.

The second relevant question asks:

Please tell us your latest blood pressure reading taken at or provided by you to your GP's surgery? We may need to check the reading you provide with your GP.

I've thought very carefully about Mr F's representations about this question and the answer given. However, on balance, I've not persuaded by the explanation Mr F has given in the circumstances of this case. Even if I accepted that Mr F gave his GP a reading this most likely would have been taken in advance of the appointment in October 2021 if it was one he took at home to provide to his GP. Therefore, the latest recording would have been that which the GP took during the appointment which was 150/90. That's not the figure Mr F provided on the application form. Furthermore, there's no note in the GP records to indicate that multiple readings were given during the appointment (or that readings were provided by Mr F). I note that on previous occasions multiple recordings were taken. But that's not what is reflected in the GP notes from October 2021.

Mr F also made the point that the difference in the blood pressure reading he declared and the GP reading isn't that significant because they still fall into the same category of Stage 1 hypertension. However, that's not necessarily how an insurer assesses the risk of a claim when they underwrite a policy. So, this point hasn't changed my thoughts about the overall outcome of this complaint.

Furthermore, I also think Mr F had a fair opportunity to highlight any concerns about his blood pressure history and the tests he had in December 2021 when he was sent the 'Checking your details' form which was completed in late December 2021. In that document he was reminded to contact Legal and General if there were any changes to his answers and had the option to change any answers online and give more information. So, this further persuades me that Legal and General have acted fairly by concluding Mr F failed to take reasonable care.

Was the misrepresentation a 'qualifying misrepresentation'?

I'm satisfied that this information mattered to Legal and General. They've provided underwriting information which demonstrates that if the correct information had been given they would have postponed the application and Mr F would have needed to reapply. Where that's the action the underwriter would have taken the relevant ABI Code of Practice says that Legal and General are entitled to treat the outcome as a 'decline'.

Legal and General concluded that the misrepresentation was deliberate or reckless. Our investigator concluded that the misrepresentation was careless. Legal and General didn't provide any further comments in relation to this. I don't think Mr F deliberately withheld information from Legal and General but I don't think enough care to provide accurate and complete information during the application process. So, I think it was a careless misrepresentation.

CIDRA says that in such cases of careless misrepresentation the insurer is entitled to decline the claim, avoid the policy and refund the premiums. That's what Legal and General has already agreed to do, despite classifying the misrepresentation as deliberate or reckless. Therefore, I'm satisfied they've acted in line with what CIDRA requires them to do when there's a careless misrepresentation. Therefore, I'm satisfied that Legal and General has acted fairly.

Delays and customer service

Legal and General accepted that there were avoidable delays and issues with the customer service Mr F received. Aviva has offered a total of £900 compensation in recognition of this. I understand Mr F accepted a payment of £550 but not a further £350 offered in the most

recent final response letter.

It's clear that the delays and poor service caused Mr F unnecessary and avoidable distress and inconvenience at an already worrying time and when he was recovering from being very unwell. I think this impact was substantial and caused ongoing disruption over a period of several months. However, overall, I'm satisfied that the total of £900 compensation fairly reflects the impact of the delays and poor service on Mr F. Therefore, I don't think Legal and General need to do anything further to put things right.

My final decision

I'm not upholding this complaint as I think the suggested settlement is fair. If Mr F wishes to accept the £350 compensation that's outstanding, he'll need to contact Legal and General Assurance Society Limited directly.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F to accept or reject my decision before 24 December 2024.

Anna Wilshaw
Ombudsman