DRN-5020360

The complaint

Mrs S on behalf of the estate of Mr S complained that Legal and General Assurance Society Limited avoided her late husband's policy and refused to pay a claim on his life assurance policy.

What happened

The late Mr S took out a life assurance policy with L&G in May 2019. Mr S sadly passed away in December 2022. Mrs S raised a claim with L&G in January 2023. After reviewing the claim, L&G declined the claim and avoided the policy. This was because they believed Mr S misrepresented when he took out the policy. As a result, Mrs S raised a complaint with L&G. L&G didn't think they'd done anything wrong, so Mrs S brought her complaint to this service.

Our investigator agreed with L&G and didn't think they'd done anything wrong. They felt Mr S had misrepresented and L&G had acted in line with the law in avoiding the policy and declining the claim. Mrs S appealed. She said L&G had led her husband to believe he was covered by requesting his medical records at the time of application. She also raised that her husband wasn't aware of some of his medical records and so had answered the questions correctly. Finally, she said her husband thought L&G had taken his medical records into account as his cover was reduced from £20,000 to £11,000. As no agreement could be reached, the complaint has been passed to me to make a final 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.

I'm very sorry to hear about Mr S's death and send my condolences to Mrs S.

At the outset I acknowledge that I've summarised her complaint in far less detail than Mrs S has, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to reach an outcome in line with my statutory remit.

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 L&G acted in line with these requirements when it declined to settle Mrs S's claim.

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.

L&G thinks Mr S failed to take reasonable care not to make a misrepresentation when he answered the following questions on his application:

> *"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?*
>
> *Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for:*
>
> > *Any condition affecting your kidneys, bladder or prostate, for example blood or protein in the urine, kidney or bladder stones?*
> >
> > *Raised blood pressure, raised cholesterol or condition affecting blood or blood vessels, for example anaemia, excess sugar in the blood, blood clot deep vein thrombosis?*
> >
> > > *Have you another condition or illness to tell us about under this heading?*
>
> *Apart from anything you've already told us about in this application, during the last 2 years have you seen a doctor, nurse or other health professional for:*
>
> > *Any condition affecting your gall bladder, liver or pancreas, for example hepatitis, fatty liver?"*

L&G has sent us Mr S's medical records. These show the following:

- February 2011 – Patient advised about alcohol
- May 2012 – Diagnosed with a kidney condition
- July 2012 – Diagnosed with a blood disorder. Alcohol related, reduce and stop
- November 2013 – Diagnosed with a liver condition
- November 2015 – Diagnosed with a liver condition
    - Kidney condition has progressed
    - Diagnosed with a blood condition
- January 2016 – Investigations for a blood condition.
    - Ultrasound showed previous liver condition and diagnosed a gallbladder condition.

- Advised to abstain from alcohol in the future

Based on the questions asked and Mr S's medical history, I do think he answered most of the questions incorrectly. I think the questions are clear. So, I don't think Mr S took reasonable care in how he answered them. I've not seen any evidence that Mr S saw a health professional about his liver or gallbladder two years before his application and so I think this question was answered correctly.

Under CIDRA, I have to see whether the misrepresentation was a qualifying one. This means, would it have made a difference to L&G had the correct information been provided.

L&G has provided their relevant underwriting manual from the time of the application. They've also provided the comments of one of their underwriters. Based on what I've seen, had the questions been answered correctly, L&G wouldn't have offered Mr S a policy. This means it was a qualifying misrepresentation. Insurers need to follow the remedies as set out in CIDRA when dealing with a qualifying misrepresentation.

L&G has avoided the policy, declined the claim and refunded all premiums paid. In the circumstances this is in line with a careless misrepresentation in CIDRA. This is the lowest category of misrepresentation in CIDRA. As such, I think L&G has acted fairly in the remedy they've applied.

In her response to our investigator's outcome, Mrs S said that her husband was led to believe his medical records had been checked at the time of application. Mr S's application was selected at random by L&G to verify the medical information provided. L&G wrote to a GP that was provided on Mr S's application. L&G also wrote to Mr S to inform him that a request had been sent. This letter also informed Mr S that he had requested to receive a copy of the medical records before it was sent to L&G. L&G received two responses from the GP to advise that Mr S wasn't a known patient at the surgery. As Mr S's application was selected at random for verification, it wasn't a requirement for L&G to verify any of his medical information. Whilst I accept L&G could have contacted Mr S to verify his GP's details or advise him that they wouldn't be completing a medical verification check after all, there was no requirement for them to do so. Under CIDRA, L&G are allowed to rely on the information provided by a consumer on an application. Mrs S has raised about how, L&G were provided with incorrect GP information. The GP details were provided on the application by a broker on Mr S's behalf. The broker was acting for Mr S and not L&G. If Mrs S is unhappy with this, she would need to take it up with the broker that sold the policy.

Mrs S also said that her husband wasn't aware of his medical records. This was in relation to his kidney condition. However, this was in relation to the severity of the condition and not the condition itself. I still think the condition had been diagnosed at the point of application and Mr S would have been aware of it and so should have still disclosed it in the application.

Finally, Mrs S said her husband thought L&G had taken his medical records into account as his cover was reduced from £20,000 to £11,000. L&G has confirmed that whilst there was a quotation run by Mr S's broker for £20,000 worth of cover, they never received an application for that amount. The only application they received was for £11,000. If Mrs S is unhappy with the amount of cover Mr S's broker applied for, she would need to take it up with the broker.

I'm very sorry that my decision doesn't bring Mrs S more welcome news at what I can see is a difficult time for her. But in all the circumstances I don't find that L&G has treated Mrs S unfairly, unreasonably, or contrary to law in declining the claim.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint. I don't require Legal and General Assurance Society Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mr S to accept or reject my decision before 30 December 2024.

Anthony Mullins
Ombudsman