DRN-5029522

The complaint

Miss W is unhappy that Aviva Life & Pensions UK Limited mis-sold her a long-term care insurance policy ('the policy').

Although Miss W is being represented in this complaint, I've referred to her throughout as she was the policyholder.

What happened

In 1995, Miss W responded to an advert about long-term care insurance, and she was visited twice by an insurance salesperson (a different insurer at the time, but now Aviva) and she decided to take out the policy. The policy started in 1996.

In 2023, Miss W contacted Aviva to make a claim on the policy. That claim was turned down because it concluded that that Miss W didn't meet the policy requirements under the definition of 'activities of daily living' ('ADLs').

Unhappy that the policy had been mis-sold to her, Miss W complained to Aviva. Aviva didn't uphold that complaint, so Miss W brought her complaint to the Financial Ombudsman Service. Our investigator looked into what happened and she felt that the policy had been mis-sold as she didn't think the ADLs had been explained to Miss W at the time of sale. She recommended that Aviva refund her the monthly premiums she paid for the policy going back to the start of the policy together with simple interest at a rate of 8% a year from the date each premium was paid until the date of settlement.

Aviva disagreed and raised a number of points in response. This complaint was passed to me to consider everything afresh and decide.

I issued my provisional decision earlier in September 2024 explaining why I wasn't intending to uphold Miss W's complaint. An extract of my provisional decision is set out below.

……..

Looking at the confidential fact-finding form completed at the time (in 1996), I'm satisfied that Miss W had a need for the policy. And considering the main terms of the policy, including its cost and the benefit payable in the event of a successful claim, I don't think the policy she ended up with was unsuitable.

I've also considered whether she was given information about what she needed to establish before a successful claim could be made under the policy for partial or full long-term care benefit.

Under the declaration section of the confidential fact-finding form, Miss W signed to say that she'd received the key features document for the policy.

The key features document sets out how the policyholder qualifies for the benefits. It explains that a partial long term care benefit will be paid if the policyholder was unable to

perform at least two of the six ADLs without personal assistance, even when using appropriate assistive devices. And the full benefit could be claimed, if they were unable to perform at least three of the six ADLs without personal assistance, even when using appropriate assistive devices.

It also says: please see the plan guide for a complete definition of the six ADLs and explanation of mental impairment.

I can't know for sure if Miss W did read the key facts document or whether the salesperson discussed the ADLs verbally with Miss W at the time. Nor do I know if she received the plan guide referred to in the key facts document.

However, Aviva has disclosed a recording of a call one of its representatives had with Miss W in April 2023 around the time she made a claim under the policy. When asked whether she was made aware of the claim criteria at the time of sale, she responds that she was and she read through the information carefully.

I've taken into account Miss W's vulnerabilities and that she may not have understood what the representative meant by claim criteria. I've also taken into account that this all happened many years ago now and memories do tend to fade with age. However, I think it's important that Miss W said she read through the paperwork carefully and that's consistent with what's said about her being in the habit of keeping all paperwork.

So, on the balance of probabilities, if she had been given the key facts document, I think it's more likely than not that she would've read it.

For similar reasons, I think it's likely that she would've read:

- the plan guide particularly as the application form completed by or on behalf of Miss W around the time same, which is signed by her, says at the start of the first page: "you are advised to read the appropriate lifetime care plan guide before completing this application form".

- the policy terms which Miss W accepts were sent to her after her application was accepted.

The ADLs are set out at page 4 of the guide as:

- Mobility – the ability to move from one room to another.

- Washing – the ability to wash, by any means, such that a reasonable level of personal cleanliness can be maintained.

- Dressing – the ability to put on and take off all necessary clothing, and to fasten or unfasten any medically necessary brace or artificial limbs.
- Feeding – the ability to consume food and drink which has been prepared and made available.

- Toileting – the ability to get on and off the toilet or commode and to maintain an adequate level of personal hygiene.

- Continence – the ability to control voluntarily bowel and bladder function, or the ability to maintain an adequate level of personal hygiene by using ostomy supplies, protective undergarments or other such aids.

And they are defined at page 20 of the policy document under the definition section.

If Miss W was unhappy with what needed to be established for a successful claim to be made under the policy, or had any further questions, she was invited at page 1 of the policy terms to contact customer services and details were given. I've seen nothing which persuades me that she did that.

The plan guide also says the policy can be cancelled within 14 days of the policy being issued and any premiums would be paid in full. If Miss W was unhappy with the how the ADLS were defined in the plan guide or policy terms and conditions, I think it's likely that she would've cancelled the policy, but she didn't.

Further, and in the alternative, even if I'm wrong about Miss W not being provided with the plan guide and not being aware of the nature of the six ADLs when the policy sold, I'm satisfied that even if she was given more information about what the ADLS involved, she would've still opted to take out the policy.

She made an enquiry about the policy initially and I'm satisfied that she was interested in having this type of cover. Based on the key facts document which she was given, I'm satisfied that she would've (at least) been aware that to qualify for benefits she had to be unable to perform at least two (or three for the full long term care benefit) of the six activities of daily living.

Had she not been given information about the ADLS at the time of taking out the policy, I don't think having more detailed information about what needed to be established under each of the ADLs would've put her off the policy as I'm not persuaded that they would've seemed overly restrictive to her at the time.

……..

I invited both parties to provide any further information in response to my provisional decision.

Aviva replied to say it agreed with my provisional decision. It also said, despite Miss W recently cancelling the policy, if she changed her mind and would like to reinstate the policy she could do so on the same terms and for the same cover – subject to paying premiums owed since cancelling the policy. That offer is open for acceptance for four weeks from the date of any final decision. Miss W should contact Aviva if she wants to reinstate the policy on that basis.

Miss W replied disagreeing with my provisional decision. In summary, she said:

- The type of policy she had the benefit of ceased to be sold in the early 2000's as it was unsuccessful and difficult to administer. Press articles were also provided.
- Miss W didn't have a need for the policy. At the time it was sold, she was around 60 years old, living alone and was concerned about her future care. Had the policy's features been available to her, she wouldn't have considered the policy suitable.
- Aside from dementia or one of the debilitating diseases, the chance of making a successful claim under the policy is virtually zero (based on how the ADLs are defined).
- There's no mention of the ADLs or the claims criteria in the confidential fact-finding form, indicating that the salesperson didn't discuss these with Miss W. As a

healthcare professional, Miss W would've raised concerns about the limitations of the policy if they had been explained or made available to her at the time.

- The key features document wasn't present in Miss W's comprehensive filed records relating to the policy, indicating that she didn't receive it. Further, this document doesn't define the ADLs.
- There's no evidence that Miss W had access to the plan guide, it's not in her file of documents and she didn't sign to say she'd seen it.
- The application form wasn't contained within Miss W's file of documents, a copy probably wasn't given to her, it had been completed by the salesperson (although signed by Miss W towards the end of the application) and she wouldn't have had an opportunity to read the top sentence "you are advised to read the appropriate lifetime care plan guide before completing the application form".
- The call recording Aviva has provided shouldn't be admissible evidence and the question asked of her about being aware of the claims criteria at the time of sale was unfair in the circumstances.
- The policy terms and conditions set out the definition of ADLs at page 20. Miss W may not have read this. But in any event, this is irrelevant as the sale had already been completed.
- £70 per month was an affordable commitment in 1996 but in total premiums amounted to over £41,000.

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.

That includes all the points made by Miss W in response to my provisional decision. I appreciate the time this must've taken. I acknowledge I've only summarised the points made in my own words, and I won't 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 we are 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 point to be able to fulfil my statutory remit.

I know Miss W will be very disappointed, but the information provided in response to my provisional decision (some of which I was already aware of when making my provisional decision), hasn't changed my mind. I'll explain why.

- Where there is contradictory evidence or a gap in the evidence, I'm required to decide what's most likely happened on the balance of probabilities. When doing so, I'm conscious that the sale took place almost 30 years ago and memories tend to fade. Further, Miss W says that certain documents weren't provided to her as they aren't contained in her file of documents. Whilst I've taken into account what she says about that, given the time that has passed, I'm not persuaded that because some of these documents are no longer in her possession means she was never provided with them.

- I'm satisfied on the balance of probabilities that Miss W was provided with the key features document as she'd signed a section of the confidential fact-finding form to say she'd received it. As I said in my provisional decision, the key features document contains some information about what needs to be established to make a claim. It

explains that a partial long term care benefit will be paid if the policyholder was unable to perform at least two of the six ADLs without personal assistance, even when using appropriate assistive devices. And the full benefit could be claimed, if they were unable to perform at least three of the six ADLs without personal assistance, even when using appropriate assistive devices. And I think it's likely that Miss W would've read this document or reasonably ought to have read it (having received a copy).

- Even if Miss W wasn't given – or didn't read – the plan guide containing more information about the ADLs, it's accepted that she did receive the terms and conditions (albeit after she agreed to take out the policy). It's submitted on her behalf that she probably didn't read the terms (or only skimmed them). However, the first page of the policy says: "please read these Conditions immediately and check that all the information shown in your Schedule is correct. You should be sure that you fully understand what your policy covers and what it does not cover. If you have any questions, at any time about your policy, please contact our Customer Services Department at the address below..." The policy terms defined the ADLs and if Miss W was unhappy with the how the ADLS were defined, I think it's likely that she would've contacted customer services to query them and/or cancelled the policy. There's no evidence that she did this.

- Further, and in the alternative, I remain satisfied that even if Miss W should've been given more information about what the ADLS involved, she would've still opted to take out the policy in the circumstances of this case. Miss W made an enquiry about the policy initially and I'm satisfied that she was interested in having this type of cover. Based on the key facts document which she was given, I'm satisfied that she would've (at least) been aware that to qualify for benefits she had to be unable to perform at least two (or three for the full long term care benefit) of the six activities of daily living. Had she not been given information about the ADLS at the time of taking out the policy, I don't think having more detailed information about what needed to be established under each of the ADLs would've put her off the policy. I've taken into account Miss W's profession and her experience in healthcare matters, but I'm not persuaded that the ADLs would've seemed overly restrictive to her at the time (to the extent of putting her off taking out the policy).

- I'm satisfied that it's fair and reasonable for me to take into account the call recording disclosed by Aviva as it's relevant to the complaint I'm determining. However, I don't think the call recording is definitive to the issue of whether the policy was mis-sold or not. Amongst other things, I've also taken into account both parties' detailed submissions and the documents from around the time of the sale.

- Miss W has referred to other cases, which I've considered, but I'm required to consider the individual circumstances of her complaint when deciding whether Aviva acted fairly and reasonably and whether the policy was mis-sold to her.

- I don't think how much the policy has costed Miss W to the date of cancellation means that the policy was mis-sold to her.

So, for these reasons and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I don't uphold Miss W's complaint.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss W to accept or reject my decision before 28 October 2024.

David Curtis-Johnson
Ombudsman