DRN-5159802

The complaint

Ms K and Mr M have complained that The Royal London Mutual Insurance Society Limited ("RL") declined the claim Mr M made on their joint life and critical illness policy and have said they won't continue the policy on the same terms.

What happened

In late November 2023, Ms K and Mr M applied to RL for a joint life and critical illness policy. RL accepted the application and the policy started on 5 December. RL wrote to them on 5 December, confirming the policy was live and asking them to check the medical information provided during the application was accurate and hadn't changed between the date the answers were given and the date the policy was put on risk. Mr M confirmed on 15 December there were no changes to be made.

On 5 December, Mr M discovered a small lump in his testicle. He contacted his GP that day, who arranged an appointment – which also took place on 5 December. Following that appointment, the GP arranged an ultrasound appointment for Mr M.

The ultrasound appointment took place on 15 December. That revealed no issues with the lump Mr M had discovered. But it did identify a lump in his other testicle which raised concerns that Mr M had cancer. Mr M had an operation shortly after. Fortunately, the lump removed was found to be benign and Mr M has made a full recovery.

Mr M made a claim on the policy a few days after his operation. RL obtained medical information from his GP and consultant to help them assess the claim. Having reviewed this, they declined the claim and cancelled the policy, because they said Mr M hadn't provided accurate answers to his health questionnaire when he and Ms K had applied for the policy. RL said if they'd known the true position, they wouldn't have offered cover until all investigations and treatment had been completed.

Mr M and Ms K complained. They said Mr M hadn't found the lump until after the policy had been put on risk. And he didn't know about the potentially cancerous lump until he'd had the ultrasound scan, some days after the policy started.

RL considered the complaint but didn't uphold it. So Mr M and Ms K brought it to the Financial Ombudsman Service. Our investigator reviewed all the information on the complaint and concluded RL didn't need to do any more to resolve it. She was satisfied RL's conclusion that Mr M had misrepresented his health was a reasonable one and that they'd followed the relevant law in how they'd addressed that.

Mr M and Ms K didn't accept our investigator's view. So I've been asked 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.

Having done that, I'm not upholding Mr M's and Ms K's complaint. I know they'll find that disappointing news and I'm sorry about that. I hope it will help if I explain my decision.

As our investigator explained, we expect insurers to deal with issues of misrepresentation in line with the relevant law. That is the Consumer Insurance (Disclosure and Representations) Act 2012 – known as 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.

There's no suggestion that Mr M didn't answer the questions accurately when he and Ms K applied for their policy. But RL say Mr M made a misrepresentation because he didn't notify them the information he'd provided had changed. Mr M says he didn't need to do that because he wasn't aware of any changes until after the policy went on risk. I've thought carefully about this.

RL say the answers to two questions should have changed. Those questions are:

"APART FROM ANYTHING YOU'VE ALREADY TOLD US ABOUT, DURING THE LAST 5 YEARS HAVE YOU HAD, OR DO YOU CURRENTLY HAVE, ANY OF THE FOLLOWING:

A tumour, lump, cyst, polyp, growth, or any mole/naevus that has bled, changed in appearance or become painful?

Please answer Yes whether seen by a doctor or not.

IN ADDITION, APART FROM ANYTHING YOU HAVE ALREADY TOLD US ABOUT:

Do you have any symptoms for which you haven't yet sought medical advice, or are you awaiting referral, investigation, results or treatment for anything else? For example: A mole/blemish which has changed in appearance, ***Any lump, growth or hardening affecting the skin, breasts or testicles****, Bleeding from the bowels, change in bowel habit, Persistent cough, Weight loss or unexplained bleeding, Onset of fits or seizures, Dizziness, blackouts/fainting"* [my emphasis]

I think both of those questions are clear. And it's clear the lump Mr M discovered fell within the examples given.

I've looked closely at the timeline. Mr M says he asked for the plan to be put on risk in the early morning of 5 December. It was only after that he found a lump, contacted his GP and was referred for an ultrasound. But all that also happened on 5 December.

I've looked at the letter RL sent to Mr M that day confirming the policy was on risk. It says:

"It is vitally important you check that the information we have is complete and accurate, and return the client review as soon as possible.

If any of the information in the application is incorrect or incomplete, and you don't tell us and give us the correct and complete information; or if there has been a change to any of the answers given to the questions in the application or any other information provided between the date the answers or information were provided and the date we assume risk on your plan and you don't tell us, it could mean we won't pay a claim."

That paragraph means Mr M should have advised RL of any changes which occurred between completing the application in late November and 5 December.

Mr M has told us he returned the form on the day he had the ultrasound. And, while I accept that was after the policy went on risk, he saw his GP and was referred for that ultrasound on 5 December – the day the policy went on risk. So I think it's reasonable to say he should have alerted RL to the changes to his answers as a result of what happened on that day.

I've listened to a call between RL and Mr M when they asked him why he didn't let them know of the change. Mr M said his GP had told him there was nothing to worry about so he didn't think it was anything. And it wasn't the lump that he'd found that had led to his surgery, but a lump in his other testicle which had only been identified during the ultrasound.

I accept this is the case. But the questions in the application simply ask about the presence of lumps and whether any investigations have been done or are scheduled. On 5 December, Mr M did have a lump and had been referred for further investigation of that lump. So I think it was reasonable for RL to say the declaration he gave on 15 December should have notified them that his original answers to those questions had changed.

I'm satisfied that, by not doing this, Mr M made a misrepresentation. And I'm satisfied that was a qualifying misrepresentation within the meaning set out in CIDRA, because RL has shown that, if they'd have known about the changes, they wouldn't have offered Mr M cover at that time, but would have deferred making a decision until the outcome of his treatment was known. And any subsequent cover they offered would have excluded critical illness cover for conditions relating to his testicles.

Finally, I've thought about the remedy RL applied. CIDRA sets out different remedies, depending on whether the misrepresentation is deliberate/reckless, or whether it's careless. If it's deliberate/reckless, CIDRA allows an insurer to decline any claim, void the policy from the start and retain the premiums paid. But if it's careless, an insurer should apply what they would have done, had they had the right information. And if that means they wouldn't have offered cover, they should refund any premiums paid.

RL haven't said how they've categorised Mr M's misrepresentation. But they applied the remedies applicable to a careless misrepresentation. I've seen two versions of a letter sent to Mr M about this. One said they'd refund the policy premiums which had been paid. The second offered Ms K and Mr M this as an option – alternatively they could continue with the policy with the addition of a term excluding critical illness claims arising from testicular issues.

Either of these would have been a fair outcome in my view. Mr M has confirmed that the policy has been cancelled and the premiums have been refunded. So I'm satisfied RL have provided a remedy which aligns with CIDRA.

I was very pleased to have read that Mr M has made a complete recovery following his treatment. But, for the reasons I've set out in this decision, I don't think RL need to do any more to resolve his and Ms K's complaint.

My final decision

For the reasons I've explained, I'm not upholding Mr M's and Ms K's complaint about The Royal London Mutual Insurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms K and Mr M to accept or reject my decision before 7 February 2025.

Helen Stacey
Ombudsman