DRN-5210536

The complaint

Miss L complains that Legal and General Assurance Society Limited avoided her life and critical illness insurance policy and refused to pay a claim.

What happened

The background to this complaint is well known to the parties, so I won't repeat all the details here. In brief summary, in May 2019, Miss L applied for life and critical illness cover with L&G. I understand the policy was sold through a broker and went live in August 2019.

Most unfortunately, Miss L was later diagnosed with complex regional pain syndrome. Miss L subsequently made a claim for total and permanent disability (TPD), under the critical illness benefit on her policy. But L&G declined the claim, saying she hadn't given full and accurate information during the application process.

L&G considered this to be a qualifying misrepresentation. It said that, had Miss L answered correctly, it would have been unable to offer a life and critical illness policy with TPD cover.

L&G refused to pay Miss L's claim, saying she had deliberately or recklessly misrepresented her circumstances on application. It cancelled her policy, but refunded the premiums paid.

Miss L complained, but L&G maintained its stance, so Miss L came to the Financial Ombudsman Service. But our investigator didn't uphold the complaint, so Miss L asked for an ombudsman to review everything and issue 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 so, I'm not upholding this complaint. I know this will be very disappointing and difficult news for Miss L and I'm sorry about that, particularly as I'm aware Miss L's condition severely impacts her day-to-day life. I'll explain my reasons, focusing on the points and evidence I think is material to the outcome of the complaint. So if I don't mention something specifically, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

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. In her submissions, Miss L has made reference to the criminal standard of proof – beyond reasonable doubt. By way of information, civil matters are decided to the civil standard of proof – that is, on balance of probability. So L&G has to demonstrate it's more likely than not that Miss L deliberately or recklessly misrepresented her circumstances when applying for the policy. This is the standard I have to hold L&G to.

L&G initially raised a number of areas of concern with Miss L. But in its claim decision letter of May 2024, with regard to respiratory issues, L&G said it felt Miss L's answer to the relevant question was understandable, given the information contained in her records. But it said that when applying for the policy, Miss L failed to take reasonable care not to make a misrepresentation when she answered no to the following questions:

> *During the last 5 years have you seen a doctor, nurse or other health professional for:*
>
> - *lupus, fibromyalgia, gout or any type of arthritis, neck, back, spine or joint trouble, for example rheumatoid arthritis, sciatica?*
>
> *During the last 12 months have you:*
>
> - *been referred to or had any investigations in hospital, for example biopsy, scan, ECG?*

L&G relied on evidence in Miss L's medical records which it says shows she should've answered these questions positively. The evidence relates to problems Miss L experienced with her knees and back.

I've reviewed the medical evidence provided and have noted a number of references to knee and back issues, significantly, throughout 2017 and 2018, ongoing until shortly before Miss L applied for the policy. I won't detail all the references, focusing instead on entries in the 12 months prior to Miss L applying for the policy.

By way of history, in February 2018, Miss L attended a private clinic and had an MRI in connection with a problem with her left knee. The imaging showed a medial plica which the consultant felt explained her symptoms. The advice was to have the plica removed arthroscopically. As Miss L did not have health insurance she asked for the name of an NHS surgeon who could perform the procedure.

In June 2018 Miss L's GP made an orthopaedic referral for NHS care. A further referral was made after Miss L spoke to her GP again in April 2019. It appears she didn't follow through with treatment due to work reasons, but now wanted to proceed.

In May 2018, Miss L saw consultant spinal and orthopaedic surgeon, Dr N, whom she'd previously seen in 2011. She reported severe low back pain over the previous two weeks with radiation down the right leg as far as the right ankle. Miss L had been seen at her local A&E department but had been discharged. In writing to Miss L's GP Dr N stressed the need for urgent investigation including an urgent MRI.

In September 2018, Miss L attended hospital for treatment on her back. In a follow-up letter to her GP, Dr N, noted the operation performed as:

> *medial branch blocks of L5-S1, caudal epidural, epidurogram and screening and right L5-S1 dorsal root ganglion block.*

Miss L attended for further follow-up including a post-operative MRI in October 2018. In December 2018, Dr N again wrote to Miss L's GP. He noted that the October MRI was compared with one he arranged previously in May 2018. He says:

> *As before she had dehydration of L4-5 but at L5-S1 her right L5-S1 prolapse has actually got larger and is compressing the transiting S1 nerve root.*
>
> *On direct questioning it is her leg pain that is worse that her low back pain.*

Dr N suggested either continuing to wait or for Miss L to undergo a right L5-S1 decompression and discectomy. Miss L was reported as wanting the procedure done sooner rather than later because the leg pain was preventing her from returning to normal activities.

Miss L has made a number of points about L&G's application form, citing what she considers to be ambiguities regarding what should and shouldn't be reported. She's also questioned what she sees as inconsistency between L&G's approach to her back and knee problems compared with its stance on her respiratory issues. She stresses that her back and knee problems are unrelated to her claim. Miss L has also said she relied on guidance notes from L&G which provided advice about completing the form. And that she called L&G for advice and was told she did not have to disclose pneumonia.

The claim log shows that L&G made various enquiries to establish what guidance notes Miss L was referring to. It found two booklets, in circulation at the time of Miss L's application, entitled 'Underwriting Explained' and 'What Happens After You Apply'. Of course, I don't know if either of these is what Miss L refers to. But having reviewed them, I'm satisfied they are information booklets, providing guidance, but not advice to customers.

Regarding the phone call, the claim log records that L&G searched its own systems to try to identify a call, using the mobile number Miss L provided. Miss L was going to try to identify a work desk number, but I've seen no evidence that this was subsequently provided. L&G also contacted Miss L's financial advisors, regarding both the guidance notes and any potential calls, but they were not able to provide any call records or further information. I understand Miss L's frustrations here, but I think L&G made reasonable investigations into these matters.

Overall, I'm satisfied the questions asked were clear and unambiguous. And that when Miss L applied for the policy, she should've disclosed her recent consultations, hospital attendances, investigations and treatment. So I'm satisfied Miss L failed to take reasonable care when taking out the policy.

L&G has provided information about its underwriting criteria to show what would've happened, had Miss L answered the questions accurately. I'm satisfied that, had Miss L done so, the full extent of her health issues would've become known to L&G. In these circumstances it would've applied a premium rating of +75% and TPD would not have been available at all. This shows that full medical disclosure would've made a difference to L&G's decision, so I'm satisfied Miss L's misrepresentation was a qualifying one.

L&G considered Miss L's misrepresentation to be deliberate or reckless, meaning she either knew, or must have known, that the information given was both incorrect and relevant to the insurer, or she acted without any care as to whether it was either correct or relevant to the insurer. Having reviewed everything, I'm satisfied there is sufficient evidence of deliberate or reckless misrepresentation. I therefore think L&G's categorisation was reasonable.

CIDRA sets out the actions an insurer can take in cases of misrepresentation. In the circumstances of Miss L's misrepresentation, L&G was entitled to cancel the policies and keep the premiums. However, I understand it refunded Miss L the premiums she paid. The action L&G's taken is more than is required under CIDRA, so I think L&G has acted fairly here.

Finally, L&G has acknowledged poor service and avoidable delays. It's apologised and paid £250 in compensation. I don't doubt that L&G's mistakes have caused considerable distress and inconvenience to Miss L. And for impact on that scale over the period in question, I'd expect to see an award in this region and think it reasonably reflects the level of upset caused.

So to conclude, I'm satisfied L&G acted fairly with regard to the claim decision made and has paid compensation which reasonably acknowledges the impact of its poor service. I'm not asking L&G to do anything more in respect of this complaint. Once again, I'm sorry to send unwelcome news to Miss L.

My final decision

For the reasons given above, my final decision is that I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss L to accept or reject my decision before 17 January 2025.

Jo Chilvers
Ombudsman