DRN-5227301

The complaint

Mrs D, Ms D and Mr D complain that Legal and General Assurance Society Limited (L&G) has turned down a terminal illness benefit claim Mr D made on a life assurance policy.

As Mr D made the claim and brought the complaint to us, I've referred mainly to him throughout this decision.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

On 16 August 2023, Mr D applied for a life assurance policy with L&G, which offered Mr D a policy.

Sadly, in December 2023, Mr D got in touch with L&G to make a terminal illness benefit claim on the policy after he'd been diagnosed with terminal cancer.

L&G obtained medical evidence to allow it to assess Mr D's claim. It said Mr D's GP surgery had told it that Mr D had contacted his surgery to make a doctor's appointment on 11 August 2023 and an appointment had been made for 17 August 2023. L&G noted that Mr D's medical records showed that during the consultation on 17 August – the day after he applied for the policy - Mr D reported that he'd had a three-week history of back pain, finger, wrist and shoulder pain and some shivering. The doctor had arranged for Mr D to undergo blood tests. And following a second consultation a few days later and further testing, Mr D had ultimately been diagnosed with cancer.

Based on the information set out in Mr D's medical records, L&G didn't think Mr D had correctly answered all of the medical questions he'd been asked when he applied for the policy. It said that if he'd disclosed his symptoms, it would have postponed offering him cover for three months until the cause of those symptoms had been established. And as the investigations ultimately concluded that Mr D had cancer, L&G said that it wouldn't have been able to offer Mr D life assurance cover.

L&G considered that Mr D had made a deliberate or reckless qualifying misrepresentation under relevant law. It turned down Mr D's claim, cancelled the policy from the start and refunded Mr D's premiums.

Mr D was unhappy with L&G's decision and he asked us to look into his complaint.

Our investigator didn't think Mr D's complaint should be upheld. L&G felt Mr D had incorrectly answered three of its medical screening questions. The investigator didn't think there was enough evidence to show that Mr D had incorrectly answered two of those questions.

But the investigator did think Mr D had answered one of L&G's questions inaccurately. In brief, he felt Mr D ought to have declared that during the three months before he applied for

the policy, he'd had symptoms that he intended to contact a health professional about for the first time. L&G had provided underwriting evidence which showed that if Mr D had answered this question correctly, it would have postponed cover. So the investigator didn't think L&G had acted unfairly when it concluded that Mr D had made a qualifying misrepresentation under relevant law. And he also felt that even if L&G had treated Mr D's misrepresentation as careless, rather than deliberate or reckless, the overall outcome would've been the same.

Mr D disagreed. In summary, he didn't think L&G's question was sufficiently clearly worded. He said he'd only contacted the GP about his back pain because he'd needed to get a fit note for work. And he hadn't considered back pain to be a symptom he needed to tell L&G about.

The complaint's been passed to me to decide.

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, whilst I'm very sorry to cause Mr D further upset at an already difficult time, I don't think L&G has treated him unfairly and I'll explain why.

First, I'd like to reassure Mr D that while I've summarised the background to his complaint and his submissions to us, I've carefully considered all he's said and sent us. I was sorry to read about Mr D's diagnosis and I don't doubt what a very difficult and upsetting time this has been for him and for his family.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the law; the terms of the insurance contract; and the available medical evidence, to decide whether I think L&G handled Mr D's claim fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). 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.

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.

When Mr D applied for the policy, he was asked a number of questions about himself, his personal circumstances and his health. L&G used the information Mr D gave to decide whether or not to offer him a policy and, if so, on what terms. L&G says that Mr D didn't correctly answer the questions he was asked during the application process. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these principles to the circumstances of Mr D's claim.

L&G thinks Mr D failed to take reasonable care not to make a misrepresentation when he

took out the policy. So I've considered whether I think this was a fair conclusion for L&G to reach.

The investigator explained why he didn't think Mr D had incorrectly answered two of the questions which L&G concluded had been answered wrongly. I agree with the investigator's findings on this point and for the same reasons. Broadly, it seems Mr D answered those questions accurately, based on what's set out in his medical records. As L&G didn't disagree with what the investigator's findings, I don't think I need to comment further on these particular questions.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions asked by the insurer were. I've seen a copy of Mr D's application form. This includes sections which ask about a policyholder's health. It says:

'When answering the following questions, if you're unsure whether to tell us about a medical condition, please tell us anyway…

During the last 3 months have you had any of the following?

- *any other symptom that you may contact a health professional about for the first time.'*

Mr D answered 'no' to this question.

In my view, this question was asked in a clear and understandable way and ought to have prompted a reasonable consumer to realise what information L&G wanted to know. I understand that Mr D doesn't feel that the word symptom is sufficiently clear and he's referred to a dictionary definition of the word symptom to support his view. He says that he didn't think back pain in and of itself was a symptom that he needed to tell L&G about – especially as he says he was aiming to get a fit note signing him off due to the pain.

However, in my view, a reasonable consumer would understand a symptom to be a sign of a potential illness or injury affecting them. And in my opinion, back pain would reasonably be considered to be a symptom of a condition potentially affecting a consumer's spine or Musculo-skeletal system. So I don't think L&G's question was unclear or misleading.

Next then, I've looked at the available medical evidence to decide whether I think Mr D took reasonable care to answer L&G's question. L&G contacted Mr D's GP. Its notes say that Mr D's GP surgery told L&G that Mr D had got in contact on 11 August 2023 to make an appointment. This was five days before he took out the policy. And it seems a telephone appointment was made for 17 August 2023 – the day after Mr D took out the policy.

The GP notes from that appointment say: '*Called as had had back pain and into fingers, wrists and shoulders. Muscles and joints. About 3 weeks. No [sic] sure of a particular trigger. Pain came on gradually…Some shivering…Plan: agreed bloods, MOT and joint pains.'*

A clinic letter, dated 29 September 2023, stated that Mr D had '*suddenly developed pains throughout his back, shoulder and chest about seven weeks ago.'*
The evidence suggests then that at the time of application, Mr D had been experiencing a new and sudden onset of symptoms of back pain, along with shoulder, finger and wrist pain and potentially muscle and joint pain. He was sufficiently concerned about those symptoms - which were serious enough for him to request to be signed-off from work - to contact his GP before applying for the policy and had arranged to speak to a health professional about his pain the day *after* the policy was taken out.

So I think Mr D ought to reasonably to have answered 'yes' to this question.

L&G has provided us with confidential underwriting evidence which shows that if Mr D had answered its question correctly, it would have postponed offering him cover for a three-month period until the outcome of the investigations into Mr D's symptoms was known. And, sadly, the investigations Mr D underwent led to him being diagnosed with cancer. As such, L&G would've declined to offer Mr D a life assurance policy. This means that I think L&G has shown that Mr D did make a qualifying misrepresentation under CIDRA and that it's therefore entitled to rely on the relevant remedy available to it under the Act.

In this case, L&G classed Mr D's misrepresentation as deliberate or reckless. Under CIDRA, in the case of deliberate or reckless misrepresentation, an insurer is entitled to turn down a claim, cancel a policy from the start and keep the premiums a policyholder has paid for the cover. In cases of careless misrepresentation, CIDRA says that an insurer is entitled to rewrite the contract as if it had all of the information it wanted to know at the outset and if it wouldn't have offered a policy, it's entitled to turn down a claim, cancel the contract from the outset and refund the premiums a policyholder has paid. I note that despite L&G's classification of the misrepresentation as deliberate or reckless, it's applied the remedy for careless misrepresentation.

It seems to me then that even if I were to find that Mr D's misrepresentation was careless, the outcome here would be the same. That's because L&G has already refunded the premiums Mr D had paid for the policy. So I find that overall, L&G's actions are in line with CIDRA and it follows that I'm not telling L&G to do anything more.

In summary, despite my natural sympathy with Mr D's position, I don't think L&G has handled his claim unfairly.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D, Ms D and Mr D of the D Trust to accept or reject my decision before 12 February 2025.

Lisa Barham
Ombudsman