DRN-5242567

The complaint

The representative of Mr H's estate (Mr K) has complained about the decision by Legal and General Assurance Society Limited ('L&G') to turn down a life insurance claim and avoid the policy.

What happened

The late Mr H took out a life insurance policy with L&G. The application was submitted to L&G on 30 April 2013 and started on 1 May 2013.

Mr H sadly passed away a few years later. A claim under the policy was submitted in 2021. After assessing the claim, L&G turned it down. It said Mr H had failed to take reasonable care not to make a misrepresentation when he provided information about his health when taking out the policy. L&G avoided the policy (cancelled it from the start) and returned the premiums paid.

Mr K complained about L&G's decision. L&G didn't change this, and so Mr K brought a complaint to this service.

Our investigator didn't recommend the complaint be upheld. She thought L&G's decision to avoid the policy had been reasonable, and in line with the relevant legislation.

Mr K didn't accept our investigator's findings, and so the matter has been passed to me for a 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.

As this complaint concerns misrepresentation when taking out an insurance policy, I've considered the matter in accordance with the principles set out under 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.

I've considered each question that L&G says Mr H answered incorrectly on the application form.

*'**Health – Ever***

…

- *Have you **ever**:*
- *had diabetes or a heart condition, for example angina, heart attack, heart valve problem or heart surgery?'*

Mr H's answer was '*no*'. However, we know he had been diagnosed with diabetes. Whilst I appreciate this was being controlled by diet rather than medication when the application was

completed, it's still the case that he did have diabetes. So, I think Mr H failed to take reasonable care when answering this question.

*'**Health – Last 5 years***

…

- *Apart from anything you have already told us about, during the **last 5 years** have you seen a doctor, nurse or other health professional for:*
- *raised blood pressure…?'*

Mr H answered '*yes'* to this question. When he was asked to select the relevant issue from a list, he selected '*Raised Blood Pressure (hypertension)*'.

The application then asked:

'Are you waiting for tests or investigations, or to be seen by a hospital doctor or specialist?'

Below this were some statements and Mr H needed to answer yes or no to these. The relevant ones were:

'Waiting for routine blood pressure check or routine blood test?'

And

'Waiting for other tests or investigations'

Mr H answered 'no' to both statements.

I've looked at Mr H's GP records, and the relevant information relating to his blood pressure was from March 2013. On 1 March, it was noted that he wasn't compliant with his blood pressure medication. He had a high blood pressure reading and was advised to restart his medication and have his blood pressure checked again the following week.

Mr H returned to the GP on 12 March to see a community practitioner. His blood pressure was still raised at this time, and he was advised to see his GP for management of his medication. Mr H returned on 19 March to see his GP – his blood pressure was taken again, and this showed that it had increased since 12 March. He was advised by the GP to increase his blood pressure medication and asked to return for a repeat blood pressure check in two weeks' time. However, Mr H didn't return before the policy started.

So, Mr H had been asked to return for a blood pressure check two weeks after 19 March 2013, but we know he hadn't done so before the application was submitted to L&G on 30 April 2013. Given that this was the month before the application was submitted, I'm satisfied that Mr H would have been aware that the investigation was outstanding at the time. I therefore find that he also failed to take reasonable care when answering this question.

L&G has explained that if Mr H had disclosed the above information, then because of the combination of diabetes and raised blood pressure, it wouldn't have accepted him for cover without him going for the repeat blood pressure check. So it would have postponed his application until this had been done.

L&G's underwriting guidance explains that if a customer is awaiting investigations, the application must be formally postponed. And if that happens, then if the customer wishes to re-apply because results have become available, a new application would need to be submitted.

ABI guidance that applied at the time says that when an underwriting decision would have been deferred then insurers should, as far as possible, try to determine what the ultimate underwriting decision would have been (in other words, when the investigation was complete). However, if it is not possible to work out whether the insurer would have offered any cover, or if the deferral decision would have required the customer to reapply at a future date, then the underwriting decision should be treated as a decline.

So, as L&G has shown that Mr H's application would have been formally postponed and he would have been required to reapply at a future date once he had gone for a further blood pressure check, that means it was entitled to say the underwriting decision would have been declined.

L&G says that Mr H's misrepresentation was deliberate or reckless, though I don't agree. Mr H did disclose that he had high blood pressure, and I don't think he would have done so if he was acting deliberately or recklessly. So I think the misrepresentation was careless instead.

As L&G has shown it wouldn't have offered Mr H cover, the remedy available to L&G under CIDRA for careless misrepresentation is to avoid the policy and return the premiums, which it has already done (even though it said it thought the misrepresentation was deliberate or reckless). So even though I don't agree with how L&G has categorised Mr H's misrepresentation, I'm satisfied this doesn't make a difference to the matter and so I don't require L&G to do anything different.

Whilst I recognise my decision will disappoint Mr K, I'm satisfied that L&G has acted fairly by avoiding the policy and refusing the claim.

Mr K has also complained about the length of time it took L&G to consider the claim, and how this impacted him. Though as our investigator has explained, Mr K is authorised to bring a complaint to this service on behalf of the late Mr H, and therefore we can't consider any impact experienced by him personally whilst representing Mr H's estate.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K on behalf of the estate of Mr H to accept or reject my decision before 26 March 2025.

Chantelle Hurn-Ryan
Ombudsman