DRN-5366372

The complaint

Mr and Mrs C complain that HSBC Life (UK) Limited hasn't settled a terminal illness benefit claim they made on an HSBC Life Protection insurance policy. They're also unhappy with HSBC's handling of their claim.

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.

In January 2020, Mr and Mrs C took out an HSBC Life Protection policy which was underwritten by HSBC.

Unfortunately, Mrs C was diagnosed with pulmonary fibrosis and given a terminal prognosis. So in February 2024, Mr and Mrs C made a claim on the policy for terminal illness benefit.

HSBC asked for medical evidence to allow it to assess the claim. Based on the information it received from Mrs C's GP, it concluded it needed further medical evidence. And one of Mrs C's treating specialists said they couldn't provide the evidence HSBC had asked for. HSBC liaised with another insurer Mr and Mrs C had claimed with to obtain the additional evidence it needed.

Based on the medical evidence, HSBC turned down the claim in late July 2024. That's because it noted that Mrs C had been diagnosed with Chronic Obstructive Pulmonary Disease (COPD) in 2017, which she hadn't told it about when she took out the policy. And while Mrs C had declared she suffered from an allergy; she'd told HSBC that she was fully recovered from it. However, the medical evidence showed that Mrs C had been suffering from an exacerbation of the allergy only a few days before she took out the policy.

HSBC therefore concluded that Mrs C hadn't answered all of its application questions correctly when she applied for the policy. It said if she'd done so, it wouldn't have offered her cover. So it concluded that Mrs C had made a qualifying, reckless misrepresentation under relevant law. It turned down her claim, cancelled the policy from the start and refunded the premiums Mr and Mrs C had paid for the policy.

But HSBC recognised that there'd been some unreasonable delays in the assessment of the claim. So it offered to pay Mr and Mrs C £250 compensation.

Mr and Mrs C were unhappy with HSBC's decision and so they asked us to look into this complaint.

Our investigator felt HSBC had made a fair offer to settle the complaint. He didn't think it had been unreasonable for HSBC to conclude that Mrs C had made a qualifying misrepresentation under relevant law when she applied for the policy. So he thought it had been fair for HSBC to turn down the claim, cancel the policy and refund the premiums Mr and Mrs C had paid for the cover.

And while the investigator thought HSBC could have progressed the claim more proactively at times, he didn't think it was responsible for many of the delays in moving the claim forwards. Therefore, he felt the £250 compensation HSBC had already offered was fair.

Mr and Mrs C disagreed and so 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 disappoint Mr and Mrs C, I think HSBC has already made a fair offer to settle their complaint and I'll explain why.

First, I'd like to say how sorry I was to hear about Mrs C's diagnosis. It's clear this has been a very difficult and upsetting time for Mr and Mrs C and their 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 and the available evidence, to decide whether I think HSBC treated Mr and Mrs C fairly.

Did HSBC handle the 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 and Mrs C took out the policy, they were asked information about themselves and their medical history. HSBC used this information to decide whether or not to insure Mr and Mrs C and if so, on what terms. HSBC considers that Mrs C didn't correctly answer some of the questions she and Mr C were 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 Mrs C's claim.

HSBC thinks Mr and Mrs C failed to take reasonable care not to make a misrepresentation when they took out the policy. So I've considered whether I think this was a fair conclusion for HSBC to reach.

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. Mr and Mrs C answered a number of questions during the application process. But I've simply set out the questions I think are most relevant to this claim. In relation to Mrs C's health, HSBC asked:

'In the last 5 years, have you had any of these?

Options - Asthma, sleep apnoea or anything else affecting your lungs or breathing, Crohns, colitis, IBS, or anything else affecting your stomach, bowel or digestive system, Kidney stones, urinary infection or anything else affecting your kidneys, bladder or urine, An abnormal cervical smear or any other gynaecological disorder that has required regular follow-up. Anything affecting your liver or pancreas?'

The application form shows the answer given was 'no'.

During the application, HSBC asked whether Mrs C had required a specialist appointment or required tests, scans, investigations or counselling. It was recorded that Mrs C had required one of these options due to an 'allergic reaction'.

Subsequently, HSBC asked for more information about Mrs C's allergic reaction. It asked:

'Are you fully recovered? (This means no treatment, discharged from any further review and not under any follow-up'.

The application form shows that the answer given to this question was 'yes.'

In my view, these questions were asked in a clear and understandable way and ought to have prompted a reasonable consumer to realise what information HSBC wanted to know. HSBC thinks that Mrs C ought to have answered its questions differently. It thinks Mr and Mrs C should have declared that Mrs C had a diagnosis of COPD and that she wasn't recovered from the allergic reaction. So I've looked carefully at Mrs C's medical records in order to decide whether I think it was reasonable for HSBC to conclude that its questions hadn't been answered correctly.

Mrs C's medical records and the medical report from her GP shows that she was diagnosed with COPD – a lung condition – in 2017. She was prescribed inhaler medication to treat her condition. A clinic letter, dated February 2018, showed Mrs C had undergone a CT scan and had been diagnosed with upper zone emphysema. I've seen a copy of a letter from a consultant respiratory physician dated August 2018, which stated that Mrs C had been diagnosed with hypersensitivity pneumonitis which had been triggered by a reaction to a pet. And a medical report from one of Mrs C's treating specialists, dated April 2024, shows that she was diagnosed with interstitial lung disease in 2017 and that she had chronic hypersensitivity pneumonitis.

The GP records show that in October 2019, Mrs C was signed off from work with pneumonitis. On 16 January 2020, she saw a GP with symptoms of a cough. The GP made reference to Mrs C's pet being kept in a separate room. She was prescribed steroids and antibiotics. On 20 January 2020, eight days before Mrs C took out the policy, she saw the GP again with ongoing wheeze and cough and was prescribed further medication.

Based on the medical evidence, I think it was reasonable for HSBC to have concluded that Mrs C likely knew about her diagnosis of COPD – a lung condition – and should therefore disclosed it. I also think it was reasonable for HSBC to have concluded that Mrs C ought to have declared interstitial lung disease/hypersensitivity pneumonitis in response to its question.

I acknowledge that an allergic reaction was declared during the application process and I accept it's possible that Mrs C believed the hypersensitivity pneumonitis was an allergic reaction to her pet. But Mrs C had appeared to experience recurring symptoms of the allergy since her diagnosis in 2018 which had required medical advice and she'd been prescribed medication to treat the condition which was due to finish three days before the application date. So I don't think it was unreasonable for HSBC to have concluded that Mrs C ought to

have answered no to the question asking if she was fully recovered from the allergic reaction because it seems her symptoms were recurrent.

On that basis, I don't think it was unfair or unreasonable for HSBC to have considered that Mrs C had made a misrepresentation under CIDRA. So I next need to decide whether I think HSBC has shown the misrepresentation was a qualifying one.

HSBC has provided us with confidential underwriting evidence which shows that if its questions had been answered correctly, it wouldn't have offered Mrs C a policy at all. Therefore, I'm satisfied that it's shown that a qualifying misrepresentation was made.

I appreciate Mr and Mrs C have told us that their other insurer treated their claim and policy differently and took different actions. But each insurer has its own underwriting guidelines and it's for an insurer to decide what level of risk it's prepared to insure. I'm satisfied that HSBC has shown that it's correctly applied its own underwriting criteria when it handled this claim.

HSBC classified the misrepresentation as reckless. Under CIDRA, this means that HSBC is entitled to decline a claim, cancel the policy from the outset and keep the premiums. In this case though, while HSBC turned down Mrs C's claim and cancelled the policy, it refunded the premiums Mr and Mrs C had paid for the policy. So it applied the remedy which would have been available to it under CIDRA had it categorised the misrepresentation as careless. In the circumstances then, I think HSBC has acted fairly.

I sympathise with Mr and Mrs C's position because I appreciate how important this claim was to them. But based on all I've seen, I don't think it was unfair or unreasonable for HSBC to turn down the claim, cancel the policy and refund Mr and Mrs C's premiums. This means I'm not telling HSBC to reinstate the policy or pay the claim.

Claim handling

It's clear from all Mr and Mrs C have told us that they're very unhappy with the way HSBC handled the claim. Given Mrs C's diagnosis and potential prognosis, they think there were unfair delays in HSBC making and communicating its claims decision. I understand how important it was to them that HSBC progressed the claim in a prompt way and that it assessed the claim as quickly as it reasonably could.

HSBC accepts that there were some delays in the handling of this claim. Having looked at its claims notes, I think there were occasions when HSBC could have chased up medical information more regularly than it did and I think it could have provided Mr and Mrs C with more proactive updates. I think its failure to do so did cause some minor, avoidable delays in it being in a position to make a claims decision.

However, it seems to me that the majority of the delays weren't down to HSBC. It asked for the medical evidence promptly after the claim was made and it paid the GP's invoice quickly. Once it received the initial evidence, it concluded that it needed more information to consider whether there had been misrepresentation. I don't think this was unreasonable. HSBC had no real control over when or whether external parties provided information in a timely way. And I think it took reasonable steps to try and share information with the other insurer to try and move things along. I don't think HSBC had all of the evidence it needed to make an ultimate claims decision until late July 2024. Once it had that evidence, I'm satisfied it made a prompt decision and communicated that decision to Mr C swiftly.

In the circumstances then, I'm persuaded that the offer of £250 compensation which HSBC has already made to Mr and Mrs C is fair, reasonable and proportionate in the

circumstances to reflect the likely impact of the periods of delay it was responsible for during the overall assessment of this claim on Mr and Mrs C.

So my decision is that HSBC must pay Mr and Mrs C £250 compensation if it hasn't already done so.

My final decision

For the reasons I've given above, my final decision is that HSBC Life (UK) Limited has already made a fair offer to settle this complaint and I direct it to pay Mr and Mrs C £250 compensation if it hasn't already done so.

HSBC must pay the compensation within 28 days of the date on which we tell it Mr and Mrs C accept my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C and Mr C to accept or reject my decision before 18 April 2025.

Lisa Barham
Ombudsman