

The complaint

Mr M complains that The Original Holloway Friendly Society Limited trading as Holloway Friendly has unfairly declined his claim and cancelled his income protection policy.

What happened

The background to this complaint is well known to both parties, so I won't repeat it in detail here. Mr M took out a My Sick Pay policy with Holloway Friendly in October 2023, through a third party business. The policy provided monthly benefit for Mr M if he was unable to work by reason of illness or accident. The benefit was payable after a four-week deferred period.

In March 2024, Mr M made a claim for benefit after falling ill overseas in January 2024. He also suffered panic attacks and heart palpitations the following month after trying to return to work. Mr M was thereafter diagnosed with anxiety.

In May 2024, Holloway Friendly rejected the claim, and instead cancelled Mr M's policy altogether on the grounds of misrepresentation.

Mr M complained. He said that Holloway Friendly should refund the premiums he had paid for the policy, as it had failed to insure him as promised. Furthermore, he felt it had taken too long to give him an answer for his claim.

In June 2024, Holloway Friendly rejected the complaint. It said it had confirmed Mr M had misrepresented his position by failing to correctly answer questions about mental health and his general health in the three years preceding the policy application. Holloway Friendly said it had cancelled Mr M's policy and retained the premiums he'd paid in line with industry guidance. It also said it had processed the claim as promptly as possible.

Mr M remained dissatisfied and brought the complaint to our service. One of our investigators reviewed the complaint, but she didn't think it ought to succeed. She said Holloway Friendly's conclusion that Mr H made a qualifying misrepresentation was reasonable. And she felt it behaved fairly by treating the misrepresentation as reckless.

Mr M said he wanted his complaint to be referred to an ombudsman. He made a number of further comments, noting:

- When the policy was taken out over the telephone, the broker answered questions for him.
- The initial investigations after he fell ill in January 2024 related to his heart; but after any cardiac cause was discounted, the conversation was steered to anxiety.
- He had never been formally diagnosed with anxiety until recently.
- Any consultations he had during the Covid pandemic were telephone-based, and he disputes the accuracy of information from that time.
- The claim process took three months – yet Holloway Friendly carried on taking his policy premiums.
- Holloway Friendly could have undertaken underwriting in 2023 but chose not to.

- He feels the claim process is heavily flawed and weighted against the policyholder – the system of being able to retain premiums allows insurers to financially benefit from mistakes made by applicants. Mr M said he feels the process was fraudulent.

Despite considering the additional comments made by Mr M, our investigator was not persuaded to change his view on the complaint. The complaint has now been passed to me.

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.

I'd like to thank the parties for their patience whilst this matter has awaited an ombudsman's decision. As I set out above, I've summarised the background of this complaint and have done so using my own words. In reaching my decision, I've focused on what I consider are the key aspects of the complaint. Our rules allow me to take this approach; it simply reflects the informal nature of our service as a free alternative to the courts. If there's something I haven't mentioned, it isn't because I've ignored it. It's since I don't need to comment on every individual argument to be able to reach what I believe is the right outcome.

I know Mr M feels there are wider issues relating to Holloway Friendly's processes which ought to be reviewed. However, we do not act in the capacity of a regulator. That remit falls to the FCA, where it may look at wider issues governing how businesses conduct their operations or exercise what may be commercial judgement on the provision of a particular service. This service's role is to investigate disputes and resolve complaints informally, including taking into account relevant laws, regulations, industry guidance such as that from the Association of British Insurers ('ABI') and best practice where applicable.

Having reviewed this complaint carefully, I agree with the outcome reached by our investigator – that means I cannot uphold the complaint. I appreciate my decision will be a disappointment for Mr M, but I'll explain my reasons for reaching this conclusion below.

The relevant law in this complaint 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.

I recognise Mr M feels that insurers should not be able to retrospectively assess insurance applications – but CIDRA and ABI guidance allows them to take that approach. In practice, it may take considerable cost and time in obtaining medical records from each prospective applicant seeking a personal protection policy. Instead, insurers can assess disclosure at the point of a claim if there is a justifiable cause that a misrepresentation might have taken place, based on the medical information that has been required to validate the claim.

Furthermore, Holloway Friendly hasn't acted fraudulently by allowing the insurance contract to continue (meaning Mr M paid monthly premiums) whilst the claim was investigated. It was

under a duty to provide the cover whilst premiums were maintained. And I have seen no clear evidence that the claim process was delayed by Holloway Friendly in any way.

After it reviewed Mr M's medical history following his claim, Holloway Friendly concluded that two policy application questions were wrongly answered. These were:

"Your mental health

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

- *Depression*
- *Anxiety*
- *Stress*
- *Any other mental issue*
- *None of these [Mr M chose this option]"; and*

"Your general health

Your mental and physical health in the last 3 years

Have any of these applied to you in the last 3 years?

You don't need to include things you've already told us about

- *I've taken or been prescribed treatment for 4 weeks or more*
- *I've been asked to attend a follow up or regular reviews with a GP, hospital or clinic*
- *I've been advised to see a specialist or have any tests, scans, investigations or counselling*
- *No [Mr M chose this option]"*

Mr M made no declarations on his policy application at all. On that basis, Holloway Friendly insured him on standard terms. However, I believe Mr M ought to have answered both of the questions set out above differently.

I say this noting I have seen medical evidence from 2020, 2021 and 2022 where Mr M sought medical assistance with his mental health. And in particular, Mr M's medical records show an attendance at hospital in May 2021 whereby he was recorded as *"an [age] y/o male with a history of anxiety who has been experiencing increasing physiological symptoms that could be linked to mental ill-health"*. I believe Mr M should have disclosed this in response to the first question by confirming a history of anxiety or any other mental health issue.

In respect of the second question, Mr M had spoken with a nurse at his GP surgery four months before the policy began. In that call, he was diagnosed with gastro-oesophageal reflux disease, sent a link for blood tests and prescribed four weeks of medicine. Again, I believe this is something Mr M should have disclosed, as the question asked about both medication and tests or investigations.

I also have taken into consideration that Mr M applied for his policy through a third party. However, Holloway Friendly sent Mr M a complete copy of his answers to check following the application on 28 September 2023. And in taking out the policy which began on 2 October 2023, Mr M signed a declaration which said:

"I confirm that I have answered the questions in this form and any additional forms honestly and accurately. The information I have provided in response to the questions is, to the best of my knowledge and belief, true and I have taken reasonable care to ensure those answers are correct.

I am aware that if I haven't answered the questions correctly, my plan may be cancelled, or its terms may be changed or a claim may be rejected or not fully paid."

Overall, I'm satisfied that Mr M's misrepresentation was a qualifying one. I can't share the underwriting evidence that Holloway Friendly has provided as it is commercially sensitive. But I'm persuaded that the evidence shows it would have acted differently – by applying exclusions - had the questions been answered correctly.

Holloway Friendly has said that the misrepresentation was deliberate or reckless and has cancelled the policy. I find that it has shown that the misrepresentation does fall into this category. I'm not persuaded that Mr M *deliberately* tried to deceive Holloway Friendly, but I do agree that in making no disclosures at all, he disregarded the importance of giving accurate answers based on the content of his medical records. It is reasonable to find that Mr M would have understood that the information sought was relevant to Holloway Friendly, since it gave an explanation as to the necessity to make accurate, honest disclosures.

I'm persuaded in these circumstances that it was fair to conclude the misrepresentation was reckless. This being so, I find that the action Holloway Friendly took in cancelling the policy without a return of premiums is fair and in line with the legislation referred to above.

Finally, I note that Mr M has raised concerns about the process of taking out the policy through the third party broker. If Mr M remains dissatisfied about that, he would need to lodge any concerns by registering a complaint with that separate business.

My final decision

For the reasons I have explained, I do not uphold this complaint or make any award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 1 September 2025.

Jo Storey
Ombudsman