DRN-5407983

The complaint

Mr M is unhappy that Liverpool Victoria Financial Services Limited (LV) cancelled his income protection policy and stopped his benefit payments.

What happened

Mr M applied for a flexible protection plan which included personal sick pay in January 2022. The policy started in July 2022 and pays a benefit in certain circumstances, after a deferred period of 4 weeks.

Mr M had an accident in February 2023 and submitted a claim on 1 March 2023. LV accepted the claim and benefits were paid monthly.

LV continued to review the claim and, as part of this process, it requested Mr M's medical records. LV reviewed the records and said Mr M didn't declare his medical conditions when he applied for the policy. And if Mr M had declared these, it wouldn't have offered any cover at all. So, it cancelled the policy and stopped the benefit payments. It also asked Mr M to pay back the benefits already paid.

Unhappy Mr M brought his complaint to this service. Our investigator didn't uphold the complaint. She said under the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) as there was a medical condition which should have been declared when Mr M applied for the policy, she didn't think LV had cancelled the policy unfairly. And the request of payments already made to Mr M wasn't unreasonable based on the evidence available.

Mr M disagreed and asked for the complaint to be referred to an ombudsman. So, it's 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.

At the outset I acknowledge that I've summarised this complaint in far less detail than Mr M has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern our service allow me to do this as we are an informal dispute resolution service.

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 must 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've gone on to think about this when looking at Mr M's complaint and his individual circumstances. LV has said Mr M failed to take reasonable care not to make a misrepresentation when Mr M didn't disclose all the medical information he should have when the policy was taken out.

Mr M was asked to complete an application form in January 2022, which included health questions.

On page 7, he was asked:

> '*In the last 5 years, regardless of whether you've consulted a doctor, required treatment or had time off work, have you had:*
>
> *Q Asthma, bronchitis, sleep apnoea or anything affecting your lungs or breathing?*
>
> *Including:*
>
> - *Chronic obstructive pulmonary disease (COPD)*
> - *Emphysema*
>
> *You don't need to tell us about:*
>
> - *Common colds and flu*
> - *One off chest infections that you have fully recovered from'*

Mr M answered '*No'* to this question.

After completing the application form, LV sent Mr M a letter in January 2022, which provided a copy of his application form, and he was asked to check the application he completed as correct and accurate. And if anything was incorrect, then to contact LV within 30 days of the letter. Some guidance notes were also provided with the letter to assist with any changes that might have been needed.

In July 2022, Mr M completed a health declaration which asked:

> *'Since the date of your original application, have you:*
>
> *2. had any illness or accident?*
>
> *3. consulted your usual medical practitioner or any other medical practitioner, counsellor or therapist?*
>
> *4. attended hospital either as an inpatient or outpatient?*
>
> *5. any expectation of seeking medical advice in the near future?'*

Mr M answered '*No'* to all of the above questions.

He was also asked:

> *'Other than for things you've already told us about, in the last 3 years have you:*
>
> *Been prescribed medication or treatment for a period of 4 weeks or more, or been referred or requested any counselling or therapy?'.*

And:

> *'In the last 2 years have you:*
>
> *Been off work due to sickness or injury for a period of 5 or more days in a row?'*

At the start of the application in January 2022, Mr M confirmed that he'd answered all questions truthfully and honestly and the answers provided in the application were honest and accurate. And he confirmed that if anything was incorrect or if anything changes before the policy starts, he will let LV know. He completed the same declaration again in July 2022.

In January 2024, LV requested Mr M's medical records. They were received in June 2024 which showed Mr M had COPD and he smoked more than he'd declared. LV considered that the misrepresentation was deliberate or reckless and it wouldn't have offered cover at all had it been made aware of his medical history. So, it declined the claim, cancelled the policy and stopped the benefit payments. It also asked Mr M to repay the benefits it had already paid.

I've considered the medical records.

- 16 November 2020, GP notes state Mr M had a previous collapsed lung and he was given antibiotics for pleurisy. He had slight issues with shortness of breath on walking and chest tightness. He was starting an inhaler for COPD.
- 17 November 2020, Mr M was provided a not fit for work certificate for cough.
- 20 November 2020, Mr M requested that the reason for his sickness to be entered was not cough but pleurisy.
- 26 November 2020, trial medication for COPD was discussed and how to use it.
- 2 December 2020, cough, mild SOB (shortness of breath), chest infection, mood and anxiety were noted as having remained. Medication was reviewed and prescribed for low mood.
- 11 January 2021 – he feels better with medication for low mood and to continue with this for the next two months with a review thereafter.

Additionally, a letter dated 2 June 2023 states Mr M was smoking more cigarettes per day rather than the 10 that he said he smoked in his application. The letter also states Mr M '*was diagnosed with COPD which according to the patient seems to be severe with having left lung disease'*

I can't see that any of the above medical conditions were declared on the application and which should have been. I do note that diagnosis of the COPD was after the policy started.

I've gone on to think about whether failing to take reasonable care makes a difference in this case. Under CIDRA, LV has classified the qualifying misrepresentation as a deliberate or reckless one.

LV has provided underwriting evidence which shows what would have happened if the correct information had been entered at the time of taking out the policy in 2022. It says had the questions been completed accurately, it wouldn't have offered Mr M cover on the policy. So, LV cancelled the policy, stopped the benefit payments, and asked Mr M to repay the amount he'd paid, less the premiums. LV has also offered Mr M a repayment plan to assist. I've carefully reviewed the underwriting evidence. This shows had Mr M completed the questions about his medical condition accurately in 2022, LV would not have offered the policy at all. This means, I'm satisfied Mr M's misrepresentation was a qualifying one.

Based on the available evidence, I'm satisfied that LV has followed the law as set out in CIDRA. Under this, LV is entitled to do this. Taking everything into account, I'm satisfied this is fair and reasonable.

I've considered Mr M's comments that he was never diagnosed with COPD before he took out the plan and the medication that he was prescribed with was experimental. He wasn't made aware of the purpose of these and had no understanding of its intended use. The COPD is also now being called to question.

Whilst I acknowledge the comments, I can't say that LV has unreasonably stopped the benefit payments or cancelled the policy. Whether the medication was experimental, or whether Mr M had no understanding of its intended use doesn't have a bearing here. The evidence shows Mr M was taking medication which he hadn't declared in his application.

The crux of the issue is that the evidence shows Mr M didn't accurately declare his medical conditions or answer the medical questions as he should have. Whilst COPD may not have been formally diagnosed before his policy application, the medical evidence suggests there was shortness of breath. Mr M didn't disclose all his medical conditions or answer the questions he was asked accurately. I don't think LV has therefore incorrectly classified the misrepresentation as deliberate or reckless and I don't think it was incorrect to cancel the policy and stop the benefit payments. I note that LV has offered a repayment plan to Mr M. I think this is fair and reasonable in the circumstances. As such, I'm satisfied it's fair and reasonable for Mr M to repay the benefits already paid.

I confirm that I cannot consider any new medical evidence regarding Mr M's COPD diagnosis. Mr M should send this directly to LV for its consideration as this doesn't form part of this complaint.

Overall, I'm sorry to disappoint Mr M, but based on the circumstances, I'm satisfied that CIDRA has been applied fairly. And I'm not persuaded that Mr M has been treated unfairly when LV cancelled his policy and stopped his payments. It follows therefore that I don't require LV to do anything further.

My final decision

For the reasons given above, I don't uphold Mr M's complaint about Liverpool Victoria Financial Services Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 12 May 2025.

Nimisha Radia
Ombudsman