DRN-5426630

The complaint

The estate of Mrs W complains because Vitality Life Limited ('Vitality') hasn't paid claims under four life insurance policies.

Mr W has brought this complaint to us in his capacity as the executor of Mrs W's estate. Mr W has appointed a representative to correspond with our service on his behalf. All references to Mr W's submissions include those of Mr W's representative.

What happened

Mrs W held four life insurance policies, provided by Vitality. The policies were taken out in 2016 and Mrs W told Vitality about some medical conditions she had when buying the policies.

After Mrs W very sadly passed away, Mr W made a claim under the policies with Vitality. Vitality said the claims weren't covered because Mrs W hadn't told it about certain medical information when buying the policies. Vitality said if it had known about this medical information it wouldn't have offered Mrs W any cover, so it cancelled the policies and refunded the premiums paid.

Unhappy, Mr W complained to Vitality before bringing the matter to the attention of our service.

One of our investigators looked into what had happened and said she didn't think Vitality had acted unfairly or unreasonably in the circumstances. Mr W didn't agree with our investigator's opinion, so the complaint has been referred to me to make a decision as the final stage in our process.

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'm very sorry to hear about the sad circumstances surrounding this complaint and I'd like to offer Mr W and his family my sincere condolences for their loss.

Vitality previously offered Mr W £300 compensation for its delays in reviewing the claims. Mr W didn't accept Vitality's offer but didn't bring a complaint to us about that matter within the six-month time limit set out by the rules that govern our service. So, this complaint and this final decision only relate to the outcomes of the claims under Mrs W's policies and not to the delays or the compensation previously offered.

I note that a number of Mrs W's life insurance policies were held in trust. The trustee is a private limited company, of which Mr W is a director. I'm satisfied that in these circumstances it's appropriate for me to address all four policies within this final decision.

I appreciate Mr W will be very disappointed with my findings and I understand the financial implications of Vitality's refusal to pay these claims, but I need to reach an independent and impartial outcome which is fair and reasonable to both parties based on all the available evidence.

Industry rules set out by the regulator say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when making my decision. I've also taken into account the relevant law (The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA')) and I've had regard to good industry practice about managing claims for misrepresentation and treating customers fairly (namely, the September 2019 Code of Practice set out by the Association of British Insurers ('ABI')), as well as what I think is fair and reasonable in all the circumstances.

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out an insurance policy. The standard of care required is that of a reasonable consumer. If a consumer fails to do this, the insurer has certain remedies available to it provided the misrepresentation is - what CIDRA describes as – a 'qualifying misrepresentation'.

For a misrepresentation to be a qualifying one, 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 a 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.

Vitality told Mr W that it thinks Mrs W failed to take reasonable care not to make a misrepresentation because of how she answered the below questions which she was asked on her insurance policy application forms in approximately July 2016 and November 2016.

I've underlined the answers Mrs W gave.

> *'Apart from any condition you have already told us about, have you had any of the following in the last 5 years:*
>
> *…*
>
> *Any mental disorder, including stress, anxiety, panic attacks, depression, nervous breakdowns or eating disorders.'*
>
> *No*
>
> *'Apart from anything you have already told us about in this form, within the last 2 years have you had any medical condition, illness or injury that you have received treatment for, over a continuous period of 2 weeks or more?'*
>
> *No*

I'll refer to these questions as 'the first question' and 'the second question'.

I won't be making any findings about how I think Mrs W should reasonably have answered the first question relating to stress. This is because Vitality hasn't provided any underwriting evidence to demonstrate how Mrs W answering this question in a different way would have impacted the cover it offered in 2016. But, for the reasons I've set out below, I don't think this

makes any difference to the outcome of this complaint.

In relation to the second question relating to treatment received within the last 2 years, I'm satisfied that this question was clear and specific. I don't agree with Mr W's submissions that it was a general and/or vague question.

Next, I need to consider whether I think the medical evidence relied on by Vitality shows that Mrs W didn't take reasonable care to answer this second question.

I should say at this point that I'm not a medical expert and it's not my role to reach my own medical opinions or to substitute expert medical opinion with my own. It's also not for me to make any assumptions based on the medical evidence provided, or to draw any inferences into what the medical records say. I've weighed up the available evidence which has been provided to decide whether I think Vitality acted fairly and reasonably in the circumstances when taking the action it did.

I note Mr W has said Vitality isn't qualified to make a medical diagnosis. Vitality hasn't made any such diagnosis. Instead, it has considered the available medical evidence to make a decision about the claim, with input from its Chief Medical Officer.

Mrs W's GP records show she had multiple telephone consultations with her GP for 'opioid type drug dependence'. These took place in August 2014, October 2014, November 2014, December 2014, February 2015, May 2015, June 2015, August 2015, September 2015 and October 2015, all in the two years prior to the policies being taken out. During these consultations, Mrs W was being prescribed medication alongside being given advice by her GP to slowly reduce the dosage on a regular basis, with the GP noting this would be reviewed monthly.

While I accept the second question doesn't directly mention medication, I'm satisfied that a reasonable consumer would consider ongoing doctor's consultations during which medical advice and support is being given and prescriptions provided to constitute 'treatment', which Vitality wanted to know about in response to the second question.

Mrs W didn't provide the information about her GP consultations for opioid drug dependency to Vitality in response to the second question, so I don't think she took reasonable care not to make a misrepresentation about her medical history.

I understand Mr W says Mrs W's opioid drug use related to a separate medical condition and Mrs W didn't consider herself to be drug dependent, but the volume of entries in Mrs W's GP records and the GP's description of matters is, I think, persuasive evidence of why Mrs W was consulting with her GP. And, even if I were to accept that Mrs W's drug use did relate to a separate medical condition, I still think Mrs W should reasonably have provided Vitality with information about the GP consultations and what was being discussed during these consultations in response to the second question. I understand Mr W says Mrs W was adhering to her GP's advice and it wasn't up to Mrs W to decide what amounted to a medical condition, but there was an obligation on Mrs W to accurately answer the questions she was asked.

Vitality has provided underwriting evidence which I'm satisfied demonstrates that it wouldn't have provided these policies to Mrs W in 2016 if she had answered the second question in the way I think she reasonably should have. The underwriting evidence is commercially sensitive information which I can't share with Mr W, but I want to assure him that I've carefully considered it and I'm satisfied it demonstrates Vitality wouldn't have offered cover on any terms in 2016 if it had known about Mrs W's opioid drug dependence. I'm also

satisfied that Vitality hasn't treated Mrs W any differently to how it would have treated other policyholders with the same circumstances.

So, regardless of what answer Mrs W gave in response to the first question, I'm satisfied that Vitality would never have offered her cover if she'd answered the second question in the way I think she should have.

This means I think Vitality has demonstrated that Mrs W made a 'qualifying misrepresentation' under CIDRA. Vitality has treated Mrs W's misrepresentation as a careless one and I think Vitality's position on this point is reasonable.

Vitality has avoided the policies, refused the claims and returned the premiums paid. Contrary to Mr W's submissions, this is a remedy for careless misrepresentation which is set out in CIDRA and Vitality is entitled to rely on this remedy regardless of whether Mrs W's sad passing was linked to the opioid drug dependency which wasn't disclosed to Vitality. Vitality's actions in declining this claim are in line with both CIDRA and the relevant ABI Code so this means I don't think Vitality has acted unfairly or unreasonably in the circumstances.

I understand a serious illness claim was previously paid under these policies. But I'm satisfied, based on the information I've seen, that Vitality had no reason to question whether Mrs W had accurately answered the medical questions asked when the policies were sold during its consideration of the previous claim. For Vitality to have done so would have been in breach of industry codes saying that insurers should only ask for relevant information about a claim, and with justifiable reasons. I'm satisfied Vitality did have justifiable reasons for requesting Mrs W's medical records when the claims were made under her life insurance policies. And, even if Mrs W's misrepresentation had been discovered previously, it wouldn't have been possible for Mrs W to simply pay an additional premium to secure life insurance cover as Mr W is suggesting.

I'm sorry to disappoint Mr W and I know this won't be the outcome he was hoping for, but I won't be directing Vitality to do anything further.

My final decision

My final decision is that I don't uphold the estate of Mrs W's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mrs W to accept or reject my decision before 7 May 2025.

Leah Nagle
Ombudsman