DRN-5432000

The complaint

Miss R complained that Zurich Assurance Ltd declined a claim on her critical illness policy.

What happened

Miss R took out a life and critical illness policy with Zurich in December 2016. Due to ill health, Miss R stopped working around December 2022. As a result, Miss R raised a claim with Zurich in May 2023.

Zurich declined Miss R's claim in January 2024. Zurich said that Miss R had misrepresented when she applied for the policy. Whilst they would have still offered Miss R a policy, they would have done so on different terms. Miss R provided Zurich with further medical evidence and Zurich endorsed their claim outcome in May 2024.

Miss R has raised several complaints with Zurich. She's complained about delays and the claim outcome. At different points Zurich has accepted there were delays and offered Miss R compensation. Zurich didn't agree they'd come to an incorrect decision on the claim due to the misrepresentation. As Miss R was unhappy, she brought the complaint to this service.

Our investigator upheld Miss R's complaint. She agreed that Zurich had reached a fair outcome on the claim. She didn't think Zurich had offered enough compensation. Zurich appealed. They said they'd already offered Miss R more compensation than the investigator had awarded. As no agreement could be reached, the complaint has been passed to me to make a final decision.

I was minded to reach the same overall outcome as our investigator, but with some additional reasoning. So, I issued a provisional decision, to give both parties an opportunity to comment on my initial findings before I reached my final decision.

What I provisionally decided – and why

I previously issued a provisional decision on this complaint as my findings were different from that of our investigator. In my provisional decision, I said:

"*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, and whilst I appreciate it'll come as a disappointment to both Miss R and Zurich, I'm intending to reach the same outcome as our investigator.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether Zurich acted in line with these requirements when it declined to settle Miss R's claim.

At the outset I acknowledge that I've summarised her complaint in far less detail than Miss R has, and in my own words. I'm not going to 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 the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to reach an outcome in line with my statutory remit.

I'm very sorry to hear about Miss R's health. I wish her all the best with her future treatment. There are two elements to this complaint which I'll deal with separately.

Claim decline

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 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.

Zurich thinks Miss R failed to take reasonable care when she answered the following questions:

"In the last 5 years, unless you have already told us earlier in this application, have you had:

- *Anxiety, stress, depression, chronic fatigue, obsessive compulsive disorder or other mental illness?*

- *Any disease or disorder of the back, bones or joints, such as arthritis, whiplash, sciatica, slipped disc or gout?"*

Miss R answered both questions "No". Zurich has provided me with Miss R's medical information. These show the following:

- *2012 – Tendonitis in shoulder*

- *February 2014 – Attended GP feeling tired. Coded as low mood and discussed possible referral to psychological therapies*

- *March 2014 – Whiplash*

- *February 2016 – injections into right wrist*

Based on the questions asked, the answers given and the medical information, I do agree that Miss R misrepresented during her application. I think the questions are clear in what they want to know and so I don't think Miss R took reasonable care when answering the questions.

Zurich have provided me with a statement from an underwriter and the relevant parts of their underwriting manual. Based on what I've seen, Zurich would still have offered Miss R the

policy, but they wouldn't have offered her total and permanent disability (TPD) own occupation. As a result, I think Miss R's misrepresentation would be a qualifying misrepresentation under CIDRA.

Zurich has categorised the misrepresentation as careless. This is the lowest level of misrepresentation and I don't think this is unreasonable in the circumstances. Based on the reasons above, I don't think the actions taken by Zurich are unfair or unreasonable in the circumstances.

Miss R still has the standard TPD cover on her policy. Zurich assessed her claim based on this definition which is as follows:

"Loss of the physical ability through an illness or injury before age 65 to do at least 3 of the 6 tasks below ever again.

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

The insured person must need the help of supervision of another person and be unable to perform the tasks on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

The tasks are:

- *Washing – the ability to wash in the bath or shower (including into and out of the bath or shower) or wash satisfactorily by other means.*
- *Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed any braces, artificial limbs or other surgical appliances.*
- *Feeding yourself – the ability to feed yourself when food has been prepared and made available.*
- *Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.*
- *Getting between rooms – the ability to get from room to room on a level floor.*
- *Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again."*

Miss R's consultant confirmed in January 2024 that she was currently attending a management group and most patients do make some recovery that affords them a satisfactory quality of life. They also confirmed that Miss R's mobility is restricted on bad days. Whilst I don't mean to downplay Miss R's condition, the policy requires Miss R to be unable to complete 3 of the tasks ever again, not just on bad days. There also hasn't been confirmed permanency of Miss R's symptoms yet. As such, I don't think Zurich has unfairly or unreasonably declined the claim. I appreciate further medical evidence has been provided since the complaint was brought to this service. I can't consider this information but would expect Zurich to continue to review the claim as Miss R's condition develops and further medical information is available.

Delays

Miss R has raised several complaints about delays in her claim being assessed. I can only consider issues brought to us within six months of the final response letters issued by Zurich. This means I can only consider delays from 8 November 2023 onwards. Having reviewed the evidence provided I can see that Zurich's underwriters provided information to the claims team on 22 November 2023. I see no reason why a claim outcome couldn't have been given

at this point. However, it took Zurich until 16 January 2024 to decline the claim. Likewise, Miss R provided additional medical information for Zurich to assess in mid-January and early February. Zurich confirmed they'd review this additional information on 23 February 2024 but didn't issue a response until 13 May 2024. On both occasions there were significant delays.

Zurich has acknowledged there were delays and offered £200 compensation. In their view, our investigator increased the compensation by a further £150 to a total of £350. Zurich said that in total they'd already offered Miss R £800 compensation for delays. However, £600 of this was for delays prior to 8 November 2023 which doesn't form part of this complaint.

I appreciate that it must have been frustrating for Miss R due to the delays especially with her health. I've considered everything in the round and I think Miss R has been caused considerable distress, upset and worry which has taken a lot of extra effort to sort out over several months. In line with our website guidelines, I think £350 compensation is fair and reasonable for the delays caused by Zurich from 8 November 2023.

I'm intending to tell Zurich to pay Miss R a total of £350 compensation to cover the distress and inconvenience caused due to the claim delays from 8 November 2023."

I set out what I intended to direct Zurich to do to put things right. And gave both parties the opportunity to send me any further information or comments they wanted me to consider before I issued my final decision.

Responses to my provisional decision

Zurich accepted my provisional decision.

Whilst Miss R didn't specifically say she disagreed with my outcome, she provided some documents and wanted to ensure they had been considered as part of the final 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.

I've thought carefully about the provisional decision I reached. I can confirm that both documents Miss R provided in response to my provisional decision were already on the file and had been considered in coming to my outcome. As such, neither party provided anything new for me to consider.

As neither party has provided anything which could lead me to depart from my provisional decision, my final decision remains the same as my provisional decision, and for the same reasons.

Putting things right

Zurich should pay Miss R a total of £350 compensation for the trouble and upset caused.

My final decision

For the reasons I've explained above, I uphold this complaint and direct Zurich Assurance Ltd to put things right by doing as I've said above, if they haven't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss R to accept or reject my decision before 6 June 2025.

Anthony Mullins
Ombudsman