DRN-5468172

The complaint

Mrs J's complained – in her capacity as trustee of the J Trust – that Aviva Life & Pensions UK Limited unfairly declined the claim she made on Mr J's life insurance policy when he died.

Mrs J has brought the trust's complaint to the Financial Ombudsman Service with the assistance of a claims management company (CMC). References in this decision to submissions and comments made by Mrs J include those made by the CMC on the trust's behalf.

What happened

In autumn 2022, Mr J applied for a life insurance policy. As part of the process, he completed a medical questionnaire. He declared he had high blood pressure. Aviva accepted the application on the basis of the information he provided and cover began in late December 2022. Mr J placed the policy into trust and appointed Mrs J as the trustee.

Just over a month later, Mr J suffered a sudden onset headache, as well as slurred speech and weakness in one side of his body. He was diagnosed as suffering from an intracerebral haemorrhage and underwent an operation. But, sadly, he died just over a week later.

Mrs J submitted a claim to Aviva. Aviva assessed the available information and declined the claim. They said that Mr J hadn't provided accurate answers to his medical questionnaire. If he had, Aviva said they wouldn't have offered him cover. Aviva explained this entitled them to cancel the policy and refund the premiums Mr J had paid – which they did.

Mrs J complained that the information Aviva had relied on in their decision appeared only in Mr J's medical records and he hadn't known there was an issue. And in a subsequent complaint, she said Aviva's decision was unfair because they'd obtained Mr J's full records, rather than making a targeted request for information.

Aviva didn't change their decision. They said that Mr J's medical records showed he'd been diagnosed with stage 3 chronic kidney disease in 2010. But he'd not declared this on the medical questionnaire. And, if they'd known about this condition, they wouldn't have offered him cover.

In response to the second complaint, Aviva said that Mr J had died very shortly after he bought the policy, from a condition linked to high blood pressure. He was also very young. This led them to question whether the details he'd provided about the management of his blood pressure were accurate. So they'd asked for his medical records for the two years leading up to his death.

Mrs J didn't accept Aviva's explanation and brought the trust's complaint to the Financial Ombudsman Service. Our investigator reviewed all the available information and concluded Aviva didn't need to do anything differently to resolve the complaint. Our investigator was satisfied Aviva's decision that Mr J had misrepresented his health had been made fairly and that their request for his medical records had been appropriate in the circumstances.

Mrs J didn't agree with our investigator's view. So I've been asked to make a 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.

Having done that, I'm not upholding the trust's complaint. I know this will be upsetting news for Mrs J to receive and I'm sorry about that. I hope it will help if I explain the reasons for my decision. I'll do so, focusing on the points and evidence I consider material to my decision. The rules that govern the Financial Ombudsman Service allow me to do this as we are an informal dispute resolution service. So if I don't mention something in particular, it's not because I haven't thought about it. Rather, it doesn't change the outcome of the complaint. I'm satisfied I don't need to comment on every point to be able to fulfil my statutory remit.

Aviva declined the claim because they say Mr J misrepresented his health when he applied for the policy. Having carefully considered the submissions made by, and on behalf of, Mrs J, I can't see that they've challenged this. Rather, the complaint is focused is on whether Aviva acted fairly in how they investigated the potential misrepresentation.

The relevant law where an insurer thinks a customer may have made a misrepresentation 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.

Aviva had concerns about several of Mr J's answers to the medical questionnaire. But, like our investigator, I've focused on the one Aviva has said would, on its own, have meant they wouldn't have offered cover.

All parties agree Mr J had high blood pressure. He declared this on his application. This triggered a number of follow up questions including:

"Have you ever had protein in your urine or any kidney problems (other than kidney stones)?"

Mr J answered "no" to this question. Aviva say he should have answered "yes", because his medical records show he'd been diagnosed with chronic kidney disease in 2010. It's been suggested on behalf of the trust that the question isn't clear, because the question about blood pressure says:

""Within the last four years have you had, or have you taken medication for, or been advised to take medication or have treatment for:

…

Raised blood pressure or raised cholesterol?"

I don't agree with that suggestion. I think the wording *"Have you **ever**…"* [my emphasis] is clear there's no time limit applicable to the question. So I think it's fair to say Mr J didn't take reasonable care in answering it. And that means he made a misrepresentation.

Mrs J has said Aviva should still pay the claim because they acted unfairly in how they obtained evidence of the misrepresentation and breached both guidance provided by the Association of British Insurers (ABI) and rules set out in the FCA Handbook. And she says what was revealed wasn't linked to her husband's death. I've thought about this.

It's usual for insurers selling this type of product to rely on the answers given by customers in their medical questionnaires to decide whether to offer cover, at what cost and whether to exclude any conditions from the policy. Customers are warned about the possible consequences of not providing accurate information and given an opportunity to check and confirm that what they said was right. That's what happened in this case.

And it's usual for an insurer to check no misrepresentation was made if they receive a claim. So I can't say Aviva acted unfairly by making those checks. I don't agree with Mrs J's submission that this amounts to an unreasonable barrier and breaches the Consumer Duty because the checks Aviva made would have been made in all claims of this type.

Aviva pursued their assessment by requesting Mr J's medical records for the two years prior to his death. Mrs J says this breaches the ABI guidance which says complete medical records shouldn't be requested. And she says the request should have focused on Mr J's high blood pressure and on his cause of death.

Guidance on this is set out in the ABI's Code of Practice "*Managing Claims Involving Misrepresentation For Individual and Group Life, Critical Illness and Income Protection Insurance Products*". The relevant sections say:

"3.5 Insurers may ask for relevant medical or other information needed to properly assess a claim.

3.6 However, insurers should have a justifiable reason for requesting medical information at the point of claim.

3.7 Accordingly, insurers should only ask for medical information beyond that needed to assess whether the insured event has occurred, or to case manage a disability claim, if and to the extent that the circumstances of the claim reasonably prompt the insurer to believe that there might have been misrepresentation by the customer. In particular, insurers should:

3.7.1 Keep an audit trail of the reasons for requesting medical information (the FOS and the Information Commissioner's Office ('ICO') are likely to be concerned at the use of medical information clearly obtained without a justifiable reason).

3.7.2 Note that an early claim is not a reason by itself (although it may be a relevant supporting factor).

3.7.3 Carefully consider the time period for which it is appropriate to request medical information and the relevant areas that should be investigated and keep an audit trail of the reasons for that time period.

3.7.4 Ensure that claims investigations are consistent with the timely collation of medical information and the need to make claims decisions promptly."

Aviva have explained that they were concerned that Mr J's death resulted from a condition related to his high blood pressure. As that happened so soon after he'd declared his high blood pressure was well managed, and in light of his age, they were concerned that he'd not been accurately reported the extent of his condition – that is to say, he'd made a misrepresentation in his application.

I think it was reasonable for Aviva to investigate whether this was the case. And I think the information they requested was relevant to that investigation. As can be seen from guidance above, insurers aren't prohibited from requesting full medical records – rather, they should be able to provide an audit trail showing why they requested what they did. I'm satisfied Aviva did that and that the information they sought enabled them to investigate whether Mr J had made a misrepresentation.

I note that Mr J's doctors provided much more information than Aviva requested. But I can't hold Aviva responsible for that – nor, having received information relevant to their consideration, do I think it's fair to say they should have – or were obliged to – ignore it.

And, even if Aviva had made a much narrower request, I think the outcome would have been the same. Mr J's GP sent them a copy of the report from the hospital where he was treated and sadly died. I think it's reasonable to expect such a report to have been supplied.

The report lists a number of co-morbidities for Mr J, including high blood pressure and chronic kidney disease. I think it's likely that seeing this would have led to Aviva asking for additional disclosure around these records – which would have identified Mr J's inaccurate answer to the question about kidney issues. So, overall, I think Aviva's assessment of whether Mr J made a misrepresentation was fair.

And I think that was a qualifying misrepresentation within the meaning of CIDRA, because Aviva have shared commercially sensitive underwriting evidence that, if they'd known about his kidney disease they wouldn't have offered Mr J cover. I can see that Aviva have refunded the premiums they received while the policy was live. That's what CIDRA requires an insurer to do in cases where they wouldn't have offered cover and decide the misrepresentation was careless. So, while I appreciate it's an upsetting outcome for Mrs J, I don't think Aviva need to do any more to resolve the trust's complaint

My final decision

For the reasons I've explained, I'm not upholding the complaint made about Aviva Life & Pensions UK Limited by Mrs J as trustee of the J Trust.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs J as trustee of the J Trust to accept or reject my decision before 10 July 2025.

Helen Stacey
Ombudsman