DRN-5495334

The complaint

Ms H has complained that Vitality Life Limited declined a claim made under her life and serious illness cover insurance policy.

What happened

The background to this complaint is well known to the parties. In summary Ms H took out the policy in January 2023 through an independent advisor. Ms H made a claim in July 2023 having recently been diagnosed with cancer. Vitality declined the claim in May 2024. It said Ms H didn't accurately disclose her medical history when applying for the policy. It explained that had she done so, it wouldn't have offered her cover.

Ms H complained, but Vitality maintained its decision was correct. It did agree that there had been unnecessary delays and had failed to keep Ms H updated. To apologise it offered £1000 in compensation.

Ms H remained unhappy and referred her complaint here. Our investigator considered all the circumstances but didn't conclude that Vitality had acted unreasonably in declining her claim.

Ms H appealed. She disputed she had been advised to reduce her alcohol intake, she said that discussions on this subject were self-initiated. She didn't agree that the blood pressure reading quoted by the investigator was the latest reading prior to taking the policy out and she didn't recall that she had been referred for specialist tests.

Our investigator didn't change his assessment, so the matter has been to me to determine.

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.

Although I've summarised the background and some sensitive medical details, no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts.

The relevant regulator's rules provide that insurers must handle claims promptly and fairly and mustn't unreasonably reject a claim. So I've considered, amongst other things, the relevant law, the policy terms and the available evidence, to decide whether I think Vitality treated Ms H fairly. Having done so I agree with the conclusion reached by the investigator. I will explain why.

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.

Vitality concluded that Ms H had failed to take reasonable care when answering the questions asked when she applied for the policy. This was based on the medical information received when assessing her claim. The questions it referred to were:

Have you ever been advised to reduce your alcohol intake because you were drinking too heavily?

Apart from anything you have already told us about on this application, in the last three years have you:

- *been referred to a specialist (including if you are still on the waiting list) or been advised to have any medical investigations for example blood tests, X-rays, urine test, scans, biopsies or internal camera investigations in connection with a medical condition or symptom even if you are awaiting the results?*

The medical evidence that Vitality received from Ms H's GP practice shows that Ms H was drinking over guidance level and advice had been given due to abnormal liver function tests.

I haven't disregarded Ms H's point that she initiated these discussions, but I don't find that Vitality treated her unfairly in relying on her medical notes. Likewise from the medical information received from Ms H's GP surgery it is stated that in October 2021 blood testing revealed abnormalities and further tests were carried out in and December 2021. Here too I note that Ms H doesn't recall being advised to have tests, but I am satisfied it was fair for Vitality to rely on the medical information received.

Your health in the last five years:

- *have you had raised blood pressure or raised cholesterol, Deep Vein Thrombosis, disease or disorder of the blood vessels including the aorta and arteries of the leg or neck or any condition affecting the blood such as anaemia or thalassemia?*

With regards to this question Ms H answered 'yes' but has said that there was a more recent blood test result to the one Vitality relies on from her GP notes dated 29 November 2022 (under a list of blood pressure readings). She has said that she was inputting her readings into an NHS monitoring service and had done since October 2021. Ms H says the response in January 2023, just prior to taking out the policy, was 'your BP reading is normal'. Ms H can present this new evidence to Vitality, but I am satisfied it was fair for it to rely on the November reading when reaching its decision.

Ms H has recently been to see her GP and has discussed the medical notes with them. To summarise, the outcome of this meeting was that Ms H answered the questions asked to the best of her knowledge and understanding and from speaking to her GP there is nothing that would indicate otherwise. I do understand this, but in this decision I am considering whether Vitality treated Ms H fairly on the information it had at the time it declined her claim.

On the basis of that evidence, and the clear questions asked, I don't find that Vitality treated

Ms H unfairly by concluding that she had failed to take reasonable care when answering the application questions. Of course, if she now has medical evidence from her GP that she thinks might lead to a different outcome she can submit this to Vitality for its consideration.

Vitality has shown by underwriting evidence that had it been aware of the correct answers as indicated by the medical record, it wouldn't have offered Ms H cover when it did. This means that the misrepresentation is qualifying under CIDRA. Although Vitality has classified the misrepresentation as reckless, it has offered to refund the premiums that Ms H paid. This accords with the remedy for careless misrepresentation set out in CIDRA. I find careless, rather than reckless, would have been the correct classification. But as Vitality wouldn't have offered cover, the only difference here would have been whether it had to refund the premiums paid or not. As it has done so I find it treated Ms H fairly I this regard.

I have no doubt that this has been a most difficult and traumatic time for Ms H – coping with her diagnosis and in addition submitting a claim. She would understandably have expected it to be dealt with swiftly. Vitality isn't responsible for any delay whilst waiting for the medical evidence, but there were unnecessary delays on its part and communication was poor. I'm pleased to note that Vitality has acknowledged this and offered £1000 compensation. I find that is fair.

Despite my natural sympathy for the position Ms H is in, I don't find that Vitality treated her unfairly by declining her claim on the information it had. I am very sorry that my decision doesn't bring welcome news at this time.

My final decision

For the reasons given my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms H to accept or reject my decision before 20 June 2025.

Lindsey Woloski
Ombudsman