DRN-5520668

The complaint

Mr and Mrs C complain that Zurich Assurance Ltd has turned down a critical illness claim Mr C made on a personal protection insurance policy.

As Mr C brought the complaint to us, for ease, I'll refer mainly to him.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I consider to be the main events.

In December 2023, Mr and Mrs C applied for a personal protection insurance policy through a broker. During the sale, Mr C disclosed that he suffered from some medical conditions and so Zurich asked Mr C's GP for a medical report. The GP's report was dated 22 December 2023. Based on that report, Zurich agreed to offer Mr and Mrs C a personal protection policy, although it applied some exclusions for Mr C. Cover began on 5 January 2024.

Unfortunately, Mr C was subsequently diagnosed with a brain tumour. So he made a critical illness claim on the policy.

Zurich obtained Mr C's full medical records. It noted that on 1 January 2024, four days before the policy began, Mr C had visited an urgent care centre after suffering from an acute episode of left-sided numbness and weakness, which had resolved spontaneously. Mr C was also recorded as having suffered from dizziness. Zurich accepted that Mr C hadn't been suffering from these symptoms when he applied for the policy.

But Zurich said the policy documentation had made it clear that Mr C needed to tell it if the answers he'd given during the application process had changed between the application date and the policy start date. It said that if Mr C had told it about his acute episode on 1 January 2024, it would have postponed offering Mr C cover for six to 12 months. And by that time, Mr C had been diagnosed with a brain tumour, so Zurich said it would have declined to offer him a policy at all. It concluded that Mr C had made a qualifying deliberate misrepresentation under relevant law. It turned down Mr C's claim, cancelled the policy and refunded the premiums Mr and Mrs C had paid for the cover.

Mr C was very unhappy with Zurich's decision and he asked us to look into this complaint. In brief, Mr C said his symptoms of 1 January 2024 had resolved and he'd had no reason to believe he'd suffered a change in health which he needed to disclose to Zurich.

Our investigator didn't think Zurich had treated Mr C unfairly. She thought it had been fair for Zurich to conclude that Mr C had made a qualifying misrepresentation under relevant law and to therefore apply the legal remedy available to it.

Mr C disagreed and I've summarised his detailed responses to the investigator:

- He maintained that he'd acted reasonably, innocently and in good faith, based on the situation at the time;

- He considered that Zurich's underwriting decision had been made with the benefit of hindsight and that its underwriting process was inconsistent and biased.;
- Medical specialists had provided clear evidence that there'd been no cause for concern about Mr C's symptoms on 1 January 2024. This evidence suggested that the symptoms had been transient. He didn't think Zurich should be able to make retrospective judgements about what investigations should have taken place at that time;
- He didn't feel that Zurich's application questions would have led to a different underwriting decision, given he wasn't diagnosed with a condition on 1 January 2024;
- He referred to other decisions issued by this service which he considered supported his position;
- He considered that Zurich's application questions were ambiguous and that its language wasn't in line with relevant law;
- Mrs C had been left without cover for six months.

The complaint's been passed to me to decide.

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 so, whilst I'm very sorry to disappoint Mr and Mrs C, I don't think Zurich has treated them unfairly and I'll explain why.

First, I'd like to say how sorry I was to read about Mr C's diagnosis. I appreciate this must have been a very worrying and upsetting time for Mr C and for his family. I do hope his treatment is going well. I'd also like to reassure Mr C that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent. In this decision though, I haven't commented on each point that's been made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the law, the policy terms and the available evidence, to decide whether I think Zurich treated Mr C fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. 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.

When Mr C took out the new policy through a broker, he was asked information about himself and his medical history. Zurich used this information to decide whether or not to insure Mr C and if so, on what terms. Zurich acknowledges that Mr C correctly answered the

questions he was asked during the broker sale at the time he applied for the policy on 13 December 2023. But it concluded that Mr C ought to have told it about the symptoms he'd developed on 1 January 2024 before cover began on 5 January 2024. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these principles to the circumstances of Mr C's claim.

Zurich thinks Mr C failed to take reasonable care to tell it about a change in his circumstances between the date he applied for the policy and the date cover began. So I've considered whether I think this was a fair conclusion for Zurich to reach.

On 5 January 2024, Zurich sent Mr C a Personal Details Confirmation (PDC) both online and by post, together with other policy paperwork. This followed Zurich's assessment of the medical report Mr C's GP had sent it, which was dated 22 December 2023 – prior to Mr C's visit to the urgent care centre on 1 January 2024. The PDC set out the information Mr C had been asked during the application and the answers he'd given. Page one of the PDC stated:

'This sets out the answers you gave us during your application. Please check this information carefully and let us know if any of the answers are now incorrect, or if any of them change before the policy start date.'

Page seven of the PDC includes a box called '*If anything changes'*. This says:

'We know how important the cover is to you so if you think anything you've told us is wrong, or has changed up to the policy start date, let us know as soon as possible. If you don't tell us about something that's incorrect we may have to cancel the policy or be unable to pay a claim.

If any of the information confirmed above needs to be corrected please make the changes on this form and complete the declaration below.'

In my view then, the PDC made it clear that Mr C needed to tell Zurich if any of the answers he'd given during the application process were now incorrect.

At application, Mr C was asked about his recent health. He was asked the following question:

'*In the last 5 years, unless you have already told us earlier in this application, have you had any of the following, or have you consulted a doctor, nurse or other health professional for:*

any tremor, numbness, loss of feeling or tingling in the limbs or face, blurred or double vision, loss of balance or co-ordination, epilepsy, seizure, or loss of muscle power?'

In my view, this is a clear question, which was worded in an unambiguous way.

Mr C answered 'no' to this question, which had been correct at the time.

However, it's clear from the discharge summary from the urgent care centre Mr C visited on 1 January 2024 that he sought medical attention because he was suffering from left-sided numbness and weakness. Zurich's question asked specifically whether Mr C had suffered from any numbness in the previous five years. So I think he should have been reasonably prompted by the PDC to tell Zurich about symptoms he'd suffered only four days before the policy began – even if he'd been reassured that they were nothing to worry about.

I appreciate Mr C feels the follow-up questions he would have been asked about his symptoms after the sale wouldn't have captured his situation because he didn't have a

diagnosis. However, it would have been for Zurich to ask Mr C questions about his symptoms and what had happened and to go on to assess whether or not it was still prepared to offer him cover.

On that basis, I don't think it was unfair for Zurich to have concluded that Mr C had made a misrepresentation.

So I now need to decide whether I think Zurich has shown Mr C made a qualifying misrepresentation under CIDRA – in other words, that it wouldn't have offered Mr C cover on the same terms, or at all, if it had known about his change in health.

Zurich has provided us with confidential underwriting evidence which shows that if Mr C had told it about his symptoms, it would have postponed cover for six to 12 months. And that following Mr C's ultimate diagnosis, it wouldn't have offered him cover at all. I'm satisfied that the underwriting evidence it's provided is based on the symptoms Mr C was experiencing on 1 January 2024, rather than retrospectively making an underwriting decision based on Mr C's subsequent diagnosis. So I think Zurich has shown that Mr C did make a qualifying misrepresentation under CIDRA and that it's reasonably entitled to rely on the relevant legal remedy.

As I've set out above, Zurich concluded Mr C had made a deliberate misrepresentation under CIDRA. However, it's turned down Mr Cs claim, cancelled his policy and refunded his premiums, in line with the remedy CIDRA sets out for careless misrepresentation. In my view, it would be fairer for Zurich to classify Mr C's misrepresentation as careless, because I don't think he deliberately sought to mis-lead it. But as it's acted in line with the remedy for careless misrepresentation in any event, I think it's acted fairly.

I appreciate Mr C has raised a number of concerns about the way Zurich has handled his claim. But I don't think it inappropriately relied on medical evidence which it obtained legitimately from Mr C's GP. And I don't think any reference by Zurich to a 'duty to disclose' makes a material difference to the outcome of this complaint.

Mr C has also referred to other decisions issued by this service which he feels are very similar to his own. However, each complaint is considered on its own specific facts and evidence. In the circumstances of this particular complaint, I think Zurich was reasonably entitled to rely on the medical evidence to conclude that Mr C had made a qualifying misrepresentation, given his specific symptoms.

I also understand Mrs C was left without cover when the policy was cancelled and that this must have been frustrating for her. But given I think Zurich handled the claim in line with CIDRA, I don't think it unfairly cancelled the overall contract. And I think it was open to Mrs C to look for alternative cover if she wished to do so.

Overall, while I'm very sorry to disappoint Mr C, I don't think Zurich acted unfairly or unreasonably when it turned down his claim, cancelled the policy and refunded the premiums.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C and Mr C to accept or reject my decision before 31 July 2025.

Lisa Barham
Ombudsman