

The complaint

Mr P complains because Liverpool Victoria Financial Services Limited ('LV') cancelled his income protection insurance policy and is seeking to recover monies paid to him.

What happened

Mr P took out an income protection insurance policy, provided by LV, in January 2012.

In 2021, LV paid Mr P an unemployment claim under the policy. In 2024, Mr P made a claim as he was unable to work due to illness. LV said the claim wasn't covered because Mr P hadn't told it about certain aspects of his medical history when he took out the policy. LV said, if it had known about these, it would never have offered Mr P the cover, so it cancelled the policy and off-set a premium refund against the previous claim which had been paid.

Unhappy, Mr P complained to LV before bringing the matter to the attention of our service.

One of our Investigators looked into what had happened and said he didn't think LV had acted unfairly or unreasonably in the circumstances. Mr P didn't agree with our Investigator's opinions, 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.

The Financial Ombudsman Service is independent and impartial. It's not our role to negotiate a compromise between the parties, and it's not for either party to tell us what our conclusions should be. We make decisions based on what we think is fair and reasonable in all the circumstances of an individual case. In doing so here, I've taken into account all the evidence which both parties have provided. This includes the solicitor's letter and the GP's statement dated 14 August 2024 which Mr P has sent to us – but these aren't determinative, and I'm not bound to follow what they say. When deciding what I think is fair and reasonable, I've also had regard to the relevant law as well as to good industry practice about managing claims for misrepresentation (namely, the Code of Practice set out by the Association of British Insurers ('ABI')). These are 'relevant considerations' under the rules which govern our Service.

Mr P needed to tell LV all the material information about his health which he knew, or ought reasonably to have known, in response to the questions it asked him.

The application form which was completed for this policy in 2012 asked:

'In the last 5 years have you had any of the following; (This is regardless of whether or not you have seen your doctor or required treatment.)

...

any ear, hearing or balance condition?’

Mr P answered ‘no’.

I’m satisfied this question is clear and specific. I don’t think it’s ambiguous, and it’s not asking only about illnesses which Mr P had a confirmed diagnosis for.

I’m not a medical expert and it’s not my role to make any findings about what Mr P’s health was at the time the policy was taken out. It’s also not for me to set out my own definition of what I think the word ‘condition’ means. Instead, I need to decide whether I think LV’s actions in this case were fair and reasonable based on the medical information available to it. Mr P’s medical records state, in February 2011 (so, within five years of the policy being taken out), he’d visited his GP who recorded the following in his notes:

‘History: tinnitus is really bad at moment – had it for years...’

I understand Mr P disputes whether ringing in the ears/tinnitus can be considered a ‘condition’ but I’m afraid I don’t agree with any of his submissions. I’m satisfied that a reasonable person would have considered that a GP visit for a ‘*really bad*’ ear issue which had been going on for some time in the year before the policy was taken out was something LV would want to know about in response to the question asked. So, I think Mr P should reasonably have answered ‘yes’ to the above question.

LV has treated this as being a careless misrepresentation under the ABI Code and has demonstrated to my satisfaction that it would never have offered Mr P any element of this policy if it had known about his ear issue (in addition to the other conditions which were disclosed to it at the time). This means it’s not unfair or unreasonable for LV to decline the claim, cancel Mr P’s policy and refund his premiums. LV has sought to offset the previous unemployment claim against the premium refund due to Mr P, which means Mr P owes LV money. I don’t think this is unfair or unreasonable in the circumstances. If this policy had never been offered to Mr P then he’d never have paid the premiums, but he’d also never have had the benefit of the unemployment claim that was paid. So, it isn’t correct to say the 2021 claim has no relevance to the 2024 claim, and it wouldn’t be fair or reasonable for Mr P to have the benefit of both the claim that was previously paid as well as a premium refund.

LV, in common with other insurers, wouldn’t generally ask for medical information at the point of offering a policy like this and it’s not something I’d expect it to have done here. There was also no obligation on LV to investigate Mr P’s medical history when assessing his unemployment claim. To do so would have been contrary to the ABI Code. I appreciate Mr P may have told LV about his family’s medical history when taking out this policy but neither that, nor the fact that Mr P’s medical records may show long periods of time until there was further medical intervention, don’t change my decision that Mr P didn’t take reasonable care when answering the question LV asked him.

LV also said Mr P didn’t tell it about another medical issue (impaired fasting glycaemia) when taking out this policy. I don’t consider it necessary to make any findings on this point, as I’m satisfied that LV was entitled to take the actions I’ve outlined above due to the tinnitus alone. Based on the evidence I’ve seen, LV didn’t ask Mr P’s GP for any additional information about his tinnitus because it didn’t need to do so. The fact that LV only asked for additional information about the impaired fasting glycaemia doesn’t mean LV has acted unreasonably or that this policy should be reinstated and Mr P’s claim paid.

I’ve taken into account what Mr P has said about being told by one of LV’s staff members that this claim would be accepted. I’ve seen no evidence that this was the case. But, even if I were to accept that LV did mistakenly say this, it still wouldn’t be fair or reasonable to require

LV to honour a mistaken statement of this nature when the claim isn't covered for the reasons I've explained above. I've thought about whether LV handled this claim promptly in line with industry rules. Overall, I'm satisfied that it did. While there were occasions where LV could have communicated updates to Mr P sooner, overall, I don't think the time taken by LV was excessive or unreasonable.

I'm sorry to disappoint Mr P, but as I don't think LV acted unfairly or unreasonably in the circumstances, I won't be directing it to do anything more and this includes paying towards Mr P's legal fees. However, I would say that I'd expect LV to consider arranging a reasonable repayment plan for Mr P in relation to the money he owes it.

As a final point, LV's decision to add exclusions to and charge increased premiums for Mr P's critical illness policy didn't form part of Mr P's complaint to LV or to our service. However, as our investigator considered and addressed this, I'm satisfied that it's appropriate for me to do the same.

I've considered the law which is relevant to the critical illness policy application (the Consumer Insurance (Disclosure and Representations) Act 2012) as well as Mr P's medical records in the five years prior to the critical illness policy being taken out.

I'm satisfied LV has demonstrated that Mr P made a misrepresentation in relation to his medical history based on the clear and specific questions asked when the policy was taken out in 2015. LV has also demonstrated that this was a qualifying misrepresentation, and it would have acted differently by offering cover on different terms if Mr P had told it what I think he reasonably should have. So, for the avoidance of doubt, I don't think LV's decision to add a retrospective exclusion and charge increased premiums for the critical illness policy was unfair or unreasonable in the circumstances. If Mr P doesn't wish for cover under the critical illness policy to continue then he'll need to contact LV directly to cancel it. But, Mr P had the benefit of the cover during the time this policy was in force so there are no reasonable grounds upon which I could fairly direct LV to refund the premiums paid.

My final decision

My final decision is that I don't uphold Mr P's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P to accept or reject my decision before 19 August 2025.

Leah Nagle
Ombudsman