DRN-5553376

The complaint

Mrs J complains that Liverpool Victoria Financial Services Limited (LV) refused to pay a claim she made on her life insurance policy.

What happened

In brief summary, in June 2020, Mr and Mrs J took out life cover with LV, through a broker. In June 2021, Mr J was diagnosed with cancer. In May 2024, Mr and Mrs J made a claim for terminal illness benefit. However, this was converted to a life claim when, very sadly, Mr J died in July 2024.

LV subsequently declined the claim, saying Mr J hadn't given full and accurate information during the application process. LV thought Mr J should've given different answers to questions related to use of tobacco, a diagnosis of angina, and alcohol.

LV considered this to be a qualifying misrepresentation. It said that, had Mr J answered correctly, it would not have offered him cover at all. LV treated the misrepresentation as deliberate and refused to pay the claim. Mr J's life cover was cancelled from the outset. LV said it would only refund Mrs J the premiums paid towards Mr J's cover after his death. But due to an administrative error, it subsequently refunded all his premiums. However, in view of the circumstances, it said it would not request repayment from Mrs J.

Mrs J complained but LV maintained its position. So Mrs J brought the complaint to the Financial Ombudsman Service, saying she and Mr J had answered honestly and to the best of their knowledge. But our investigator didn't uphold the complaint. He thought LV had acted fairly in declining the claim, treating the misrepresentation as deliberate and refunding Mr J's premiums.

Mrs J didn't accept our investigator's opinion and asked for an ombudsman to review the complaint and issue 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 so, I'm not upholding this complaint. I know this will be very disappointing news for Mrs J and I'm sorry about that, particularly as I'm aware Mrs J has faced some very challenging times in recent years. I hope it will help if I explain the reasons for my decision. I've focused on the points and evidence I think is material to the outcome of the complaint. So if I don't mention something specifically, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

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.

Mr J disclosed some health and lifestyle matters when applying for the policy. But LV says he failed to take reasonable care not to make a misrepresentation when he answered the following questions:

> *Q: Please choose the best description of your smoking habits*
> *Please choose smoker if you have used any tobacco products including cigarettes, cigars, or nicotine replacement products in the last 12 months.*
> *Options – Non-smoker, Smoker*
> *A: Non-smoker*
>
> *Q: Which of the following best describes you?*
> *Options – I've never smoked, I used to smoke but stopped over a year ago, I've smoked in the last year but not every day, I've vaped or used e-cigarettes in the last year, I've used other nicotine replacement products in the last year.*
> *A: I've never smoked.*
>
> *Q: Have you ever had any of these?*
> *Options – Cancer, cancer-in-situ, leukaemia, Hodgkin's disease or any other tumour, Heart attack, irregular heartbeat, cardiomyopathy, valve disorder or any other heart condition or heart surgery, A stroke, TIA, brain haemorrhage or damage or surgery to your brain, No*
> *A: No*
>
> *Q: Have any of these applied to you?*
> *Examples of recreation drugs include cannabis, ecstasy, cocaine, heroin, amphetamines and anabolic steroids*
> *Options – I've been advised by a medical professional to cut down or stop drinking alcohol, I've been referred for alcohol or drug specialist support such as Alcoholics or Narcotics Anonymous, I've used recreational drugs in the last 10 years, No*
> *A: No*

LV says Mr J should've answered these questions differently, based on evidence from his GP record. I've reviewed the medical and claims evidence provided.

The medical records show an entry in October 2020 – four months after the policy was taken out – where the history is recorded as:

> *'Some coughing persists at night and in morning, no SOB, no phlegm no haemoptysis, no wheeze, chews tobacco, no hoarse voice, ? throat irritation.'*

A repeat chest x-ray is requested as well as a fast track referral for suspected cancer. The record relating to the chest x-ray notes the clinical history as *'chews tobacco long term, persistent cough for 2 months.'*

I'm also aware that, in November 2024, Mrs J told LV Mr J had probably stopped chewing tobacco at the beginning of 2020 as a new year's resolution. I appreciate Mrs J later told LV this was a mistake and Mr J had actually stopped in 2015. However, I don't think it was unreasonable of LV to rely on the answer Mrs J first gave and the medical evidence shortly after the policy was taken out, to conclude that Mr J had likely chewed tobacco within the 12 months prior to taking out the policy.

The medical evidence also confirms that Mr J was diagnosed with angina in 2009, following a referral to the chest pain clinic and investigations. The GP record notes that this was explained to him and Mrs J by the GP and Mr J was also referred to cardiology.

Mrs J maintains she and Mr J were only asked if they smoked. And she's said that Mr J had no further angina symptoms and never used his prescribed GTN spray. She's also said that Mr J experienced language difficulties. As English was not his first language he wouldn't have understood his medical circumstances.

I think the smoking-related questions make it clear that use of any tobacco products within 12 months of taking out the policy should've been disclosed. And I think the question referring to any other heart condition reasonably includes an expectation of disclosure of angina.

Ultimately, the applicant is responsible for ensuring all questions are answered correctly. I'm aware Mr J had the opportunity to review his answers and made some corrections. Given this, I think Mr J failed to take reasonable care when answering LV's questions. LV was entitled to rely on the answers he provided when deciding whether or not to offer cover. And as our investigator has already explained to Mrs J, the broker who sold the policy is responsible for responding to any issues Mrs J has with the application process.

LV has provided evidence about its underwriting criteria to show what would have happened, had Mr J answered the questions accurately. This shows that the combination of Mr J's angina history and smoker status would've led to cover being declined. As LV would've acted differently, Mr J's misrepresentation was a qualifying one.

LV has treated Mr J's misrepresentation as deliberate, citing the evidence of tobacco use and diagnosis of angina. The Association of British Insurers' Code of Practice – Misrepresentation and Treating Customers Fairly, says that for a misrepresentation to be deliberate or reckless, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. Relying on the medical evidence, I think this was a reasonable categorisation.

I'm satisfied it was fair to place Mr J's misrepresentation in the deliberate/reckless category. So I've looked at the actions LV can take in accordance with CIDRA. In these circumstances, an insurer can avoid a policy, treating it as if it had never existed, and keep the premiums. It is not obliged to pay any claim. However, following his death, LV declined the claim, cancelled Mr J's part of the policy but, albeit in error, refunded the premiums he'd paid and has said it will not seek repayment. This is more than is required under CIDRA. I think LV has acted fairly in this regard.

For completeness, I should clarify that I've taken note of Mr J's historic use of alcohol and receipt of lifestyle advice from his GP to reduce his drinking. I'm aware from LV's underwriting evidence that this alone would've resulted in an additional loading being applied to any cover. But I've not commented any further on this as it doesn't make a difference to the overall outcome and the actions LV was entitled to take under CIDRA.

So to conclude, in light of all the circumstances, I don't think LV needs to do anything more in respect of this complaint. Once again, I'm sorry to send unwelcome news to Mrs J.

My final decision

For the reasons given above, my final decision is that I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs J to accept or reject my decision before 15 July 2025.

Jo Chilvers
Ombudsman