DRN-5566051

The complaint

Mrs M has complained that she was mis-sold a Life and Critical Illness Cover ('CIC') policy by TenetLime Limited, trading as PRIMIS Mortgage Network ('Tenet'). To put the matter right Mrs M wants redress equivalent to the full policy amount of £50,000 plus compensation for distress and inconvenience.

What happened

In October 2012 Mrs M took out a Life and CIC policy upon the advice of Tenet. In 2023 Mrs M was diagnosed as disabled and made a claim on her policy, but the claim was rejected by the policy provider because Total Permanent Disability and Loss of Independent Existence benefits were excluded from Mrs M's policy.

Mrs M wasn't happy and raised her concerns about this and how the policy was sold to her with Tenet. It responded to say that it wasn't upholding the complaint;

- Mrs M was sent the policy Acceptance Illustration by the product provider further to her meeting with Tenet and which mirrored the information she had been given. It referred to the exclusions of the policy and explained those were decided by the product provider and not Tenet.
- It wasn't in the position to ascertain from the adviser as to why he would have used different references for the Financial Conduct Authority ('FCA').
- It would have been the Acceptance Illustration document that detailed the specifics of the policy terms and Total Permanent Disability Cover.
- It couldn't confirm if the adviser told Mrs M her policy was more expensive than her partner's.
- The £200 Mrs M had referred to was likely to be the commission payment the adviser would receive from the policy provider for arranging the cover which didn't seem excessive.
- Some brokers are 'tied' to one particular company and can only recommend those products, and this would have been detailed in the Initial Disclosure Document but there was no certainty the adviser was 'tied'.

Correspondence continued but remaining unhappy with the outcome Mrs M brought her complaint to the Financial Ombudsman Service. Our investigator who considered the complaint didn't think it should be upheld. He said;

- While he didn't have all the documents from the time of the sale, but including Mrs M's testimony he was satisfied he had enough to reach a fair and reasonable outcome.
- While the policy had exclusions it did provide cover for a variety of illnesses, so he didn't think it was unsuitable.
- Mrs M had signed a Declaration confirming she would receive confirmation from the policy provider and would check the details were correct and complete. Copies of

correspondence showed the correct address for Mrs M, so it was more likely than not the documents were received. If they weren't we would expect a customer to contact the business.

- He couldn't be sure what was discussed with the adviser so there wasn't enough to evidence Mrs M had been misled.
- Mrs M has said the adviser is under investigation for fraud, but he couldn't comment on that, and he couldn't see that even if the adviser did use a different FCA reference number this would have any impact on the policy she was sold.
- It was likely Mrs M's policy was cheaper than her partner's because of the exclusions.
- It wasn't unusual for a business to no longer have contact with an ex-employee as in this case and ultimately it is the business that is responsible for the advice given.
- There wasn't enough to say that the adviser acted improperly.

Mrs M didn't agree with the outcome and asked for her complaint to be referred to an ombudsman, so it has been passed to me for decision. Mrs M also provided further submissions for my consideration.

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.

After doing so, I've reached the same conclusions as the investigator and broadly for the same reasons. I know Mrs M will be extremely disappointed, but I'll explain why.

Mrs M has complained that Tenet breached some of the regulator's rules and Principles. These have a wide application, and I have therefore considered all of Mrs M's points about the firm's regulatory obligations when deciding what I consider to be a fair and reasonable outcome to the complaint.

First, I should say I'm aware Mrs M has raised a complaint about the policy provider, but I don't consider there is any need for her complaint about that business and Tenet to be worked alongside each other. I say this because they both raise separate issues, and I'm satisfied the outcome of one of the complaints is not contingent upon the other. So, in this decision, I will only be addressing Mrs M's complaint about Tenet. Mrs M has also commented about another insurance sales business the adviser was linked to, but again, for this complaint I will only be looking at the role of Tenet as it is the entity responsible for the sale of the policy, so I am not assessing whether there was anything untoward with the other insurance business.

I'm aware I've set out the background to this complaint in far less detail than the parties and I've done so using my own words. I'm not going to respond to every point made by the parties involved. No discourtesy is intended by this, and I'd like to assure the parties I have very carefully considered all the information, evidence and submissions I have been provided. This includes Mrs M's verbal submission, and I fully appreciate Mrs M has been through a very difficult time but in reaching my conclusion 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. If there's something I haven't mentioned, it isn't because I've ignored it. I haven't. I'm satisfied I don't need to comment on every individual argument to be able to reach what I think is the right outcome.

Mrs M has kindly provided information, her verbal submission and copy correspondence from health professionals and similar, to evidence her current poor health. Clearly, I am sorry to hear the impact Mrs M's condition is having on her but for the purposes of this decision, Mrs M's current condition and circumstances aren't relevant as it is the point of sale that is being decided in this decision. So, while I have every sympathy for Mrs M it wouldn't be right for me to consider her current circumstances when deciding this complaint.

I appreciate we don't have all the point-of-sale documentation on file, but I don't find this surprising as the sale was more than ten years ago, and businesses aren't obliged to keep documents indefinitely. I also understand we don't have the adviser's testimony but again, this isn't unusual as employees move on and in any event the complaint is against Tenet and not the adviser, and Tenet has accepted responsibility for the sale. And I'd like to assure Mrs M this isn't a matter of questioning her integrity or her word against Tenet's. But this service is impartial so the absence of any evidence or documentation, in and itself, doesn't automatically lead me to conclude there has been any failing on Tenet's behalf. But in the absence of all the evidence or when I have conflicting testimony, I have to base my decision on the balance of probabilities or what I consider more likely happened taking into account the whole circumstances of the complaint.

I understand Mrs M and her now ex-partner had a meeting with the adviser at their home on 5 October 2012. Mrs M has given her recollection of the events. She says the adviser visited her and her ex-partner with a pre-printed Aviva Declaration and generic key feature document, and the adviser said that he would go away and get some insurance quotes for her and her ex-partner.

However, while I acknowledge Mrs M's recollection of events, as explained above, I have to take a balanced approach when considering a complaint so need to take into account what evidence I have from the point of sale about this and be persuaded about what I think more likely happened based on all the evidence I do have. I can see on 5 October 2012 – the date of the meeting – Mrs M signed the policy provider's Declaration that allowed her adviser to electronically submit her Life and CIC application on her behalf. As part of that Declaration it said Mrs M would;

- '…receive a Confirmation Schedule from the Company [the policy provider] confirming details of the application received by the Company.
- I must check these details are correct and complete.
- If any of the details are incorrect or incomplete I must amend and return the Confirmation Schedule within 14 days. In such cases, the Company reserves the right to amend the terms or decline the cover.
- I agree that the contract will comprise the Confirmation Schedule, Plan Schedule and the Plan Conditions.'

I appreciate Mrs M may not recall signing the Declaration or what the intention of that document was but from what I have seen, I am satisfied the signature is hers. And I've also borne in mind that applying for insurance might not be the most memorable of events and that memories can and do fade over time so I think it's understandable why Mrs M may not correctly remember every detail of the meeting, signing and dating the document or what it was for.

I also understand Mrs M has concerns about the Declaration pre-dating the writing of the policy but that document allowed the adviser to make the insurance application on her behalf so I can't find any wrongdoing here. I think its most likely Mrs M's adviser had provided the quotes for the premiums and was processing the application for Life and CIC with the policy provider for Mrs M. I know Mrs M has real concerns about this and her completion of the

Declaration in advance of the policy being written and her and her ex-partner's recollections are that the Declaration allowed for access to their medical records and for the adviser to obtain a quote. But from my knowledge of such insurance applications this is how online applications were carried out. So, I'm satisfied this was all part of the application process. It might be that Mrs M can't recall the process in detail from the time, but I haven't been shown anything was untoward during that process.

After Mrs M had provided her personal details and medical history on the insurance application and signed the Declaration the adviser electronically forwarded this to the policy provider. As part of that Declaration Mrs M agreed to inform the policy provider if there were any changes to her circumstances, allowed the policy provider to review her medical records, seek information from other insurance companies etc. In response, and as outlined in the Declaration, the policy provider sent Mrs M Acceptance Terms detailing the cover it was to provide. Those Acceptance Terms for the Term Assurance are recorded as being printed on 8 October 2012 and its clear from that document the policy provider could provide Mrs M Life and CIC cover but with special provisions. Those provisions were;

> 'Any critical illness claim on the life of [Mrs M] will be excluded from the policy if it is caused by or results from; -
>
> *Total Permanent Disablement & Loss of Independent Existence'

While I can't make a finding on any complaint about the policy provider, in the normal course of events it would send the Acceptance Terms and Key Features Document on to the customer. I've seen a copy of the policy provider's document dated 9 October 2012 addressed to Mrs M which showed the cover it was to provide. Mrs M has said she didn't receive this, but this wouldn't be Tenet's responsibility. However, I've also seen a copy of a letter sent by the policy provider to Mrs M on 16 October 2012 with an update about the term policy and which included a copy of the Plan Conditions Alteration Document. And the policy provider wrote to Mrs M again on 22 October 2012 with an update on her policy and improvements to the CIC. From the evidence presented to me it's clear the policy provider had the correct address for Mrs M and while it's understood that some post does go missing, I think it's more likely than not that the majority of correctly addressed mail is received by the intended recipient.

Bearing in mind Mrs M signed the Declaration to confirm;

- she would check the Confirmation Schedule/Acceptance Terms that was to be provided by the policy provider,
- was committing to pay monthly policy premiums of £14.45 for 25 years and
- the cover provided by the policy was so important to her,

I would have expected her to have chased her adviser or the policy provider if it wasn't received.

And while Mrs M may argue she wasn't aware she had applied for the policy, I also think the additional letters sent to her on 16 and 22 October 2012 should have prompted her to ask her adviser or contact her policy provider about the Acceptance Terms if she hadn't received them already or wasn't aware she had applied for a policy as clearly the policy had been written by this time. The policy provider would also have started taking the direct debits for the premiums from Mrs M's bank account so again, I'm satisfied she would have known at some point that the policy was up and running and could have queried why she hadn't received the Acceptance Terms she had agreed to check or if she hadn't applied for such a policy.

Mrs M has provided an Acceptance Terms document she has recently been given by the policy provider and that it asks for an e-signature to confirm consent. Mrs M says the adviser used the pre-dated signature of 5 October 2012 without her knowledge or understanding of the policy. However, the Acceptance Terms Mrs M has provided are dated 8 October 2012 and I have seen an internal email from Tenet sent at 17:36 on the same date asking for the policy to start on 9 October and 'the decs [declarations] were faxed just now.' So, it seems likely to me that the adviser provided the Declaration to the policy provider after the policy had been written which meant that consent was given. As mentioned above, I'm satisfied the Declaration was part of the application for the policy.

Mrs M has said she was only shown a generic policy by her adviser and had no reason to question it. She says that if she had been made aware of exclusions, she would have wanted to read the policy and seek further advice. I note from the policy provider's Declaration document that it said;

> `'The…Term Assurance plan Terms and Conditions and Key Features are important and you should take the time to read them. You should have received them with this application. Please ask for a copy of these documents if you have not already received them. If there are any terms that you do not understand then you should ask for further information.'

So, Mrs M's recollections about this are correct, and she was provided with generic policy terms and Key Features at the outset, but it is known this was followed up with the actual personalised policy – the Acceptance Terms – which made clear the exclusions. Clearly, I can't know what was said during Mrs M's meeting with the adviser where Mrs M says she was told the policy would cover her in all eventualities but as I've concluded above, I'm satisfied the personalised policy documents were likely sent to Mrs M and on the balance of probabilities, were delivered to Mrs M's address. So even if Mrs M was told by the adviser the policy would cover all eventualities, I don't think it's unreasonable to assume this was corrected by the policy provider in its provision of the policy documents.

Mrs M has said the adviser presented himself as being independent and not tied to any one product provider. She says Tenet had a duty of care to discuss this and whether other company policies would have been more beneficial for her. Tenet hasn't been able to confirm whether this was correct or not at the time but I note the Declaration included the policy provider's name on several occasions so Mrs M would have known who she was applying for insurance with. So, it could just as likely have been a whole of market sale.

And the fact that the adviser received commission doesn't mean he was a tied agent as at that time, both independent and tied advisers could receive commission. And while I can't know for sure but looking at Mrs M's application – her health record and that of her family – it doesn't seem unlikely that other insurance companies would also have had similar exclusions. However, I appreciate Mrs M's point here and that she didn't have the opportunity to explore this but there's no evidence Mrs M would have got full cover elsewhere or whether Mrs M could have obtained or afforded a different sort of income protection. There's not enough for me to make a finding on whether the adviser was tied, whether his tied or independent status was made clear to Mrs M and consequently whether that had a detrimental impact on the sale.

Because of Mrs M's professional roles, she says she was aware of how people can struggle if they can't work and so wouldn't have accepted the policy if she had been aware of the exclusions. Its clear Mrs M has substantial knowledge of critical illness and the importance of insurance coverage, and I acknowledge this point. I'm also aware of the reasons behind Mrs M's decision to take insurance in the first place. Clearly, Mrs M had been through a very

difficult time, and I am sorry to hear what Mrs M had to experience. She was the sole biological parent to her two children – who both have lifelong health conditions – and wanted to ensure she would be in the financial position to still take care of them if she wasn't able to work or that they could financially benefit upon her death.

I can fully understand Mrs M's frustration and upset that the policy wouldn't pay out the benefit she thought it would because of the exclusions. But as I have already concluded above, I am satisfied the policy exclusions were made clear in the policy provider's Term Assurance document dated 8 October 2012. I appreciate Mrs M is adamant that this wasn't received but I have no reason to believe it wasn't mailed to Mrs M as intended and to the correct address. And as I've mentioned above, the policy document was sent to Mrs M by the policy provider so I can't see that Tenet has done anything wrong here or was responsible for the provision, or otherwise, of that document.

Mrs M and her ex-partner paid two different premiums – £14.40 (the policy document states this was £14.45) for Mrs M and £22.80 for Mrs M's ex-partner. Mrs M says she was told by the adviser that she would be paying the higher amount to fully cover her because of her medical history. And Mrs M says that as she was the higher earner and had a more secure job than her ex-partner it's clear they would have tried to protect her financial position for the benefit of her children rather than his, but she recently was shocked to have found that her premiums were the lower of the two.

First, the fact that Mrs M was told about the premiums suggests to me that the adviser did give the actual policy insurance quote at the meeting rather than him leaving the meeting and saying he was going to look at insurance quotes. However as mentioned already, I can't know what Mrs M was told but I'm satisfied it could equally be the case that Mrs M's premiums were lower because of her health history and the exclusions that would apply to the policy because of that, and she was advised of this at the time. I've also borne in mind Mrs M would have seen the lower premiums as detailed on her bank statements which related to her policy number rather than her ex-partner if she was paying for both. And in any event, they were quoted on the Term Assurance document sent to her which superseded what she says she had been told.

Mrs M has referred to Tenet's regulatory obligation to ensure the advice she was given to take the policy was right for her. While its clear there were exclusions about permanent disability and loss of independent existence there were plenty of other health circumstances under which the policy could have benefited Mrs M as well as on her death. So, I don't think the advice to take the policy was unsuitable for Mrs M.

Mrs M has said Tenet was aware of her mental and physical health issues as declared on her application, but it did not adjust its sales process or communications to suit her needs. Mrs M has said Tenet had an anticipatory duty under the Equality Act 2010 to make reasonable adjustments for customers with disabilities and that because of her post traumatic stress disorder ('PTSD') information should have been provided in clear written form and allowed her additional time to consider complex information to ensure she understood the policy terms. Mrs M has also said her PTSD was dismissed, and this aggravated her mental health difficulties and fatigue. While I am obviously sorry to hear of Mrs M's mental health condition, there's no note of this on her application and Mrs M has told us that sometime after 2010, she had 'since been diagnosed with PTSD' so it might not have been evident at the time of the sale in 2012.

Mrs M's ex-partner has provided his recollections of the meeting of 5 October 2012. He told us Mrs M was visibly distressed as she disclosed what had happened to her in the past and she believed those details might be relevant to her insurance. I've reviewed Mrs M's application for the policy and note she confirmed she was receiving treatment for

depression, had experienced symptoms of that more than once but hadn't taken any time off from work in the previous two years. Mrs M had once suffered from irritable bowel syndrome the previous year and taken five days off from work but was 'fully recovered.' She was also receiving treatment for sciatica in her lower back which was an ongoing condition but hadn't taken any days off from work in the previous two years.

So, at the time of application Mrs M had ongoing depression and sciatica but I note that Mrs M said they didn't cause 'restrictions in lifestyle or mobility'. While I am sorry to hear of Mrs M's poor health, I don't think there was sufficient indication for the adviser to have caused him to seek out further information from Mrs M about the impact they had on her and whether she needed any extra support such as additional time to read documents or the need to give her further information as examples. And I'm aware Mrs M's ex-partner was also present at the meeting which he says was to support her, and he also took a policy, so Mrs M did have some support at the time of the sale from a third party to help her if she needed it.

But I can't see that the health issues Mrs M has referred to would have impacted on her ability to participate in the sales process or the completion of the application. And there's nothing to suggest that she didn't have the capacity to understand what she was applying for. While I appreciate Mrs M may have become upset at the meeting with the adviser, I don't consider it would be fair or reasonable for me to conclude there were clear indicators of vulnerability that the adviser ought to have recognised in his dealings with Mrs M. And to the extent that during the sales process he should reasonably have sought additional information about Mrs M's depression, whether that stemmed from PTSD at the time and to consider whether she needed additional support when completing the application.

I can't agree that its more likely Mrs M presented indications of significant vulnerability during Tenet's dealings with her – she did say her depression didn't cause 'restrictions in lifestyle' – and while I don't doubt Mrs M and her ex-partner's sincerity, I can't fairly conclude that Tenet failed to act on any concerns it ought reasonably to have had from its interactions with Mrs M. While I agree Mrs M could potentially considered to be a vulnerable customer in line with FCA guidance – which wasn't issued until February 2021 – I don't think Tenet did anything wrong in 2012.

I appreciate it took Mrs M sometime to establish who she should be raising a complaint against as she couldn't track down the adviser, but we've recorded Mrs M did raise her formal complaint with Tenet on 17 February 2025 and it responded to that complaint on 24 February 2025 with follow up correspondence on 5 March 2025. So, it dealt with her complaint promptly and within the timescales permitted by the regulator. While no doubt the whole experience has been very stressful for Mrs M and impacted on her health, I can't agree that this was exacerbated by anything Tenet did during the actual process of the complaint.

Mrs M has concerns about another FCA reference number she says the adviser used. She says the adviser is being investigated for fraud and she wasn't told his name by Tenet until 2025 which she says hampered her ability to obtain evidence. But it is Tenet that has taken responsibility for this complaint, not the individual adviser. I can't know why the adviser may have used a different FCA reference number, but I don't agree that use of another FCA reference number would have had any impact on what information Mrs M was given by the adviser about the policy or how the policy was set up. And I haven't seen anything to suggest that the 'transaction may have been conducted "off the books" or at least outside the proper control framework' or the firm allowed deceptive practices. So, while I recognise Mrs M's concerns, I don't think this point has an impact on how the policy was sold to Mrs M which is the crux of this complaint.

In its response to Mrs M's complaint, Tenet made clear it would have carried out due diligence to ensure the adviser was regulated to and authorised to sell insurance products. It has also said that at the time advice was given to Mrs M, there's no evidence to indicate that the adviser's conduct wasn't in line with regulatory requirements and at that time the adviser was only registered with Tenet (or the predecessor business of Tenet). As such, Tenet has also said he would have been subject to regular training and monitoring to ensure he was compliant with his own and Tenet's regulatory obligations. While I appreciate Mrs M has concerns and says the adviser is being investigated for fraud, in my review of this complaint I can only consider how the adviser acted in his dealings with Mrs M.

Mrs M wants me to explicitly recognise Tenet's failing and recommend regulatory action so that no other customer endures what she has gone through. But it is not for this service to fine or punish businesses, that is the role of the regulator, the FCA. And this service only considers a complaint on the individual circumstances relevant to that complaint.

Overall, I haven't been persuaded that the Tenet has done anything wrong, or the policy was unsuitable for Mrs M. I fully understand that Mrs M will be extremely disappointed with the outcome to her complaint. It's very clear how important it is to her, and she understandably feels very strongly about it but there is inevitably an element of hindsight in this type of case, and I've also borne in mind how long ago the sale took place and the impact that length of time can have on recollections. And it wouldn't be fair or reasonable of me to reach my conclusion based solely on Mrs M or her ex-partner's testimony. I also must add weight to the evidence that is available and what I think most likely happened taking all this into account.

But I'd like to thank Mrs M for the time and effort she has spent in bringing her complaint and I am sorry to hear of the difficult circumstances Mrs M is now in and for the difficulties she has experienced in her past. But my role is an impartial one and I hope I have been to explain how and why I have reached the decision that I have.

It follows that I don't uphold Mrs M's complaint.

My final decision

For the reasons given, I don't uphold Mrs M's complaint about TenetLime Limited trading as PRIMIS Mortgage Network.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 18 July 2025.

Catherine Langley
Ombudsman