DRN-5595600

The complaint

Ms O and Mr S complain that Zurich Assurance Ltd ('*Zurich*') has declined their critical illness claim and cancelled their protection policy. They also complain that Zurich has acted unreasonably in its handling of the claim.

What happened

Ms O and Mr S applied for a Zurich Personal Protection policy through a third party broker in November 2022. It offered them decreasing term life assurance and critical illness cover over a 27-year term, for an agreed monthly premium of £148.05.

In May 2023, Ms O sadly suffered from a stroke. She and Mr S therefore made a claim under the policy for critical illness benefit.

After review of the medical evidence, Zurich said Ms O had incorrectly answered a question about smoking in the policy application. It said Ms O did not disclose her history of smoking which had taken place within five years of the policy application when she was in fact an ex-smoker, and it felt she had done this deliberately. Zurich therefore declined the claim and cancelled the policy altogether on the grounds of misrepresentation. It also refunded the premiums that Ms O and Mr S paid for their policy.

Ms O and Mr S complained to Zurich. They said Ms O's GP had amended her medical records and these showed she was an ex-smoker as of December 2017.

Zurich rejected the complaint. Ms O and Mr S thereafter lodged their complaint at this service, where it progressed to a provisional decision by one of our ombudsmen.

The ombudsman noted how the broker recorded Ms O as never having used tobacco or nicotine, but this wasn't correct. And since Mr O and Mr S were sent a copy of their answers to check for accuracy, she agreed with Zurich that reasonable care hadn't been taken by Ms O when answering the question. However, the ombudsman didn't think there was enough persuasive medical evidence to show that Ms O was a smoker at the time of the sale, rather it was more likely that Zurich should class Ms O as an ex-smoker.

The ombudsman noted how relevant industry guidance from the Association of British Insurers ('*ABI*') on managing claims involving misrepresentation set out that a deliberate misrepresentation did not apply in cases involving a premium rating if the rating resulting from the misrepresentation would not have been more than +50% (or £1/mil) for the applicable life assured. She therefore believed the misrepresentation was 'careless' rather than 'deliberate or reckless'. This would have meant that the policy premium should have been rated for Ms O's ex-smoker status, giving the correct premium as £171.13 per month.

Zurich disagreed with the provisional findings. It said other misrepresentations had been made at application stage by Ms O – but these had not been looked into further since it had fairly voided the policy on the grounds of misrepresentation of her active smoker status.

Our ombudsman issued a final decision in December 2024. She said it wouldn't be

reasonable for her to make findings on new evidence relating to other disclosures that Ms O hadn't had a chance to comment on. She otherwise maintained her view that the misrepresentation was careless. The ombudsman therefore directed Zurich to reinstate the policy subject to repayment of refunded premiums and asked it to reassess the claim.

Ms O and Mr S returned their premium payment to Zurich in December 2024.

Zurich thereafter reconsidered the claim. However, on 5 March 2025, it refused the claim again. It set out that it still believed Ms O had misrepresented at the time of the policy application. Zurich said two questions relating to Ms O's health had been answered negatively, when they should have elicited further medical disclosures. One question related to neurological symptoms and the other to medical investigations. Zurich noted how Ms O had consulted her GP in April 2022 regarding numbness and pins and needles in her arm – and this should have been disclosed in relation to both questions.

Zurich said that it could not have offered Ms O any cover at all, had it known of her outstanding neurological referral. And so, it refunded the policy premiums.

Ms O and Mr S complained to Zurich, but it would not change its view on the claim or the policy cancellation. It said the questions were clear and had been wrongly answered. That Ms O had a normal MRI wasn't relevant – Zurich ought to have been told that she had been referred for investigations, irrespective of the outcome of those investigations.

Zurich did, however, agree it had taken too long to reassess the claim upon receiving the medical evidence. It sent Ms O and Mr S £100 for the inconvenience they had been caused.

Ms O and Mr S thereafter brought their second complaint to this service, where it was reviewed by one of our investigators. He agreed that Ms O had made a qualifying misrepresentation. He also felt Zurich acted fairly in the circumstances of the claim. He noted how Zurich had shown it couldn't have offered Ms O cover, had she answered the two policy questions differently.

In respect of administration, our investigator felt the offer of £100 was fair in circumstances where Zurich had taken longer than its usual service standards to review the medical evidence sought from Ms O's GP. However, overall, he felt the time frame to reassess the claim and provide an outcome to Ms O and Mr S had been otherwise fair and reasonable.

Ms O said she and Mr S disagreed with our investigator. They said, in summary:

- Their complaint isn't just about the new issues since December 2024, but the circumstances of both complaints.
- The fact the new decision came after a timescale of three months was not paramount in their concerns about poor service.
- What they were unhappy about is Zurich failing to contact them during those three months, whilst unbeknownst to them, the next refusal of the claim was being made.
- Furthermore, Zurich had almost two years to review the application and scrutinise it in order to reject the claim.
- They question why Zurich didn't consider some type of proportionate remedy for the claim.
- Ms O said she did make a disclosure of sciatica which led to refusal of total and permanent disability cover for her. And sciatica can be linked to arm pain as a wider nerve compression issue.
- Ms O therefore maintains that she did disclose to Zurich about the issue with her arm.

- The medical notes from 12 May 2022 clearly state that her head and neck MRI was normal, so this does not equate with Zurich saying it wouldn't have insured her.
- Ms O and Mr S feel that Zurich has used the later knowledge of her unrelated stroke to apply hindsight and refuse to pay a claim.
- Ms O was not aware that any referral to neurology had been made by her GP, and no contact was made with her about that until after she had suffered a stroke.
- The fact she believed nothing else would happen is borne out by the lack of contact from the GP after the normal MRI was confirmed.
- In Ms O's line of work, she is required to maintain good character and conduct, yet Zurich has unreasonably called her character into question.

Since our investigator wasn't prepared to change his view on the complaint, it was referred for review by an ombudsman. Zurich had no other comments to make. The complaint has now been passed to me.

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.

I was very sorry to learn of Ms O's circumstances, and I can see from her submissions how challenging things have been – and continue to be – for her, Mr S and their family. I note the impact of the amount of time taken across both complaints and the hardships Ms O has set out following her stroke. I do not underestimate these factors; however, I cannot uphold a complaint merely because of my empathy for a complainant. I must be fair to both parties in the complaint and make an objective decision based on the evidence before me.

I also thank the parties for their patience whilst this matter has awaited an ombudsman's decision. I'm aware I've set out the background to this complaint in less detail than the parties and I've done so using my own words. However, in reaching my conclusion I've focused on what I consider are the key issues. 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. It's since I don't need to comment on every individual argument to be able to reach what I believe is the right outcome.

Having reviewed this complaint carefully, I agree with the outcome reached by our investigator – that means though I realise my decision will be disappointing for Ms O and Mr S, I won't be asking Zurich to do anything further to resolve the complaint. I'll explain my reasons below.

We do not act in the capacity of a regulator. That remit falls to the FCA, where it may look at wider issues governing how businesses conduct their operations or exercise what may be commercial judgement on the provision of a particular service. This service's role is to investigate disputes and resolve complaints informally, including taking into account relevant laws, regulations, ABI industry guidance and best practice where applicable.

I realise in her comments to our investigator that Ms O has explained how she considers the entire process across both complaints to be unfairly handled by Zurich. However, a final decision was issued to the parties in December 2024 by one of our ombudsmen. Ms O and Mr S accepted that decision, which meant it was binding upon Zurich. I can therefore only look at matters after this date, which led to Zurich's final response letter of 24 March 2025.

The relevant law in this complaint 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 otherwise careless.

After it reviewed Ms O's medical history upon direction of the ombudsman from the first complaint, Zurich concluded that two policy application questions were wrongly answered by Ms O. These were:

> "*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?*
>
> *Other than for the conditions you have already told us about earlier in this application:*
> *In the last 2 years, have you had or been advised to have any medical investigations, or are you waiting for any test results, appointments or investigations with your doctor or other medical professional?*"

The application submitted to Zurich gave the answer "*no*" to both questions. Ms O did make one disclosure of sciatica in relation to a different question which asked specifically about diseases of the bones, back and joints. And I can see when appealing to Zurich following its claim refusal on 5 March 2025, Ms O explained that:

> "*The appointment at my GP on 13th April 2022 after the incident at work, that I disclosed during application, was due to some numbness being apparent on my right arm and fluctuating pins and needles (paraesthesia). As stated, my GP sent me to have an MRI scan, which came back as negative or 'normal'. A negative MRI. No further action.*
>
> *The GP had suggested they may add me to a list and stated if my shoulder improved on its own, I would drop off the list or that I should cancel any appointments made if not required. No appointment was ever made, no contact regarding this list was ever made to me. From this incident until applying for the insurance policy - was a total period of 8 months. I had no confirmation of being on this list.*"

I accept Ms O says she made a clear disclosure in relation to sciatica. I don't doubt her recollection of what was said to the broker. However, there is no clear evidence of any such disclosure set out within the policy application from November 2022. In the application, sciatica was disclosed, and Ms O was presented with a subset of further questions relating to that condition. When asked if it caused numbness or tingling, Ms O said "*no*". And when asked how long ago the sciatica symptoms occurred, Ms O's answer was "*3 to 5 years*".

I am therefore not persuaded that the sciatica disclosed in the application related to the medical matter of April 2022; and I believe Ms O ought to have answered both of the questions set out above differently.

I say that noting how Ms O accepts that she had issues with her right arm following a work-related incident leading her to seek medical advice from her GP in April 2022. Her GP record of April 2022 showed she sought medical help for "*few days reduced sensation in right arm from shoulder to fingers*" and was referred for a head and neck MRI.

Looking at the two questions above, I believe it is clear Ms O needed to answer them both positively. And because she didn't do so, a misrepresentation occurred. On balance, I consider Ms O ought reasonably to have been able to recall seeking medical evidence and undergoing the MRI scan little under eight months before the policy application.

In relation to the first question, Ms O had experienced the symptoms being asked about. And in relation to the second question, she had been advised to have a medical investigation in the form of a scan. That the MRI went on to provide a normal result was not relevant to what was being asked – Zurich needed to know about the presence of any investigations, tests or medical appointments regardless of any results. I am satisfied the second question was clear in requiring a disclosure of any medical investigation not already answered elsewhere in the application – and this was relevant because Ms O hadn't made a disclosure in relation to the first question.

I also have taken into consideration that Ms O and Mr S applied for their policy through a third party, which meant questions were posed by the broker and relayed to Zurich. However, to ensure that it had accurate information upon which to offer insurance, Zurich wrote to Ms O and Mr S in a letter dated 11 November 2022 showing a copy of the questions asked and the answers given via the broker. In that letter it said:

> "*About your personal details confirmation*
> *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.*"

That letter also set out the declaration Ms O and Mr S signed when applying for the cover which told them how – in completing and checking their application– each of them had given their confirmation of accurate answers. It said:

> "*I declare that:*
> - *I have checked the answers to the questions in this form, and I have provided amended details where necessary*
> - *I have completed the information on this form fully, honestly and accurately, to the best of my knowledge*
> - *I am aware if I haven't answered the questions correctly the policy may be cancelled, or its terms may be changed, or a claim may be rejected or not fully paid. Cancelling a policy means that no cover or other benefits will be provided.*"

I am satisfied that Zurich made Ms O and Mr S sufficiently aware of the importance of checking the answers they had given on their application via the broker. And Ms O and Mr S didn't make any amendments to those answers; this meant Ms O made two misrepresentations.

Overall, I'm satisfied that Ms O's misrepresentations were qualifying under CIDRA. I can't share the underwriting evidence that Zurich has provided as it is commercially sensitive. But

I'm persuaded that the evidence shows it would have acted differently – by postponing cover until a neurology referral had been provided - had the questions been answered correctly.

I realise Ms O has explained how she had no idea a neurology referral was awaited given her scan came back as normal. I understand that. However, for the purposes of underwriting, Zurich has provided us with relevant pages of its underwriting manual which show how it would need to seek confirmation from the GP regarding the symptoms reported in April 2022. And if it had been able to do that at the time, it would have learned about the neurology referral which took place after the MRI outcome was known.

The GP record of 12 May 2022 said how "*recently instead of just numb [arm] [Ms H] getting some burning sensations. And on a couple of occasions has had to drop what she is holding. Feels she does not require anything for these sensations just now but will call again if this changes. Otherwise MRI head and neck normal and will ref to neurology*". And in the medical report supplied to Zurich of February 2025, Ms O's GP explained how Ms O suffering with a stroke in May 2023 had unfortunately "coincided with the neurology appointment", and Ms O had to cancel it.

I therefore accept Zurich's conclusion that had it approached the GP, it would have been informed of Ms O's awaited neurology referral. At that time, it would have postponed the application for up to two months and thereafter declined it. So it follows that if Zurich had the correct medical information at its disposal upon receipt of the application in November 2022, it would not have been able to offer Ms O any insurance at all until such time that her neurology referral had taken place (and dependent on the outcome of that referral).

I am satisfied that Ms O did not behave deliberately or recklessly in these circumstances. However, a lack of care in checking the application answers meant that Zurich did not have the correct medical disclosures at the time it underwrote Ms O' and Mr S' insurance policy. Though the remedy available to Zurich under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless, in this case, both classifications would have provided the same outcome – that being that Zurich would have had to decline to offer any insurance to Ms O at all. So, Zurich cannot now offer to pay any proportionate remedy that Ms O has asked for because it wouldn't have entered into any insurance contract with her from the outset.

As an aside, I haven't seen any evidence from either party in respect of Mr S' cover. This could have potentially been able to continue, providing the policy allowed for it – as the misrepresentation relates to Ms O. Though that hasn't been pursued as an aspect of this complaint, Mr S remains free to liaise with Zurich about his cover, if required.

Finally, I have looked at the customer service issues raised by Ms O and Mr S. What this service does is consider if a business has treated a complainant unfairly because of its actions or inactions. And if it has done so, we then go on to consider what ought to be done to put the mistake(s) right. As well as putting right any financial losses in a complaint (though there are none in this circumstance since I agree the policy was fairly voided), we also consider the emotional or practical impact of any errors on a complainant.

Zurich has told us how the updated medical information took some time to receive. This was firstly because the consent it held was out of date and could not be accepted by the GP and secondly, because the surgery asked it to settle the fee owing before it would release the medical report. The fee was paid in January 2025, the medical information was received in February 2025 and the claim outcome given to Ms O and Mr S on 5 March 2025.

Though I do not consider the timescale above to be unreasonable of itself, it is clear from the evidence I've seen that Zurich's failure to keep Ms O and Mr S appropriately updated as to

the status of their claim – given the fact it was approaching two years since the first claim - caused additional concern to them at what was already a difficult time, and some compensation ought to be awarded for that.

When we consider awards of this nature, we do not fine or punish businesses; the FCA undertakes the role of regulator. Instead, we consider the impact upon a complainant. It may also be helpful for Ms O and Mr S to review the guidance available on our website which explains the amounts and types of awards made in instances of upset, trouble, inconvenience and distress caused by businesses in the complaints we see at this service.

Overall, I believe the proposed payment of £100 was reasonable in the circumstances where Zurich's claim handling procedures caused undue upset and frustration for Ms O over a short-term period. This naturally was upsetting. I am satisfied the amount Zurich offered to Ms O and Mr S was fair in the circumstances of that upset and in line with an award this service would otherwise direct, had the compensation not already been paid.

My final decision

I know my decision won't be what Ms O and Mr S have hoped for. However, for the reasons I have explained, I do not uphold this complaint or make any award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms O and Mr S to accept or reject my decision before 9 February 2026.

Jo Storey
Ombudsman