DRN-5597788

The complaint

Mr C complains that Vitality Life Limited declined a claim on his joint life and serious illness policy.

Throughout the claim and complaint process, Mr C has had a representative helping him. In this decision, any reference to Mr C includes the actions and comments of his representative.

What happened

Mr C took out a joint life and serious illness policy with Vitality in August 2019. The policy was taken out in joint names with his wife Mrs C. I'm very sorry to hear that Mrs C died in October 2024. I send my condolences to Mrs C's friends and family at what must be a very difficult time.

Mrs C was diagnosed with cancer and raised a claim. Vitality declined the claim, avoided the policy and refunded the premiums paid due to a misrepresentation during the policy application. Mr and Mrs C raised a complaint. Whilst Vitality accepted there had been service issues, they didn't think the claim had been unfairly declined. Mr C remained unhappy and brought the complaint to this service.

Our investigator didn't uphold the complaint. They didn't think Vitality had done anything wrong. Mr S appealed. He maintained the questions had been answered accurately. As no agreement could be reached, the complaint has been passed to me to make 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.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether Vitality acted in line with these requirements when it declined Mr C's claim and avoided the policy.

At the outset I acknowledge that I've summarised his complaint in far less detail than Mr C has, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I'm satisfied I don't need to comment on every individual point to be able to reach an outcome in line with my statutory remit.

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.

Vitality thinks Mrs C failed to take reasonable care when she answered the following questions:

"*Your health in the last 5 years*

Any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel, including Hepatitis, Colitis or Crohn's disease? Ignore minor indigestion, heartburn, appendicitis (operated and fully recovered) or irritable bowel syndrome (IBS) that only causes occasional mild discomfort and for which you have not required investigation or hospital referral and none are planned"

Recent and current health

Apart from anything you have already told us about in this form, within the last 2 years have you been advised to have or undergone any investigation such as blood tests, scans or biopsies? If so, for what condition (or suspected condition)?"

Mrs C answered both the above questions "*No*". Vitality has provided me with Mrs C's medical records. These show the following:

- March 2019: referred for a [investigative procedure]

Mrs C underwent the above investigative procedure initially in November 2020 but it had to be abandoned and was completed in December 2020. This had a normal result.

Mr C has said Mrs C wasn't aware of the referral for the investigative procedure at the point of application. Our investigator thought the medical records showed Mrs C was made aware of it in March 2019 and she also completed a hospital questionnaire for the referral. Mr C has said there's no evidence of Mrs C being at her GP surgery in March or that the referral was discussed. I don't agree. There is a record in March 2019 in which the following comment is made:

"*[Hospital] request referral for [investigative procedure]. Also discussed [separate medical condition]*"

Whilst I agree the records provided don't confirm that Mrs C specifically visited her GP, it does confirm there was a conversation with Mrs C as the record specifically states "*Also discussed*". The word 'also' suggests the investigative procedure was discussed as well as the separate medical condition. In the referral to the hospital, Mrs C's GP enclosed a completed bowel symptoms questionnaire. This had been completed by Mrs C on the same day. Whilst she might have collected the questionnaire previously, completed it at home and then dropped it off at the GP surgery, it's more likely based on the record it was completed whilst in an appointment with the GP. I don't think a reasonable person would complete a hospital questionnaire and either not be told why they needed to complete it or wouldn't ask

why they needed to complete it. Whilst it's not possible to know exactly what was discussed, based on the record, I think it's most likely Mrs C was informed of the colonoscopy in March 2019.

Based on the questions asked, the answers given and the medical information, I do agree that Mrs C misrepresented during her application.

Mr C has argued that the questions aren't clear. He's said Mrs C didn't have a disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel and if she did, it would be classed as minor and so didn't need to be disclosed under the second part of the question. He's also said the second question only sets out investigations such as blood tests, scans or biopsies and Mrs C's investigative procedure wasn't one of these.

Mrs C was requested to complete a questionnaire relating to symptoms of one of the above body parts. So, I don't think a reasonable person wouldn't think the question wasn't relevant to them. On the second part of the question, it says you don't need to tell Vitality about a list of minor conditions but sets out that it doesn't apply if you were required to have investigations or hospital referrals or have them planned, which Mrs C did. As I think Mrs C was aware of her investigative procedure, I think a reasonable person in the same circumstances would have disclosed the investigation under this question. In regard to the second question, the question sets out some examples of investigations but sets out "*any*" investigation. I think a reasonable person would think Mrs C's investigative procedure would be classified as an investigation. I don't think Vitality need to list every single possible investigation on their application form.

I think the questions are clear in what they want to know and so I don't think Mrs C took reasonable care when answering the questions.

Vitality have provided me with a statement from an underwriter and the relevant parts of their underwriting manual. Based on what I've seen, Vitality would have postponed the application until the results of the investigative procedure were known. Due to the amount of time the investigations took, Vitality has confirmed a new application would have been needed and the application would have been treated as declined. As a result, I think Mrs C's misrepresentation would be a qualifying misrepresentation under CIDRA.

Vitality has confirmed they've treated the misrepresentation as reckless. Based on the circumstances and definition in CIDRA, I don't think a categorisation of reckless is unfair or unreasonable. As Vitality has declined the claim and avoided the policy, this is in line with a reckless misrepresentation under CIDRA. Based on the reasons above, I don't think the actions taken by Vitality are unfair or unreasonable in the circumstances. I note that Vitality has also refunded the premiums, something they didn't need to do under CIDRA in the circumstances.

Mr C has said he doesn't think Vitality would have done anything different. He's stated the following guidance supplied to insurers by the Association of British Insurers (ABI):

"*The underwriting decision would have been deferred or where the decision to defer the cover would have been made – in this case, insurers should, as far as possible, try to determine what the ultimate underwriting decision would have been (that is, at the end of the deferred period or when the investigation was complete) and apply the appropriate remedy, as above. If it is not possible to work out whether the insurer would have offered cover, or if the deferral decision would have required the customer to re-apply at a future date, then this should be treated as a decline*"

One of Vitality's underwriters have confirmed the deferral period was six months and the application would have expired in February 2020. This was before Mrs C had her investigative procedure. In line with the ABI's guidance above, at the end of the deferral period, no underwriting outcome was possible. Again, in line with the above, this would lead to the application being treated as being declined.

*****Mr C has argued Vitality should have continued to assess the application up to the point of the normal investigative procedure in December 2020. I don't agree, the deferral period had expired with the investigation still being needed, as such, the policy was treated as being declined and a new application would have been needed. By treating the application as declined, Vitality have followed the guidance as set out by the ABI above.

I'm very sorry that my decision doesn't bring Mr C more welcome news at what I can see is a very difficult time for him. But in all the circumstances I don't find that Vitality has treated Mr C unfairly, unreasonably, or contrary to law in declining the claim and avoiding the policy.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint. I don't require Vitality Life Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 15 October 2025.

Anthony Mullins
Ombudsman