DRN-5606595

The complaint

Mr L is unhappy that Vitality Life Limited has declined a claim on his life and serious illness cover policy.

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

What happened

Mr L says he was approached by an independent financial adviser (IFA) in December 2022. Mr L has said he completed a handwritten application form which was returned to the IFA. A policy application was submitted electronically by the IFA on 6 January 2023 with the policy starting on the same day.

I was sorry to hear that Mr L was diagnosed with one of the listed policy conditions in March 2023. As a result, Mr L raised a claim with Vitality. Vitality reviewed the claim but declined it on the basis of a misrepresentation. This decision was later reversed as Vitality accepted that Mr L had taken reasonable care when answering the questions of concern. However, having reviewed the claim further, Vitality felt a different question was answered incorrectly and again avoided the policy. Mr L raised a complaint.

Vitality upheld Mr L's complaint. They said that whilst they didn't think they'd done anything wrong in regard to the claim outcome, there had been service failings with how long this had taken. A total of £500 compensation was awarded over three separate responses. As Mr L was still unhappy, Mr L brought the complaint to this service to review.

Our investigator initially upheld the complaint. They didn't think Vitality had fairly declined the claim. After considering Vitality's response and the information further, the investigator reversed their decision and felt Vitality's claim outcome was fair. Mr L appealed. He said that Vitality were aware that he hadn't been stable for three months and so this contradicted Vitality's underwriting philosophy. As no agreement could be reached, the complaint has been passed to me to make a final decision.

Because I disagreed with our investigator's view, I issued a provisional decision in this case. This allowed both Vitality and Mr L a chance to provide further information or evidence and/or to comment on my thinking before I made my final decision.

What I provisionally decided – and why

I previously issued a provisional decision on this complaint as my findings were different from that of our investigator. In my provisional decision, I said:

"I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Based on what I've seen so far, I intend to uphold Mr L's complaint. I've provided the reasons why below.

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 to settle Mr L's claim.

At the outset I acknowledge that I've summarised his complaint in far less detail than Mr L 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.

I'm very sorry to hear about Mr L's health. I wish him all the best with his future.

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 L was asked the following question on the application form:

"Apart from any condition you have already told us about, have you had any of the following in the last five years:

> *Any mental health problem including depression, stress, anxiety, panic attacks or eating disorder that has required treatment, consultation with a health professional or time off work?"*

Mr L answered the above question yes. He was required to submit a condition which he answered as "Anxiety and Depression". This then led to a series of further questions. The key questions in this case were as follows:

"When did you last experience symptoms of this condition? (This includes when you last required any time off work or your daily activities were restricted as a result of this condition)?"

Answered – 2022-12

"Over the last 12 months, for how many days has this condition restricted your ability to perform your usual daily activities such as work attendance, household chores, etc?"

Answered – 0

"Which of the following best summarises the result of your last medical consultation for this condition:"

Answered – Condition stable/ Condition resolved

Vitality has provided me with Mr L's medical records. These show the following:

• 2 December 2022 – Patient has been feeling low for the last 7 years but still increasing over the last 2 years. Patient has moved. Patient has to register with new surgery in his catchment area.

• 12 December 2022 – Has had mental health issues since his early 20's. not sleeping, emotional, crying a lot, poor concentration. PLAN – try [medication] and r.v 4 weeks.

- *Not fit for work note was issued until 15 January 2023.*

• 3 January 2023 – [medication] has helped a little, less emotional. Struggling with sleep however. Continue [medication] for now, no dose change.

Vitality have suggested that each of the above questions were answered incorrectly. I'll review them individually below:

"When did you last experience symptoms of this condition? (This includes when you last required any time off work or your daily activities were restricted as a result of this condition)?"

The above question was answered "December 2022". Vitality has said that this should have been answered January 2023. Mr L has said that he completed a handwritten application form with his IFA in December 2022, as such, this question was answered correctly at the time. Whilst Mr L hasn't provided any evidence to confirm this, there is also no evidence to contradict his account. However, whilst I don't disagree that Mr L was still having symptoms in January, looking at Vitality's underwriting for this question, it wouldn't have made a difference. This is because the date was translated into a number of months which then distinguished the next question. There was no difference to the underwriting based on it being 0 or 1 months as it all fell into a 0-12 months category.

"Over the last 12 months, for how many days has this condition restricted your ability to perform your usual daily activities such as work attendance, household chores, etc?"

The above question was answered "0". Vitality has argued that as Mr L had an active not fit for work note, he should have answered this question differently. They've said that Mr L was working at this time and so was off work.

Having reviewed the evidence, I don't agree. In the GP records from his consultation on 12 December 2022 when the fit note was issued, it's recorded that Mr L was "unemployed at the moment, was a dog breeder, enjoyed it". Whilst a not fit to work note was issued, this doesn't mean that Mr L's condition has restricted his ability to perform his usual daily activities. As he wasn't working at the time, it couldn't have affected his work attendance.

There is no evidence that it effected his ability to perform household chores either. Prior to being unemployed, Mr L was a self-employed dog breeder. His testimony is that he still completed his work tasks as a dog breeder. The onus is on Vitality to show that a question

was answered incorrectly. Based on what I've seen, and for the reasons above, they haven't shown that this question was answered incorrectly.

Whilst I accept that had the above question been answered differently, it would have changed the next question to Mr L, as I don't think he answered it incorrectly, this change in question is irrelevant.

"Which of the following best summarises the result of your last medical consultation for this condition:"

This question was answered "Condition stable/ Condition resolved". Vitality has argued that as Mr L was still within a not fit for work note period, it's not possible for his response to have been stable or resolved. I disagree. Whilst I accept Mr L's condition wasn't resolved, I don't think it's unreasonable for him to have answered stable.

Mr L had a phone consultation three days prior to his application being submitted. This confirmed that the medication had helped a little. I accept Mr L was still struggling with his sleep but his medication wasn't being changed. The other options available to choose were either "Symptoms not under control yet" or "Other/Not sought medical consultation".

The definition of stable is not deteriorating in health, which I agree based on the medical evidence is the case here.

Had Mr L had answered differently, which I don't think he needed to, his application would have gone to manual underwriting. An underwriter at Vitality has said the policy would have been postponed until Mr L's condition had been stable for three months. However, Mr L had already informed Vitality in the application that his condition hadn't been stable for three months at the point of application when he informed them that his most recent symptoms had been in December 2022. Vitality still offered the policy to Mr L on this basis.

Based on the questions asked, the answers given and circumstances so far, I don't agree that Mr L misrepresented during his application. As such, under CIDRA, Vitality can't take any action and need to continue to assess the claim further.

Vitality has offered Mr L £500 compensation for the delays in coming to their outcome. Based on what I've seen, I think this is fair and reasonable for the trouble and upset caused. However, this doesn't take into account the trouble and upset caused in declining the claim unfairly. So, I think Vitality should pay Mr L a further £300 on top, making a total of £800 compensation for the additional trouble and upset caused in unfairly declining the claim."

I set out what I intended to direct Vitality to do to put things right. And gave both parties the opportunity to send me any further information or comments they wanted me to consider before I issued my final decision.

Responses to my provisional decision

Vitality confirmed they didn't agree with my provisional decision. They maintain that Mr L underplayed his condition and symptoms. In particular, they dispute that Mr L's symptoms were stable and still believe that he was unfit to work. They've also raised that Mr L misrepresented his employment status.

Mr L didn't confirm whether they agreed with the provisional decision or not, but they provided further points for consideration:

- All premiums should be refunded

- Compensation isn't high enough for the trouble and upset caused
- Interest should be added to any claim payment

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've thought carefully about the responses to my provisional decision. Having done so, while I appreciate it will come as a disappointment to both Vitality and Mr L, my conclusions remain the same. I'll explain why.

As a starting point, Vitality have said they shouldn't be held responsible for Mr L's IFA delaying his application. I agree completely with Vitality on this point but I'm unsure why Vitality have made this comment as I haven't held them responsible for any application delays by Mr L's IFA.

From the misrepresentation perspective, I have to consider the information supplied on the date of the application against Vitality's underwriting criteria. This is what I did in coming to my provisional decision and Vitality hasn't provided anything that changes the outcome I came to.

Vitality has said that Mr L's symptoms weren't stable as he wasn't sleeping and continued to be on medication. They go on to say that Mr L's condition hadn't stabilised as Mr L had an ongoing issue that required medication. I don't agree with Vitality's interpretation of the word stable in the answer given by Mr L. The Oxford Languages definition of the word stable is as follows:

"*(of a patient or their medical condition) not deteriorating in health after an injury or operation.*"

In Vitality's response to my provisional decision, they've said the answer provided by Mr L wasn't correct because he hadn't improved/recovered. But the definition for stable only needs Mr L to be not deteriorating in health, which at his most recent consultation on 3 January 2023 he wasn't. So, I don't agree with Vitality that Mr L answered this question incorrectly.

Vitality has also placed emphasis on the medical certificate certifying Mr L as unfit to work. They maintain that Mr L couldn't work during this period. However, I think it's important to consider this inline with the question that was being asked. The question was as follows:

"Over the last 12 months, for how many days has this condition restricted your ability to perform your usual daily activities such as work attendance, household chores, etc?"

Whilst Mr L was signed off work, I've not seen any evidence that the condition had meant Mr L was unable to perform his usual daily activities. Whether this was unemployed or employed. Mr L has stated that when he was self-employed as a dog breeder, he was still able to complete his daily work tasks. As such, based on the question, the evidence provided and Mr L's answer, I don't think the question has been answered incorrectly.

Vitality has raised that they weren't aware that Mr L was unemployed at the time of the application and so this is another misrepresentation. This point hasn't been considered in this complaint as it hasn't been raised previously. Vitality will be able to explore this in full

when reconsidering the claim further.

I've also considered the three points raised by Mr L:

All premiums should be refunded

As Vitality will be considering the claim further, I'm unable to say what the outcome will be. So, I can't outline what should happen with the premiums. Once Vitality has finished considering the claim further, should Mr L still be unhappy with what's happened with the premiums, he'll be able to raise this as a further complaint.

Compensation isn't high enough for the trouble and upset caused

I've considered what Mr L has said about the compensation. However, our usual approach is to consider the appropriate level of compensation overall – not to apportion particular amounts to individual elements of a complaint. I appreciate that it has been a difficult time for Mr L and he's said he's felt as though he's been accused of lying. Considering everything in the round, I think Mr L has been caused substantial distress, upset and worry which has taken a lot of extra effort to sort out over many months. In line with our website guidelines, I think a global sum of £800 compensation falls into this category of compensation which is why I think it's fair and reasonable in the circumstances.

Interest should be added to any claim payment

As above, Vitality will be considering the claim further and the claim may not be payable. So, at this time I can't comment on whether interest should be paid. Once Vitality has finished considering the claim further, should Mr L still be unhappy he'll be able to raise this as a further complaint.

Putting things right

To put things right, Vitality should do the following:

- Assess the claim further;
    - Vitality can request further information from Mr L if deemed needed;
- Pay a total of £800 compensation

My final decision

For the reasons I've explained above, I uphold this complaint and direct Vitality Life Limited to put things right by doing as I've said above, if they haven't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 11 July 2025.

Anthony Mullins
Ombudsman