DRN-5693063

The complaint

Mr and Mrs S has complained that Legal and General Assurance Society Limited ("L&G") unfairly declined Mr S's critical illness claim.

What happened

Mr and Mrs S applied for a life and critical illness policy from L&G in summer 2023. They completed a health questionnaire as part of the application process. L&G accepted the application on their standard terms and cover started in July 2023.

In November 2023, Mr S was diagnosed with a rare type of blood cancer. So he made a claim on the critical illness part of the policy. L&G obtained medical records to help them assess the claim. Having reviewed those records, they concluded Mr S had failed to mention that, shortly before he and Mrs S bought their policy, he'd been advised to have blood tests. Those tests ultimately led to his diagnosis.

L&G said, had they known about the blood tests, they would have postponed offering Mr S any cover until the results were available. And they wouldn't have offered him critical illness cover once the results were known. L&G said this was a misrepresentation by Mr S, which entitled them to decline his critical illness claim and cancel the policy. They did so, and refunded the premiums Mr and Mrs S had paid.

Mr and Mrs S complained about L&G's decision and the time they'd taken to make it. They said that, at the time Mr S was advised to have a blood test, he was undergoing regular tests to monitor his response to treatment for a vitamin deficiency – which he had disclosed. He thought the advice he'd received was just part of that monitoring and didn't give it much thought. He didn't know it was anything more serious until after the policy started.

L&G didn't change their decision about the claim. But they did accept there were shortcomings in their customer service, for which they paid Mr and Mrs S £350 compensation in summer 2024 and later offered them a further £200.

Mr and Mrs S weren't satisfied with L&G's response and brought their complaint to the Financial Ombudsman Service. Our investigator reviewed the information provided by both parties and concluded L&G didn't need to do any more than they had to resolve the complaint. She said it was reasonable to L&G to have concluded Mr S made a misrepresentation in his application by not disclosing he'd been advised to have a blood test. And she was satisfied L&G had dealt with that in line with the applicable law.

Mr and Mrs S didn't agree with the investigator's view. So the complaint's been passed to me for a 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 that, I don't think L&G need to do more than they've already offered to resolve Mr and Mrs S's complaint. I know that it's the news they wanted to hear and I'm sorry about that. I hope it will help if I explain the reasons I've reached that decision. I'll do so, focusing on the points and evidence I consider material to my decision. So if I don't mention something in particular, it's not because I haven't thought about it. Rather, it doesn't change the outcome of the complaint.

My role isn't to decide the claim – it's to decide if L&G's decision to decline it on the basis of a misrepresentation by Mr S was fair and reasonable, taking into account the relevant law in this area.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA 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.

L&G say Mr S made a misrepresentation in relation to the question:

"Apart from anything you've already told us about in this application, during the last 5 years have you been in contact with a doctor, nurse or other medical professional for:

…

- *any condition affecting blood or blood vessels, for example, anaemia, excess sugar in the blood, deep vein thrombosis?*

Mr S answered "no" to this question. L&G say he should have answered "yes" because he'd had blood tests in relation to raised platelets.

The test in question followed a text sent to Mr S by his doctor which said:

"Dear Mr S, you may be aware the surgery has been investigating you for raised platelets. We have discussed your case with Haematologists who have asked for a more detailed blood test. Please book an appointment with the surgery."

Mr S has said that he just booked the test without giving it much thought as he was having regular blood tests to monitor an ongoing vitamin deficiency – which I can see he disclosed. And he's said he couldn't be expected to know the test was relevant and that the question L&G asked was vague. I've thought carefully about this.

Dealing with the question first, I don't agree with Mr S. I think it's clear that it's asking about anything related to blood. I appreciate it gives examples of several conditions that would fall under this heading. But those are examples, not an exhaustive list. So I don't think it's reasonable to say an issue with platelets doesn't need to be disclosed.

Nor do I think medical knowledge is needed to link platelets with a question about blood. Even if it were, I think the doctor's text makes it clear the two are linked because it refers to having a more detailed blood test to investigate.

I'm also satisfied the text makes it clear that this wasn't the "usual" blood test Mr S was having regularly at this time and that it was for something other than the vitamin deficiency monitoring. So I'm satisfied it's reasonable to say it should have been disclosed in response to the question. And it's fair to say Mr S made a misrepresentation by not answering it with "yes".

And I'm satisfied that the misrepresentation is a qualifying one as defined in CIDRA, because L&G have provided evidence to show that, had they known about the test, they would have postponed offering cover until the result of the test was known. And they would never have offered Mr S critical illness cover.

Finally in relation to the misrepresentation, I've considered the remedy L&G have applied. As I've said above, that depends on whether the misrepresentation is categorised as deliberate or reckless, or was careless.

L&G categorised Mr S's misrepresentation as careless. I think that was fair because it's reasonable to say L&G would have considered information about the blood tests to be relevant. I can't agree with Mr S that the misrepresentation was innocent, because that requires a reasonable person to have considered the information – the blood test – not to be relevant to L&G. I can't reasonably say that's the case.

Where a misrepresentation is careless, CIDRA says the insurer should put the customer in the position they would have been had the misrepresentation not been made. In this case, L&G wouldn't have offered cover. So it was fair for them to cancel the policy. CIDRA also requires insurers in these circumstances to refund premiums – which L&G did after Mrs S confirmed she didn't want to continue the policy in her sole name.

Mr and Mrs S also wanted L&G to pay them more compensation and told the investigator they'd not received the second amount of compensation (£200) L&G had offered them. I've thought about this. But Mr and Mrs S's comments are based on the amount of time its taken to deal with the claim and the complaint. Our awards aren't calculated on a "time spent" basis – they're made to reflect the impact of what went wrong.

In this case, I can't make an award in relation to the claim decision because I've not upheld that part of the complaint. There were some delays. But I think the total compensation L&G offered was sufficient to address this. They now therefore need to pay the £200 they previously offered Mr and Mrs S. But I don't think they need to do any more than that to resolve their complaint.

My final decision

For the reasons I've explained, I think Legal and General Assurance Society Limited need to pay Mr and Mrs S the £200 compensation previously offered to them.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S and Mrs S to accept or reject my decision before 17 September 2025.

Helen Stacey
Ombudsman