DRN-5703914

The complaint

Mr S complains that Liverpool Victoria Financial Services Limited ('*LV*') would not accept his application for an income protection policy.

To resolve his complaint, Mr S wants a declaration that he was unfairly refused insurance. He also believes he should be compensated for the stress he has been caused and the time he has lost in having to deal with both LV and his GP.

What happened

Mr S applied for an LV Flexible Protection policy through a third party independent financial adviser ('*IFA*') on 11 October 2024. In his application, Mr S made a number of disclosures, including an explanation of how he had been diagnosed with Benign Fasciculation Syndrome ('*BCS*') which causes muscle twitches and spasms. Mr S disclosed that his symptoms had ended two months prior, but he had not fully recovered from the condition and continued to take medication.

On 14 October 2024, LV emailed Mr S to ask further questions about his disclosed BFS which he gave by return email. It also sought a medical report from Mr S's GP. In the interim, Mr S underwent a further appointment with a consultant neurologist in November 2024.

On 23 December 2024, LV told Mr S that it couldn't offer to insure him because of the BFS. It said that the impact of the symptoms of this condition together with other disclosures relating to migraine, psoriasis and herpes simplex meant it couldn't offer cover.

On 30 December 2024, Mr S complained. He said it was unfair to rely on conditions which were no longer active to refuse him cover.

Mr S later explained that he was concerned that LV had placed weight on a GP report which included two 'active' significant conditions: a spasm diagnosed in September 2023, and a spasmodic movement diagnosed in June 2024. However, this report had since been superseded by another report which removed the entries. Mr S therefore explained that LV should be referencing a second report that did not contain the same 'active' information under the 'significant conditions' heading, which in the new report was blank.

LV wrote to Mr S's GP in January 2025 for clarification regarding BFS, noting how Mr S told it that the condition had been erroneously diagnosed.

On 17 February 2025, LV rejected Mr S's complaint. It said it had only received the second report on 20 December 2024, and its underwriting decision was based on the correct report. However, that report neither confirmed nor denied the BFS diagnosis. LV also explained that it had told Mr S's IFA why it had written to the GP in January 2025.

In early March 2025, the GP supplied a response to LV confirming Mr S had been seen by a consultant neurologist in November 2024 who removed the working diagnosis of BFS and instead said the cause of Mr S's symptoms was the result of a normal motor system at the hyperexcitable end of the spectrum. He therefore stopped Mr S's medication and set out that

in his experience, such symptoms often tended to ‘burn out’ of their own accord within two to three years.

However, on 11 March 2025, LV told Mr S that it still could not offer him income protection insurance because of the impact of his symptoms.

In a further letter dated 26 March 2025, LV told him it wasn’t able to change the outcome of the complaint or the decision not to insure him. Its approach was to look at what has happened in an applicant’s medical history and use that evidence as an indication of future health. It noted if Mr S’s symptoms resolved, it would be able to insure him; however, it would not offer cover for these documented symptoms for five years after resolution, even if the BFS was erroneously recorded.

Mr S therefore brought his complaint to this service. He said that LV’s later refusal to insure him was unacceptable as it had relied on conditions within his medical records which were not clinically active nor limiting, such as mild migraines and psoriasis. He also said that LV had unduly prolonged matters and caused him additional stress by writing to his GP without telling him it would do so – when it likely knew that it wouldn’t be prepared to insure him anyway.

Mr S explained how he considered he was in excellent health; he had proven to LV that he had only missed work for one day in the last six years – and that wasn’t for medical reasons. Despite this, it considered him uninsurable, which not only affected him financially through lack of cover but emotionally and practically by wasting his time for several months.

An investigator from this service reviewed the complaint but she did not think it should succeed. She said that even with the revised diagnosis of BFS, the rejection of Mr S’s insurance application was reasonable and in line with LV’s underwriting guidelines. She was also satisfied that LV had made its updated decision in light of the consultant neurologist’s updated view of BFS. Finally, she noted that Mr S had previously provided consent for LV to contact his GP, so she didn’t think it had behaved unfairly in January 2025 by writing out for further information based on Mr S having appealed its underwriting decision.

Mr S said he didn’t agree with our investigator based on one sole premise: once LV had the updated information from the GP, this was the best possible scenario in which to reconsider insuring him. So, if the outcome of the best possible scenario was still going to result in a negative outcome, he questions why LV would place him through the additional time, stress and effort for several months. Mr S therefore considered he was unfairly misled by LV, and he asked for his complaint to be referred to an ombudsman.

Mr S also reiterated that even if the investigator had seen no evidence that LV was going to alter its decision upon seeking further update from his GP – he took the view that this was self-evident, because his medical records were corrected. What he cannot understand is why LV entertained revisiting its original refusal of cover if it knew or should have known the decision wasn’t going to change.

LV confirmed it didn’t have anything else to add. 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.

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 Mr S, I won’t

be asking LV to do anything further to resolve the complaint nor can I direct it to settle the complaint in the way he wishes. I'll explain my reasons below.

I have summarised the history of this complaint using my own words above, as an overview of what has gone on. Given my remit to make findings on what I believe to be fair and reasonable in the circumstances, I am not required to address each point raised. Instead, I will set out what I determine are the central issues in this complaint. Our rules permit me to take that approach.

It's important for me to point out that we do not act in the capacity of a regulator. That remit falls to the Financial Conduct Authority, 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, industry guidance and best practice where applicable.

As already explained by our investigator, on general grounds this service would deem it fair for an insurer to decide what risk it is willing to accept, and for what possible cost. That includes refusing to insure an applicant altogether, after underwriting based upon an applicant's disclosed medical history. Where a business exercises this judgement fairly and consistently, in line with its internal guidelines, we would not look to interfere with that process given we aren't a regulator. I therefore have looked at the evidence to decide if LV has treated Mr S fairly in all of the circumstances by refusing the cover and its process for doing so.

Mr S originally complained to LV about its reliance on incorrect medical evidence. And whilst I can see his complaint has now progressed to one specific concern about the need for additional contact with his GP, I have looked at all of these wider circumstances.

Turning firstly to the original decision to refuse cover, LV replied to Mr S giving him a further explanation as to why it couldn't offer cover to him via email on 24 December 2024. It set out that:

> "*Your General Practitioner has provided information regarding your benign fasciculation syndrome including symptoms of twitching affecting your sleep as recent as October and November 2024. We note that your dose of medication was increased in recent months to help control your symptoms.*
>
> *Your neurologist notes that symptoms were worsening and more frequent around March 2023 and in December 2022 your work and concentration levels were impacted. Income Protection is a high-risk policy whereby a claim could be met should you be unable to work for 3 months or more.*
>
> *In addition to the above, we have also taken into consideration time off work in the last 2 years with psoriasis, a history of health anxiety and migraines. Due to the above combination of health problems, I'm sorry to advise that we remain unable to offer a high-risk Income Protection policy*."

I don't find LV's underwriter to have acted unfairly in providing that explanation. And though Mr S places emphasis on the fact he was discharged from the neurologist by November 2024 and at that time had no 'active' conditions – that is not the measure used by LV to decide whether or not to offer insurance.

LV looked at Mr S's medical history in order to determine the risk of a possible claim, and the impact of any medical symptoms he had, rather than the diagnoses. And in this case, the symptoms of muscle twitching across his limbs, hands, feet, chest and face) that Mr S recounted to his medical practitioners had occurred since November 2022 and persisted in varying degrees up to October 2024.

I cannot relay the medical underwriting I've seen from LV here, as it's told us that information is commercially sensitive. However, it took account of Mr S's symptoms, which by the time of discharge had no known cause along with Mr S's additional medical history. I've seen no objective evidence that the underwriting was improperly carried out or that LV relied on incorrect information. Instead, it reached a decision on whether to offer insurance based on Mr S's medical history, and it was fairly entitled to do so. I therefore do not believe LV has behaved unfairly or unreasonably in respect of its decision not to insure Mr S.

I realise that thereafter, Mr S feels LV wasted his and his GP's time by seeking additional clarification regarding the previous working diagnosis of BFS. I have considered his point on that carefully, but I don't agree.

LV returned to the GP because Mr S specifically told it via email that in a letter of 3 December 2024 his consultant had changed the view of BFS, and it had been erroneously diagnosed. Whilst this did not alter Mr S's history of symptoms, Mr S contended that the consultant did not consider these symptoms unexplained either, but instead the "*a result of a normal motor system*". Given the strength of both Mr S's complaint and grounds of that complaint, I don't think LV was unfair to check this evidence with the GP.

Ultimately, the further response from Mr S did not change LV's underwriting decision. I have seen LV's internal reasoning on its choice to return to the GP given that its underwriters' decision on the evidence would not change. However, it noted how the GP may hold a more qualified view on the matter, and it ought to undertake that step for completeness since Mr S's complaint emailed referenced additional evidence. I find that fair. I also note that LV explained to Mr S how it had obtained his consent to contact his GP.

I don't think it was unreasonable for LV to decline income protection cover for Mr S on that basis and the underwriting guidance it had in place at the time both in December 2024 and March 2025.

I know this will be a disappointing outcome for Mr S. I understand his frustrations at not being provided with cover and moreover, at having to wait several further months for the same overall outcome. But I'm satisfied LV didn't treat him unfairly – it was able to decline cover based on the risk it was prepared to take, provided it calculated that risk based on relevant and reliable information. And for the reasons set out above, I'm satisfied that is what has happened here.

My final decision

Though I know my decision won't be what Mr S hoped for, I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 5 January 2026.

Jo Storey
Ombudsman