DRN-5719151

The complaint

Miss K complains because Liverpool Victoria Financial Services Limited ('LV') declined her income protection insurance claim and cancelled her policy.

What happened

Miss K took out an income protection insurance policy provided by LV in December 2023. The policy was taken out through an independent broker, and Miss K declared two pre-existing medical conditions.

In mid-2024, Miss K made a claim under the policy. In February 2025, LV said the claim wasn't covered because Miss K hadn't told it about certain aspects of her medical history when she took out the cover and, if she had, LV would never have offered her the policy. So, LV declined Miss K's claim, cancelled her policy and refunded the premiums she'd paid.

Unhappy, Miss K complained to LV before bringing the matter to the attention of our Service.

One of our Investigator's looked into what had happened and said he didn't think LV had acted unfairly or unreasonably in the circumstances. Miss K didn't agree with our Investigator's opinion, so the complaint has been referred to me to make a decision as the final stage in our process.

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.

The facts of this case are well known to both parties, so I haven't repeated them at length, but I want to assure both parties that I've carefully thought about all the events which took place.

Industry rules set out by the regulator say insurers must handle claims fairly and shouldn't unreasonably reject a claim. The rules also say insurers must provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress. I've taken these rules, as well as the content of the other regulatory guidance which Miss K has quoted, into account when reaching my decision.

I've also considered the relevant law (The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') and I've had regard to good industry practice about managing claims for misrepresentation and treating customers fairly (namely, the July 2023 Code of Practice set out by the Association of British Insurers ('ABI')) as well as what I think is fair and reasonable in all the circumstances.

For the avoidance of doubt, I'm not bound to follow any previous decisions made by our Service in other cases. Previous decisions do not set precedent, and we base our decisions on the specific facts of an individual complaint.

CIDRA requires consumers to take reasonable care not to make a misrepresentation when

taking out an insurance policy. The standard of care required is that of a reasonable consumer. If a consumer fails to do this, the insurer has certain remedies available to it provided the misrepresentation is - what CIDRA describes as – a 'qualifying misrepresentation'.

For a misrepresentation to be a qualifying one, the insurer must 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 a 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.

LV thinks Miss K failed to take reasonable care not to make a misrepresentation because of how she answered some of the below questions which were asked on her insurance policy application form in late 2023. I've underlined the answers which Miss K gave.

> *'**In the last 5 years, regardless of whether you've consulted a doctor, required treatment or had time off work, have you had**:*
>
> *…*
>
> *Q Diabetes, raised blood sugar levels or sugar in your urine?*
>
> *A No*
>
> *…*
>
> *Q Anything affecting your liver or pancreas?*
>
> *Including*
>
> - *Hepatitis, jaundice*
> - *An abnormal blood test or scan of your liver*
>
> *A No'*
>
> *'**Other than for things you've already told us about, in the last 3 years have you:***
>
> *Q Been prescribed medication or treatment for a period of 4 weeks or more, …*
>
> *Including:*
>
> *…*
>
> - *Prescriptions from a doctor, even if you didn't take them*
>
> *A No'*
>
> *Q Been asked to attend a follow-up or regular review with a doctor, hospital or clinic?*
>
> *Including:*
>
> *…*

- *Reviews or check-ups that you have been asked to attend even if you didn't*

  A No'

  'Q Have you been referred to, or consulted a specialist or been treated at hospital as an in-patient?

  A No'

  'Q Requested any or been advised to have any medical investigations?

  Including

- *A blood test or biopsy*
- *Ultrasound, x-ray, CT or MRI scan*
- *ECG or other heart investigations*

  A No'

I'm satisfied these questions were all clear and specific. It wasn't up to Miss K to determine what information she thought LV wanted to know, or to make her own judgment about whether any of her medical conditions were linked. There was a duty on Miss K to take reasonable care to accurately answer the questions she was asked, and LV wasn't only asking about medical conditions which Miss K may have been having treatment for at that time.

I'm not a medical expert and it's not my role to make any findings about what Miss K's health was at the time the policy was taken out. Instead, I need to decide whether I think LV's actions in this case were fair and reasonable based on the medical information available to it.

I've reviewed the medical records which I've been provided with. These include blood test results from 2021 showing elevated liver function and high blood sugar levels, a letter from a consultant dated July 2022 stating that Miss K had diabetes and multiple references to headaches and migraines in 2021, 2022 and 2023. The medical evidence also shows Miss K was waiting for an MRI to be rescheduled at the time the policy was taken out.

I think a reasonable person would have realised from the questions asked that LV wanted to know about all of this medical information. In particular, one of the questions specifically referenced MRI scans which the applicant had been advised to have. What subsequently happened with Miss K's MRI scan doesn't change my decision that Miss K ought reasonably to have told LV about it, and the letter from Miss K's GP dated March 2025 doesn't change my findings in this regard either.

Overall, I don't think Miss K took reasonable care when answering the questions LV asked her.

LV has provided evidence to our Service which I'm satisfied shows it would never have offered this policy to Miss K if she hadn't misrepresented her medical history. This is based on the premium loading originally applied to the policy due to Miss K's stated BMI and high blood pressure, taken together with the other medical issues which I think ought reasonably to have been declared.

This means I think LV has demonstrated that Miss K made a 'qualifying misrepresentation' under CIDRA and it's therefore entitled to apply the remedies available to it under the

legislation regardless of whether the condition being claimed for is linked to the conditions which were misrepresented. I don't agree with Miss K's submissions that this is unfair.

LV has treated this misrepresentation as careless and has refunded Miss K's premiums. This is fair and reasonable in the circumstances and reflects the applicable law rather than what Miss K views as an admission that LV has treated her unjustly in some way.

LV, in common with many other income protection insurers, wouldn't generally ask for medical information at the point of offering this policy and it's not something I'd expect it to have done here. This isn't how policies like this work. An insurer is entitled to carry out reasonable investigations into and request reasonable evidence in relation to a claim, and I'm satisfied LV acted in line with the ABI Code when doing so. I'd also say that I'd generally expect a policyholder to cooperate with an insurer's reasonable enquiries if they want their claim paid.

While there were times when I think LV could have progressed Miss K's claim more proactively, overall, I don't think there were any excessive or unreasonable delays on the part of LV in this case. It would have been premature for LV to decline Miss K's claim without obtaining all the medical evidence it needed to fairly consider it.

If Miss K thinks LV breached data protection laws, then this is a matter for the Information Commissioner's Office.

LV's actions in attempting to collect a direct debit for the policy premiums from Miss K after the cover had been cancelled didn't form part of her original complaint to LV. So, as our Investigator has already explained, we cannot consider the issue as part of this complaint.

For the reasons I've explained, I don't think LV has acted unfairly or unreasonably in the circumstances and I won't be directing it to do anything further.

My final decision

My final decision is that I don't uphold Miss K's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss K to accept or reject my decision before 25 August 2025.

Leah Nagle
Ombudsman