

The complaint

Ms A complains that Royal London Insurance Society Limited trading as Scottish Provident (RL) declined a claim and avoided her life and critical illness policy. Ms A was also unhappy with how the claim was handled.

Throughout the complaint process, Ms A has had a representative helping her. In this decision, any reference to Ms A includes the actions and comments of her representative.

What happened

Ms A took out a life and critical illness policy with RL which started in 2006. Ms A was diagnosed with cancer in 2015. She was diagnosed with cancer in a further site in 2021. Ms A raised a claim with RL. Whilst investigating the claim, RL became aware of Ms A's medical history and believe she misrepresented during her application. As a result, RL declined the claim, avoided the policy and offered Ms A a refund of her premiums. Ms A was unhappy and raised a complaint. RL didn't uphold Ms A's complaint as they didn't think they'd done anything wrong. Ms A was still unhappy, so brought the complaint to this service.

Our investigator didn't uphold the complaint. They didn't think RL had done anything wrong. Ms A appealed. She made the following points:

- Her medical history had no connection or relationship to her more recent cancer diagnosis.
- She was fully recovered and had no further treatment or follow-ups.
- She signed a form of authority and thought RL would check her medical records at the point of application.
- She hasn't had a previous diagnosis of cancer and so her previous medical condition didn't need to be disclosed.

As no agreement could be reached, the complaint has been passed to me to make a final decision.

I was minded to reach the same overall outcome as our investigator, but for some different reasons. So, I issued a provisional decision, to give both parties an opportunity to comment on my initial findings before I reached my final decision.

What I've 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 don't intend to uphold Ms A's complaint. I know this will be disappointing for Ms A, but I've explained my 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 RL acted in line with these requirements when it declined to settle Ms A's claim.

At the outset I acknowledge that I've summarised her complaint in far less detail than Ms A 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 Ms A's health. I wish her all the best with her future treatment/recovery.

Our investigator has said the relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). However, the policy was taken out in 2006, which is before CIDRA came into force. CIDRA isn't retrospective and so isn't relevant to this complaint. The relevant law in this case would be The Marine Insurance Act 1906. The Association of British Insurers also has guidance on how insurers should handle claims involving misrepresentation. As a service, we take both of these into account and have a well-established approach for pre-CIDRA policies.

RL thinks Ms A failed to take reasonable care when she answered the following question:

"Have you suffered, or any of your natural parents, brothers or sisters suffered or died before age 65 from any of the following or from any other hereditary disorder:

- Cancer, tumours or growth"*

Ms A answered the above question "yes" and disclosed hypertension only. RL has provided me with Ms A's medical records. These show the following:

- A type of childhood cancer diagnosed in 1979*

In a letter from one of her consultants, it states the following:

"She gave a history of having had treatment for childhood ovarian cancer"

Based on the question asked, the answer given and the medical information, I do agree that Ms A misrepresented during her application. I think the question is clear in what it wants to know and so I don't think Ms A took reasonable care when answering the question.

RL have provided me with a statement from an underwriter and the relevant parts of their underwriting manual. Based on what I've seen, RL wouldn't have offered the policy to Ms A.

Whilst I haven't seen the category of misrepresentation applied by RL, as they've avoided the policy but refunded the premiums, this is in line with a careless misrepresentation under the ABI's guidelines. I don't think careless is an unfair or unreasonable category for the misrepresentation. Based on the reasons above, I don't think the actions taken by RL are

unfair or unreasonable in the circumstances.

Ms A has said her medical history had no connection or relationship to her more recent cancer diagnosis. Whilst this may be the case, it doesn't mean Ms A didn't answer the question incorrectly. It also doesn't change that RL wouldn't have offered Ms A the policy had it been disclosed. RL have the commercial decision to underwrite policies how they perceive risk.

Ms A has also said she was fully recovered and had no further treatment or follow-ups and that she hadn't previously had cancer. Based on the medical information above, I don't think RL has acted unreasonably. If Ms A has further medical evidence which shows her condition in 1979 wasn't cancer, a tumour or a growth, she would need to provide this to RL to consider further. Whilst she may have fully recovered from the condition, the question doesn't specify when you don't need to disclose conditions. So, I still think the condition should have been disclosed.

Ms A has said she signed a form of authority and thought RL would check her medical records at the point of application. There's no requirement for insurers to check medical records on every application. Consent is taken in case they do need to check medical records to avoid delays after the application has been submitted. Insurers are allowed to rely on the information provided by consumers on their application.

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

I've also reviewed the claim history. Having done so, I don't think RL has caused any unnecessary delays to the process. So, I don't think they've handled the claim poorly."

Therefore, I wasn't minded to direct RL to do anything further as I didn't think they'd done anything wrong.

Responses to my provisional decision

RL accepted my provisional decision.

Ms A confirmed she didn't agree with my provisional decision. She made the following points:

- Her childhood cancer wasn't reported to her or her family as cancer at the time of the operation as a child. She subsequently had many years illness free and assumed was not an issue to the insurers and did not fall within the remit of the proposal questions.
- She hasn't received any notification regarding the premium refund. She wanted to know when and where it was paid.

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 Ms A, my conclusions remain the same. I'll explain why.

Ms A has said that her operation as a child wasn't reported to her as being for cancer at the time. Whilst this might be the case, she hasn't said that she wasn't informed or became aware of it being for cancer later in life. She's said she was illness free for many years and didn't think it fell within the remit of the question. This suggests she was aware about the details of the condition at the point of application but chose not to disclose it. As I set out in my provisional decision, I think the question was clear in what it wanted to know. Whilst she may have fully recovered from the condition, the question doesn't specify when you don't need to disclose conditions. So, I still think the condition should have been disclosed.

As such, my outcome remains the same as in my provisional decision for the same reasons.

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 Royal London Insurance Society Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms A to accept or reject my decision before 24 September 2025.

Anthony Mullins
Ombudsman