DRN-5827321

The complaint

Mr O is unhappy that The Original Holloway Friendly Society Limited ('the Society') declined a claim made on his income protection insurance policy and cancelled the policy.

What happened

Earlier in September 2025, I issued a provisional decision explaining why I wasn't intending to uphold this complaint. An extract of my provisional decision is set out below:

……

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

That includes The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I'm satisfied that it is relevant law.

I've also taken into account the relevant ABI Code of Practice for managing claims for individual and group life, critical illness and income protection insurance products ('the ABI's Code of Practice').

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. 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 several 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.

The Society has concluded that Mr O didn't take reasonable care when applying for the policy. Had he done so, and not misrepresented his answers to certain questions, it says the policy wouldn't have been offered to him at that time.

I have every empathy for Mr O's situation. I know that the Society's decision has impacted him financially. However, for reasons I'll go on to explain, I'm intending to find that the Society has acted fairly and reasonably.

Did Mr O make a misrepresentation when applying for the policy?

Mr O made an application for income protection insurance through an independent third party. I've seen the completed application which Mr O was sent in 2024 reflecting the answers he provided.

Mr O was asked:

> In the last five years have you had any of these?
>
> …raised blood pressure, cholesterol or chest pain.

I'll refer to this as 'the blood pressure question', It's reflected that he answered 'no'.

Mr O was also asked:

> Have any of these applied to you in the last 3 years? You don't need to include things you've already told us about.
>
> • I've taken or been prescribed treatment for 4 weeks or more
>
> • I've been asked to attend a follow-up or regular reviews with a GP, hospital or Clinic
>
> • I've been advised to see a specialist or to have any tests, scans, investigations or counselling.

I'll refer to this as 'the tests question'. It's reflected that Mr O didn't tick any of those options. Instead, the box next to 'no' has been ticked.

Towards the end of application, there's a section entitled: "some other things you need to know". It then says:

> Please remember, we use your answers to see if we can insure you. Please answer our questions fully, truthfully and to the best of your knowledge. If you miss out important information, or give us the wrong information, we might not be able to pay your claim. We may also have to cancel your insurance and we won't be able to refund you. So, if you notice anything that's not quite right, please call us straight away on…

And:

> You must tell us, if between the time you completed your application and the start date of your insurance, any of the following change:
>
> • your health….

Further, the Society's letter to Mr O dated the end of July 2024 (confirming that the policy had started, enclosing the application for him to check, and other documents), includes a document entitled: "important reminder". It says:

> And we can't emphasise this enough…
>
> It's really important you answer our questions truthfully and in full. If you miss out important information, or give us the wrong information, we might not be able to pay your claim. We may also have to cancel your insurance and we won't be able to refund you.
>
> So, please take another look at the answers you gave. If you spot something that's not quite right, or if you need to tell us some extra information, please call us on …or email us at…as soon as possible and we'll be happy to help.

I've seen nothing to convince me that Mr O did contact the Society at the time to correct the application.

CIDRA also says a failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation.

Looking at Mr O's medical history, I'm satisfied the Society has fairly and reasonably concluded that Mr O answered the blood pressure and the tests question incorrectly. That's because:

- Around three weeks before the policy started – and the date of the Society's letter referred to above - Mr O's GP notes reflect that he visited his GP, the problem being 'Essential hypertension' – described as a 'new episode'.

- A week after – so around two weeks before the policy starting – his GP notes reflect that his blood pressure was taken, it's recorded as high and he was asked to complete a home monitoring blood pressure diary. Further, he was referred for a blood test and it showed abnormal results for urea, electrolytes, potassium and glucose and a repeat test was needed. Mr O was also referred for an ECG on his heart and a referral was made to a dermatologist about a 'painful' lesion on his arm.

- The ECG, further blood test and the consultation with the dermatologist hadn't taken place – and were still outstanding – at the time the policy started.

I've taken into account the reasons why Mr O says he answered the blood pressure and tests questions in the way he did (and didn't correct the information once he received the completed application to review at the end of July 2024). I think those questions are reasonably clear and given the medical entries above, shortly before the policy started, I'm satisfied the Society has fairly and reasonably concluded that he should've declared he'd had raised blood pressure and confirmed that he'd been advised to see a specialist, to have tests and investigations.

Was Mr O's misrepresentation a 'qualifying' misrepresentation?

Looking at the underwriting information provided by the Society in conjunction with the medical records, I'm satisfied that had Mr O answered the blood pressure and tests questions correctly, the policy wouldn't have been offered at the time.

I'm therefore persuaded that Mr O's misrepresentation is what CIDRA refers to as a 'qualifying' misrepresentation.

Has the Society acted fairly and reasonably by taking the action it did?

The Society has concluded that Mr O's misrepresentation was reckless (as opposed to carelessly made). That is that Mr O knew or must've known that the information given was incorrect and relevant to the insurer. Or that he acted without any care as to whether the information was either correct or relevant to the insurer. I'm conscious that it's for the Society to show this on a balance of probabilities.

Taking into account the relevant ABI Code of Practice (and what it says about classing misrepresentations as reckless) I'm satisfied the Society has acted fairly and reasonably by concluding Mr O acted recklessly.

The ABI's Code of Practice says the category of reckless is more likely to apply in situations where the mispresented information concerns recent or ongoing treatment, specialist consultations and/or other medical investigations about matters that a reasonable consumer would have understood to be important to their health. Mr O had experienced high blood pressure a few weeks before the policy started and had been referred for other medical tests and investigations during this time, some of which were outstanding at the policy start date.

I've looked at the actions the Society can take in line with CIDRA if a qualifying misrepresentation is deliberate or reckless.

I'm satisfied it can avoid the policy, decline the claim and cancel the policy from the start date. It also doesn't have to refund the premiums Mr O paid for the policy. That's in line with what the Society has done here. And I'm satisfied that it has fairly relied on CIDRA by taking this action.

I appreciate that the further tests ultimately came back as normal after the policy started. But I'm satisfied that the Society has fairly focussed on what would have happened had Mr O answered the blood pressure and test questions correctly or had corrected his answers around the time the policy started.

……..

In invited both parties to provide any further information in response to my provisional decision.

The Society replied saying it had nothing further to add and that it accepted my provisional decision.

Mr O replied, disagreeing with my provisional decision. In summary Mr O said:

- the tests he had were repeated because they'd originally been done wrong.
- it's good practice to repeat tests.
- all his health issues were resolved, and he was healthy up until he needed a limited amount of time off work and made a claim under the policy.
- he was in good health and the tests he had amounted to an 'MOT' and were routine tests.
- it's unfair to rely on bad test results over a few weeks when everything then returned to normal.
- the premiums he paid for the policy before it was cancelled should be donated to charity.

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.

That includes the further points made by Mr O.

Having done so, I'm satisfied that there's no compelling reason to depart from my provisional findings. I'll explain why.

For reasons set out in my provisional decision, I remain satisfied that the blood pressure and tests questions were clear and that the Society has fairly concluded that Mr O made a qualifying misrepresentation when answering them incorrectly.

Although tests were repeated, I remain satisfied that at the point the policy was applied for, the Society has fairly concluded that Mr O acted recklessly in the way the questions were answered. He may have believed that the test results were wrong and that he wasn't worried about his health. However, he had tests and it's recorded that he experienced high blood pressure shortly before applying for the policy.

If Mr O had answered the questions correctly, I'm satisfied from the evidence I've seen that the policy wouldn't have been in place for Mr O to have claimed on the policy when he later took time off work.

Because I'm satisfied that the Society has fairly retained the premiums Mr O paid for the policy, I don't think it would be reasonable for the total sum of the premiums Mr O paid for the policy before it was cancelled to be donated to charity.

For these reasons, and for reasons set out in my provisional decision (an extract of which is set out above and forms part of this final decision), I don't uphold Mr O's complaint.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr O to accept or reject my decision before 20 October 2025.

David Curtis-Johnson
Ombudsman