

The complaint

Miss L complains that Liverpool Victoria Financial Services Limited (“LV”) applied an exclusion to her income protection policy which led to her claim being declined. Miss L is also unhappy about how LV dealt with the claim, how it communicated with her and the service it gave.

What happened

Miss L took out an income protection policy through an independent broker on 26 March 2024. The policy was provided by LV. Miss L made a claim to LV in July 2024 as she was signed off work.

I issued a final decision on Miss L’s previous complaint and considered the following issues:

- How long it took for LV to assess the claim up until 18 December 2024 (when it issued its final response on the delays).
- How LV calculated the benefit Miss L was entitled to under the policy. Miss L said this should be £1,200 per month as she’d signed up, and paid a premium, for.
- How long it took for LV to send her the policy documents (final response issued on 20 November 2024).

So, the above issues don’t form a part of this decision. In this decision, I’m considering the following complaint issues:

- LV’s decision to apply an exclusion on the policy which led to Miss L’s claim being declined.
- Failure to make reasonable adjustments to Miss L’s communication needs.
- How LV dealt with Miss L’s Subject Access Request.
- How LV dealt with the claim between 18 December 2024 and 11 April 2025 (when it issued a further final response), and the service it gave her.

One of our investigators reviewed what had happened. Having done so, she didn’t agree LV had fairly applied the exclusion on Miss L’s policy. So, she thought LV should remove the exclusion and reassess the claim.

The investigator didn’t agree LV had communicated with Miss L as well as it should have done following her requests for reasonable adjustments. She also thought there were further delays in dealing with the claim, and a delay in sending Miss L the information she had requested. Overall, the investigator thought LV should increase its compensation offer from £500 to £850.

LV didn’t accept the investigator’s outcome. It maintained that it was fair to apply the exclusion on the policy. And whilst LV agreed to increase the compensation to a total of £750, it didn’t agree £850 was fair or reasonable.

Miss L wants LV to now pay the full amount of her claim in one payment, and she says it should pay her more compensation for how it dealt with everything and the impact this had on her.

As no agreement was made, the complaint was assigned to me to decide. I issued my provisional decision in September 2025. Here's what I said:

"Miss L has provided detailed submissions and extensive evidence in support of her complaint. However, I've focused on the points that I think are important to the outcome of this complaint. This simply reflects the informal role of this Service.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must deal with claims fairly and promptly. I've taken these rules, and other industry guidance, into consideration when deciding what I think is fair and reasonable in the circumstances of Miss L's complaint.

LV's decision to apply an exclusion on the policy which led to the claim being declined

The main considerations under this complaint are the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA"). This is designed to make sure that consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the Act.

A misrepresentation is a "qualifying misrepresentation" when 1) a consumer fails to take reasonable care not to misrepresent facts which the insurer has asked about, and 2) the insurer shows that without the misrepresentation it would not have entered the contract at all or would have done so only on different terms. If there is no qualifying misrepresentation, the insurer cannot do anything.

I've considered if Miss L failed to take reasonable care when taking out the policy. The standard of care required is that of a reasonable consumer. And one of the factors to be considered when deciding if a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

There are two main questions in dispute. Both are under the heading "Your mental health". The first question asks the following:

"In connection with your mental health, have you ever

If you are under the care of the community mental health team then you will have a key worker or be under the care of a community psychiatric nurse.

Options – Required hospital treatment or been advised to attend hospital, Been seen by or advised to see a psychiatrist, Been referred to the community mental health team, None of these"

In the application form, Miss L answered this as "none of these". I cannot consider anything Miss L's broker has done under this complaint. But for context, Miss L explained to the broker that she had previously been referred to the community mental health team ("CMHT") due to her autism spectrum disorder ("ASD") diagnosis. The broker explained that ASD doesn't come under mental health, so it didn't need to be declared.

After LV told Miss L she should have declared the referral in her application, she explained that she has never formally been diagnosed with a mental health condition. And any references to these in her medical notes were observations made by her parent, rather than a formal diagnosis by a medical professional.

Miss L's medical notes show that she was first diagnosed with ASD in 2011, and she was referred to CMHT in 2014. The GP notes in April 2014 show that Miss L's parent had a telephone appointment with the GP practice and she wanted Miss L to be referred to CMHT. Miss L's diagnosis was recorded as ASD with history of secondary anxiety and obsessional symptoms. This was reflected in the referral letter.

There were other referrals for mental health services in November 2015 and March 2017, but the notes don't refer to these being CMHT specifically, unlike the referral in 2014. The referral in 2015 was following an appointment with Miss L, but the one in 2017 was again a telephone appointment by Miss L's parent.

Considering the question LV asked, and what Miss L has explained, I'm currently satisfied she took reasonable care to answer this question as "none of these". The clear referral for CMHT was in 2014, when the primary diagnosis was ASD. And whilst a history of mental health issues was noted, the GP notes make it clear the appointment that led to the referral was with Miss L's parent.

In connection with information online, including the NHS, ASD is not a mental health condition. It's also important to note that the referral happened ten years before Miss L took out the policy with LV. So, I consider a reasonable consumer is more likely to remember the reason for any referral that long ago to be for any primary diagnosis, rather than anything secondary suggested by their parent. As Miss L's understanding was that the referral to CMHT was due to her ASD, rather than anything in connection with her mental health, I'm satisfied she took reasonable care to answer this question as "none of these". That means that I don't currently think Miss L made a misrepresentation in response to this question.

The second question under the same heading asks the following:

"In the last 5 years have you consulted a health professional, required treatment (including counselling) or have you required time off work for any of the following?"

If you are not working, have any of these stopped you doing your normal daily activities?"

Options – Depression or anxiety, Stress, Eating disorder, Another mental health issue, None of these

Miss L answered this as "none of these". But LV has noted the following entries in Miss L's medical records:

- On 22 December 2023: "wants a bespoke letter to state stress of bank caused flare up of skin"*
- On 26 July 2024: "pt has been having work related stress last 3 yrs"*

LV says that she should have declared "stress" in response to the above question due to her having experienced stress for the last three years.

Firstly, the question doesn't ask about symptoms, it asks if the applicant has consulted a health professional, required treatment or time off work due to the listed mental health issues. The note in July 2024 is after the policy was taken out, and this only refers to stress as a symptom. It doesn't say that Miss L had consulted a health professional, required treatment or time off work for this.

I've considered the note on 22 December 2023 carefully. But I see that this appointment was in relation to Miss L's skin condition. The GP issued a fit note due to this and specifically declined Miss L's request. Miss L has also explained that her absence from work was due to her physical condition and the impact of this, and not in relation to mental health.

I don't currently think LV has been fair or reasonable by saying Miss L should have declared "stress" in response to the above question. I think the note in December 2023 is clear that Miss L consulted a health professional due to her skin condition, not due to her mental health or stress. This is supported by the fit note the GP issued during this appointment, which shows that the reason Miss L required time off from work was due to her skin condition. So, I currently think Miss L took reasonable care when she answered this question as "none of these".

Based on everything I've seen so far, I'm not persuaded that LV has shown Miss L made a misrepresentation. This means that I don't currently think LV has been fair or reasonable when it applied the exclusion for "autism, depression, anxiety, other mental disorder, neurodevelopmental disorder or chronic fatigue syndrome, fibromyalgia, myalgic encephalomyelitis (ME) and post-viral fatigue" on Miss L's policy. It should therefore reinstate the policy, remove the exclusion and reassess Miss L's claim without applying the exclusion.

It appears like LV refunded Miss L the premiums she paid when it declined the claim. So, when LV reinstates the policy, Miss L needs to pay back those premiums for LV to now reassess the claim. But I think LV should give Miss L a claim decision before asking her to pay any further premiums she's missed out on paying since. I think it would be fair and reasonable to allow Miss L to decide at this point if she wants to continue with the policy or not. If she does, LV can then make sure that Miss L is up to date with her premium payments.

I think LV has caused Miss L unnecessary distress and inconvenience when it unfairly applied the exclusion on her policy and declined the claim. This has clearly been very distressing for Miss L during an already difficult time. I will consider below what is the fair amount of compensation considering all the circumstances of this complaint.

Miss L has said I should direct LV to now pay her claim in full, in one payment. But this complaint is about LV applying an exclusion on Miss L's policy and declining her claim because of this. It's now for LV to reassess her claim.

Failure to make reasonable adjustments to Miss L's communication needs

LV has accepted that it didn't always identify and communicate with Miss L in a way that it should have done, including providing the requested reasonable adjustment in relation to written communication. And having listened to calls Miss L had with LV, it's clear that its agents weren't always aware of all of Miss L's communication needs. LV has paid Miss L £500 to compensate her for the distress and inconvenience caused by its failings.

It's not for this Service to decide if a business has breached the Equality Act 2010 – that's a matter for the Courts. But as it's relevant here, I have taken this law into consideration when deciding what's fair and reasonable in all the circumstances of this complaint.

It's clear that LV hasn't done everything right here, for the reasons it has explained. But I can also see that LV has tried to accommodate Miss L's requests, for example by speaking to her over the phone when requested. It's unfortunate that some of these conversations ended up being extremely distressing for Miss L. But I think the reason for this was primarily due to what LV was explaining to her, rather than how. That said, I accept that as LV's agents weren't always aware of all of Miss L's communication needs, they also didn't always tailor their communication fairly, and as needed.

It's clear that LV has caused Miss L unnecessary distress and inconvenience in how it communicated with her. I've taken this into consideration in my compensation award below.

For clarity, any further conclusions I make in relation to how LV dealt with everything or communicated with Miss L doesn't include what it did in relation to her requests for reasonable adjustments. Rather, the following findings are purely about the service LV gave Miss L.

How LV dealt with Miss L's Subject Access Request ("SAR")

It's not for this Service to decide if a business has breached any data protection laws – that's a matter for the Information Commissioner's Office ("ICO"). But as Miss L's request relates to how LV managed her claim, I've considered what's fair and reasonable in all the circumstances of this complaint.

Miss L says she made a SAR to LV in January 2025, but it didn't send the information to her until April 2025. But I can't see that Miss L made a formal SAR in January 2025. And LV says that she didn't make a formal SAR until March 2025. Nevertheless, LV's agent told Miss L in March 2025 that it was going to raise a SAR for her already in January 2025 and send her all call recordings and emails. So, it's not surprising that Miss L was disappointed with how long it took for her to receive the information.

I appreciate Miss L wasn't happy with how she received the information, and the problems she encountered trying to access everything. But I can see that LV has tried to help her with this. It also explained why it couldn't send all the information in the format Miss L had asked.

Overall, I think LV has caused Miss L some unnecessary distress and inconvenience, which I've taken into consideration when deciding what compensation it needs to pay her in all the circumstances of the complaint.

How LV handled the claim between 18 December 2024 and 11 April 2025 (when it issued a further final response), and the service it gave her

Miss L has said that some conversations she had with LV had a significant detrimental impact on her mental health. I've listened to a specific call she referred to in January 2025, and it's clear that she was extremely distressed by the call. But as I explained previously in my decision, I think this was primarily due to what LV was explaining to her, rather than because LV didn't manage the call well.

I can see that LV ultimately applied the exclusion on the policy based on the medical evidence it already had previously. But it requested further information as Miss L disputed LV's suggestion that it would need to apply an exclusion on her policy, and LV needed more information to understand the underlying reason for Miss L's absence from work.

LV received the final medical information from the GP on 20 March 2025, and LV declined Miss L's claim due to misrepresentation on 26 March 2025. So, I think it made the final decision on the claim promptly at this point.

However, it's clear that LV hasn't managed everything as well as it should have, for the reasons I've explained in this decision. Having considered everything, I currently think LV should pay Miss L £850 for the unnecessary distress and inconvenience it caused her in the circumstances of this complaint (inclusive of the £500 it has already paid her)."

I have summarised Miss L's main comments following my provisional decision:

- LV should reinstate the policy to provide cover for £1,200 per month.
- LV should pay her claim as a lump sum to date, after deducting the missed premiums from the payment. And it should make the payment within 28 days from my final decision.
- LV should accept and pay the claim by using the evidence it already has.
- I should consider both the financial impact and the distress LV's actions have caused Miss L.

LV didn't agree with my provisional decision, and I've detailed below its main comments:

- The referral to CMHT in 2014 wasn't the only time Miss L had been referred to mental health services. She was supported by Children and Adolescent Mental Health Services ("CAMHS") in 2013, and other mental health services in 2015 and 2017.
- There's no requirement for there to be a diagnosis for a mental health condition in the question LV asked, rather, the question refers to mental health broadly. And Miss L's medical records note several symptoms relating to her mental health, in addition to her ASD diagnosis.
- Miss L's parent being involved with the referral process doesn't take away the underlying reason, symptoms and medical condition that was consulted for and managed.
- When Miss L saw a GP in December 2023, the records show that she discussed two aspects, a gynae referral, and stress which she believed was exacerbating her physical health. She was clearly concerned enough to ask her GP to write a letter to her employer in this regard.
- It would be remiss to say that this consultation was only regarding one aspect of Miss L's health, when multiple issues were discussed. As she had consulted her GP regarding stress, she should have declared this when she bought the policy.
- LV doesn't feel further compensation is due to Miss L, beyond the £500 it already paid her.

As both Miss L and LV have now had the opportunity to review and comment on my provisional decision, I'm issuing my final 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.

I've reviewed Miss L's medical records again, as well as her testimony, and I've considered LV's comments. But it's important to consider that I need to decide if Miss L took reasonable care when she answered the questions LV asked.

As a reminder, both questions are under the heading “Your mental health”. So, I’m satisfied that a reasonable consumer would answer these questions considering that the questions specifically relate to their mental health. And the first question was as follows:

“In connection with your mental health, have you ever

if you are under the care of the community mental health team then you will have a key worker or be under the care of a community psychiatric nurse.

Options – Required hospital treatment or been advised to attend hospital, Been seen by or advised to see a psychiatrist, Been referred to the community mental health team, None of these”

It’s not in dispute that Miss L hadn’t required hospital treatment or been advised to attend hospital in connection with her mental health, or been seen by or advised to see a psychiatrist. The main issue is if Miss L should have answered yes to the question *“in connection with your mental health, have you ever been referred to the community mental health team”*. And the question also clarified that *“if you are under the care of the community mental health team then you will have a key worker or be under the care of a community psychiatric nurse”*.

So, this is a very specific question LV asked in relation to Miss L’s mental health. LV has referred to Miss L having experienced symptoms and her being referred to other mental health services. But it didn’t ask her if she’d experienced any symptoms or if she’d been referred to any mental health services. So, I don’t agree these alone meant that Miss L should have declared these to LV, as it didn’t ask her about these specifically. But I have considered these in the context of the question it did ask.

LV has referred to other mental health service referrals in 2015 and 2017. But I’ve not seen that either was specifically a CMHT referral. LV also specifically noted that the one in 2015 was for primary care, and it seems like CMHT is secondary care. I also haven’t seen any reference in the 2017 referral that this was a CMHT referral specifically. It seems like this referral was also done following an appointment with Miss L’s parent. So, I think the key referral was the one in 2014, as this was a specific referral to CMHT.

Unlike LV says, I do agree the fact that Miss L’s parent attended the appointment where the CMHT referral was made is material here, and the GP notes were based on the discussion they had with the GP. Miss L has been consistent in her testimony that the referral to CMHT was due to her ASD diagnosis, as well as her learning difficulties. And her ASD was noted as the primary diagnosis in the referral. What I consider material here is Miss L’s understanding of what the CMHT referral was for, the same as for any reasonable consumer answering this question.

LV has also referred to Miss L having been supported by CAMHS before the referral to CMHT. Firstly, LV specifically asked about a referral to CMHT, which wasn’t done until 2014. That said, Miss L was underage when she was under the care of CAMHS, and she has explained that due to this her parent represented her. And she has maintained consistently that she was under the care of CAMHS due to her ASD diagnosis and learning difficulties, rather than due to her mental health.

I'm still persuaded that Miss L took reasonable care when she answered this question as "none of these". LV asked specifically about a referral to CMHT, and the clear referral for this was in 2014. And I'm persuaded by Miss L's testimony that her understanding was that the referral was due to her ASD diagnosis and learning difficulties, rather than in connection with her mental health. In any event, as I explained in my provisional decision, I believe a reasonable consumer would more likely remember a referral that took place ten years previously to be for any primary diagnosis, rather than any secondary diagnosis suggested by and discussed with their parent.

Overall, I'm satisfied Miss L didn't make a misrepresentation when she answered this question as "none of these".

The second key question was also under the heading "Your mental health", and this was as follows:

"In the last 5 years have you consulted a health professional, required treatment (including counselling) or have you required time off work for any of the following?"

If you are not working, have any of these stopped you doing your normal daily activities?"

Options – Depression or anxiety, Stress, Eating disorder, Another mental health issue, None of these

The key question is if Miss L consulted a health professional about stress, when LV asked her this about her mental health. LV says that she did, based on the GP note in December 2023 which included the following note:

"wants a bespoke letter to state stress of bank caused flare up of skin"

LV says that Miss L consulted a health professional about stress, as she wanted a bespoke letter about this from her GP. Again, I believe it's important to remember that the question is if Miss L took reasonable care to answer the question LV asked.

The question was under the heading "Your mental health". I've seen that Miss L discussed physical conditions in this appointment, a gynae referral and her skin condition. And the fit note the GP issued supports this. I've also considered Miss L's testimony, and that she explained that her absence from work was due to her physical condition and the impact of this, ie the stress on her body, and not in relation to her mental health.

Overall, I don't agree the request she made to the GP is enough for me to say that she failed to take reasonable care when she said she hadn't consulted a health professional about stress, when asked about her mental health specifically. So, I'm satisfied Miss L didn't make a misrepresentation when she answered this question as "none of these".

I've already explained that I considered in a previous final decision the complaint about how LV calculated the benefit Miss L was entitled to under the policy. Miss L had said this should be £1,200 per month as she'd signed up, and paid a premium, for. So, as I considered Miss L's comment about the amount of benefit she's entitled to under the previous complaint, I make no finding on this under this complaint.

Miss L says that LV should now accept and pay her claim using the evidence it already has. I agree that LV should take into consideration all the evidence it already has, and it should only request further evidence if it requires this to now reassess the claim. If there are delays in LV assessing the claim, Miss L would need to submit this as a new complaint to LV in the first instance.

Having considered everything, I'm satisfied the compensation award takes into consideration all the unnecessary distress and inconvenience LV caused Miss L in all the circumstances of her complaint. Overall, I've reached the same conclusions as I did in my provisional decision, for the same reasons.

My final decision

My final decision is that I uphold Miss L's complaint, and I direct Liverpool Victoria Financial Services Limited to do the following:

- reinstate the policy subject to Miss L paying back the premiums LV refunded,
- remove any records of voiding or cancelling the policy from any internal and external databases,
- remove the exclusion applied,
- reassess Miss L's claim without the exclusion in accordance with the remaining terms and conditions of the policy,
- after doing so, allow Miss L to decide if she wants to continue with the policy or not before asking her to pay any missed premiums, and
- pay Miss L a total of £850 compensation for the distress and inconvenience caused*.

*LV must pay the compensation within 28 days of the date on which we tell it Miss L accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% simple per annum.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss L to accept or reject my decision before 27 November 2025.

Renja Anderson
Ombudsman