DRN-5949440

The complaint

Miss B complains that Legal and General Assurance Society Limited declined a claim on her critical illness policy.

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

What happened

Miss B took out two policies with L&G which both started in January 2023. One policy was for life and critical illness cover, the other was just life insurance. Miss B had taken out the policies through an independent financial adviser (IFA) who she said she first contacted in October 2022.

I'm very sorry to hear that Miss B was diagnosed with a neurological condition not long after taking out the policies. I wish Miss B all the best for the future. Miss B raised a claim with L&G but it was declined as L&G believed Miss B had made a misrepresentation during her application. L&G cancelled both policies and refunded all premiums she'd paid. Mrs B raised a complaint. L&G didn't uphold the complaint as they didn't think they'd done anything wrong. Still unhappy, Miss B brought the complaint to this service.

Our investigator didn't uphold Miss B's complaint. She didn't think L&G had acted unfairly in declining the claim or cancelling the policies. Miss B appealed. She maintained she hadn't provided any incorrect information to her IFA and this meant L&G were still liable to pay the claim. She also didn't think it was reasonable for a lay person to micro-check the application form which there was also no evidence she'd signed to confirm it was all correct. As no agreement could be reached, the complaint has been passed to me to make a 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.

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 L&G acted in line with these requirements when they declined Miss B's claim.

At the outset I acknowledge that I've summarised her complaint in far less detail than Miss B 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.

Miss B has also raised about a phone call she received from L&G when she asked not to be called. This was addressed by L&G in a final response in November 2024. The complaint was raised with this service in July 2025. We can only consider complaints brought to us within six months of the final response letter. So, I won't be addressing this issue in this decision.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). 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 a number of 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.

L&G thinks Miss B failed to take reasonable care when he/she answered the following questions:

"Have any of your natural parents, brothers or sisters, before the age of 60, had multiple sclerosis (MS).

During the last 5 years have you been in contact with a doctor, nurse or other health professional for:

- *A growth, lump, polyp or tumour of any kind?*

- *Paralysis, numbness, persistent tingling or pins and needles, tremor, facial pain other than dental pain or memory loss, dizziness or balance problems?*

During the last 3 months have you had any of the following:

- *Unexplained changes with walking, movement or mobility, numbness or tingling, mental functioning, or changes to your vision?*"

The above questions were all answered "No". L&G has provided me with Miss B's medical records. These show the following:

- April 2012 – neurology consultation
    - She was just informed by her [relative] that she was diagnosed with MS
- April 2022 – GP consultation
    - Numbness and weakness in arms and partial paralysis esp in the night and wakes her
    - Tries to get up but sometimes in the night her legs are weak too
    - Also lymph nodes in neck are swollen in neck at times
- January 2023 – Dermatology consultation

- Reported co-existent neurological issues of numbness and tingling in hands and legs

I think it's important at this stage to set out that as Miss B went through an IFA, and because the IFA was acting on her behalf, the answers submitted by the IFA would be treated as being submitted by her. So, any misrepresentations caused by her IFA, would be treated as though being caused by her.

Based on the questions asked, the answers given and the medical information, I do agree that there has been a misrepresentation during this application. I think the questions are clear in what they want to know and so I don't think reasonable care was taken when answering the questions. This means the misrepresentation would be deemed as a qualifying one under CIDRA.

Miss B has said that she was initially told that a relative had MS but was later given conflicting information on this. So, the information provided to the consultant in 2012 was based on hearsay. The consultant's report suggests that Miss B was informed directly by her relative about the diagnosis. I don't think it would be unreasonable for L&G to rely on this information without Miss B providing evidence to support her relative not having a diagnosis of MS.

Miss B doesn't think it's reasonable for a layperson to micro-check the application form and there's no evidence to show she signed it. Miss B wouldn't be required to sign the form; the policy would still proceed anyway. The other option for if a form wasn't signed would be for the policy to be cancelled which would leave Miss B in no different a position. The onus is for customers to provide correct information to insurers during an application process. I don't think the information supplied on L&G's "check your details" form is unreasonable for Miss B to have checked.

Miss B has correctly pointed out that she disclosed two conditions which had been suggested as potential causes for her numbness and weakness. Whilst these were disclosed, it doesn't detract from Miss B not answering a relevant question correctly. Different conditions can affect individuals in different ways with different symptoms. For an insurer to get an accurate assessment of the risk, the questions need to be answered in order, which didn't happen in this instance. Her medical records also indicate that Miss B was suffering with neurological issues within 12 months of her application, but she disclosed it was three years ago on the application.

L&G have provided me with a statement from an underwriter and the relevant parts of their underwriting manual. Based on what I've seen, L&G would have postponed the application until Miss B's neurological investigations had been completed. Following her diagnosis, L&G wouldn't have offered critical illness cover. They would have still offered life insurance, but this would have been at an increased premium. As a result, I think Miss B's misrepresentation would be a qualifying misrepresentation under CIDRA.

L&G have treated Miss B's misrepresentation as deliberate or reckless. This allows them to decline any claims, avoid the policy and retain any premiums paid. Having reviewed the circumstances, I don't think L&G has acted unreasonably in treating the misrepresentation as deliberate or reckless. This is based on the guidance in both CIDRA and provided by the Association of British Insurers. I note that whilst they're allowed to retain the premiums, L&G have offered to refund these to Miss B on this occasion. Based on the reasons above, I don't think the actions taken by L&G are unfair or unreasonable in the circumstances.

Miss B has said that CIDRA puts liability on an insurer where an IFA's actions cause a misrepresentation and a consumer has provided accurate information. Miss B hasn't

provided the specific part of CIDRA that gives her this impression. I'm not aware of a part of CIDRA that makes this the case, particularly in the specific circumstances of this complaint. Had the IFA been acting for L&G, then there may have been a liability on L&G, but that isn't the case in this complaint.

I'm very sorry that my decision doesn't bring Miss B 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 L&G has treated Miss B unfairly, unreasonably, or contrary to law in declining the claim.

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 Legal and General Assurance Society Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 29 December 2025.

Anthony Mullins
Ombudsman