

## The complaint

Mr and Mrs P complain that they were mis-sold two life and critical illness policies by Openwork Limited as they excluded cover that was an important requirement for them.

## What happened

The background to the complaint will be well known to both parties, so I'll only give some key details here.

Mr and Mrs P first met with the Openwork adviser in September 2020 at which point he recommended a decreasing term joint life and critical illness (CIC) policy to cover the mortgage of around £340,000 on a property they were in the process of purchasing. The purchase went ahead, but cover wasn't implemented at that point.

A further meeting with the adviser in July of the following year resulted in a new recommendation, a similar decreasing term life and CIC policy along with an additional £50,000 level term life and CIC policy. An application was made, an offer issued by the policy provider and Mr and Mrs P proceeded with the policies.

Later, in August 2024, Mr P became aware that the policies excluded critical illness cover for cancer for him. He complained to Openwork about this, explaining that cancer cover had been a particularly important consideration for him and Mrs P when taking out the policies because of his family history. He therefore felt the policies had been mis-sold. He said he'd cancelled them and taken out a replacement policy that did provide him with critical illness cover for cancer.

Openwork didn't uphold the complaint. It explained that the suitability letters issued to Mr and Mrs P had highlighted the possibility of exclusions being applied and therefore the importance of checking the provider's documentation upon receipt. The offers from the provider, which it said were emailed and sent by post, had clearly set out the exclusion. Openwork did however offer Mr and Mrs P a payment of £200 in acknowledgment of a delay in dealing with the complaint.

Mr and Mrs P didn't accept Openwork's response and referred the complaint to this service.

An investigator looked into the matter and concluded that the complaint should be upheld. He felt the adviser had failed to properly consider Mr P's medical circumstances in making the recommendation. So, he suggested an additional £300 should be paid to compensate for the distress incurred by them in realising they'd taken out a policy that didn't provide cover that was important to them.

And further, the investigator felt the overall recommendation of the two policies had been unsuitable because it involved a duplication of cover. He noted that the replacement cover Mr P had now put in place was cheaper than the unsuitable recommendation, so asked Openwork to refund the additional amounts that had been paid for the unsuitable policies.

Openwork maintained its view that the adviser had acted correctly in respect of the exclusion

and didn't accept that there'd been a duplication of cover. It considered the recommendation of the two policies had been suitable for Mr and Mrs P

The investigator wasn't persuaded to change his opinion, so the matter was referred to me review.

I issued a provisional decision in which I explained why I thought the complaint shouldn't be upheld. I said, in part –

*"In respect of the concern initially raised by (Mr and Mrs P), that the recommendation was unsuitable because the policies didn't provide cover for cancer, I don't think the adviser, nor Openwork more generally, acted incorrectly in that respect.*

*The adviser was clearly aware of Mr P's two medical considerations – a (non-cancer related) condition with which he'd been diagnosed and the fact that he had a family history of cancer. These considerations were both detailed in the application form, which it appears the adviser completed for Mr and Mrs P.*

*He made his recommendation, as explained in the 2021 suitability letter, as the chosen provider was able to provide "the most competitively priced solution to meet your needs", having sought quotes from a range of providers. However, as with all such applications for cover it had to be underwritten once the chosen provider received full personal information from Mr and Mrs P. As the provider's quote explained, "The quote shows important details of your cover and the premium you might pay. These are based on our standard rates and your current age. These may change once we've fully assessed your application".*

*Further, the suitability letter issued to Mr and Mrs P that explained the recommendation was very clear on the importance of checking details of the cover being offered when the written documentation was received. It said the new provider would "confirm if a rating has been applied that could affect a claim, such as a pre-existing condition. It is important you use this as an opportunity to check the cover being offered in order to make sure that it meets your needs and is acceptable to you. If it is not acceptable, or you have any queries, you agreed to contact me".*

*The critical illness exclusion for cancer for Mr P was clearly set out in the documentation provided to both him and Mrs P, sent by email and by post. Mr P says he couldn't upload the policy files from the new provider as he was never able to access them via the provider's portal, and also that he has no recollection of ever receiving a postal copy. He could have raised the portal issues with either the provider or the adviser, but in any event he and Mrs P would've been aware that they hadn't seen the details of the offer when they proceeded with it.*

*So, in all the circumstances, I'm not persuaded that the adviser acted incorrectly with regard to the exclusion. He made a recommendation of cover, as is usual, having obtained quotes based on limited standard information regarding Mr and Mrs P's needs and circumstances. But he wouldn't have known what impact the more detailed information given in the application would have. Hence why the importance of checking the final offer was made clear. I've no reason to think that if Mr and Mrs P had checked and seen the exclusion and brought it to the adviser's attention, he wouldn't have helped them further to obtain cover that didn't have the exclusion.*

*Turning to the general suitability of the recommendation, I don't think it was wrong of the adviser to suggest a joint decreasing term life and critical illness policy. It's quite normal to want to protect such borrowing and the policy correctly matched the details of the mortgage.*

*Although Mrs P wasn't in employment at the time, so had no income, the couple had a young child and in the event of anything happening to Mrs P, repayment of the mortgage would have provided very useful financial support for Mr P as a single parent.*

*The same reasoning applies to the level term policy. While this could be seen as a 'nice to have', the adviser's notes recorded that it was recommended so Mr or Mrs P would benefit from an additional lump sum of cash, which they felt was important, with the £50,000 sum being the maximum available with their available budget. The suitability letter explained it was recommended to protect their standard of living and ultimately there was no requirement that take up the additional policy if on reflection they didn't feel it was necessary. Both policies were maintained for three years prior to the complaint being made, which indicates the recommended cover was affordable.*

*As I've said, I appreciate my provisional decision will come as a disappointment to Mr and Mrs P. But in all the circumstances, as things stand, I find I'm unable to conclude that Openwork acted incorrectly or unfairly in either respect – regarding the exclusion or the general suitability."*

Openwork accepted my provisional decision and confirmed it had nothing further to add.

Mr and Mrs P provided a further submission focussing on why they maintained the advice had been unsuitable, primarily in line with the investigator's view of the matter.

In brief, they felt the suitability of the recommendation needed to be considered as a whole and that the cancer cover had been a fundamental requirement and not a secondary feature. They felt that reliance on post-offer checking didn't cure unsuitable advice and a suitable policy addressing their primary protection need could've been obtained at a lower overall cost than the combined premiums they'd 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.

While I've carefully considered Mr and Mrs P's further submission, I find I've not been persuaded to depart from my provisional conclusions. For the reasons given, I remain of the view that those conclusions are fair and reasonable.

Regarding the exclusion issue, the application form shows that the adviser engaged in detail with the provider, specifically regarding Mr P's diagnosed pre-existing condition. So, I don't feel that he looks to have acted carelessly in making the recommendation and dealing with the application, given what he knew about Mr P's 'medical considerations'.

As I said before, he couldn't be certain of the final detail of the provider's offer. That was why it was stressed as being important to check the details once an offer was made. While I of course wasn't privy to the discussions between the adviser and Mr and Mrs P, the documentation available from the time of the advice didn't record cancer cover as being an absolute requirement, nor did it indicate that the adviser committed to checking the offer in this respect on behalf of Mr and Mrs P.

I accept that the provision of documentation doesn't by default render a recommendation suitable. But I think in the specific circumstances here, the adviser did all he could reasonably have been expected to do to ensure the suitability.

I note that Mr P has said that he didn't feel it was a priority to check the 'fine print'. However,

given the importance to him of the particular aspect of cover and having been made aware that changes/restrictions post-application were possible, I think on balance it's reasonable to expect him to have checked.

Regarding the other issue, the level of cover, I remain satisfied it was a broadly suitable recommendation for Mr and Mrs P's circumstances and objectives, that was clearly set out and explained to them.

### **My final decision**

For the reasons given, my final decision is that I don't uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P and Mrs P to accept or reject my decision before 6 March 2026.

James Harris  
**Ombudsman**