DRN-6133217

The complaint

Mr D is unhappy that Zurich Assurance Ltd have declined a claim he made on a life insurance policy.

What happened

Mr D and his late wife, Mrs D, held a life insurance policy. Mrs D sadly died and Mr D claimed on the policy. Zurich declined the claim as they said Mrs D hadn't accurately disclosed information about her medical history. They said, had she done so, they wouldn't have offered the policy.

Mr D complained to Zurich but they maintained their decision was fair. Unhappy, Mr D complained to the Financial Ombudsman Service about the decision to decline the claim and the length of time the claim took.

Our investigator looked into what happened. He thought Zurich had fairly declined the claim in line with the relevant legislation and had provided a decision about the claim within a reasonable timescale. Mr D didn't agree and asked an ombudsman to review the complaint. He didn't agree the claim had been fairly declined. And he said there had been failings by Zurich in relation to the correspondence he and Mrs D had been sent around the time of the application as it coincided with them moving house. He also didn't feel Zurich had acted in line with the spirit of the policy and the principles of the Consumer Duty. He highlighted that the process had been emotionally and financially exhausting.

These further representations didn't change our investigators thoughts about the overall outcome of the complaint. He remained of the view that Zurich had acted in line with the relevant legislation and that there hadn't been any unavoidable delays. Mr D didn't agree and asked an ombudsman to review the complaint.

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.

The relevant rules and industry guidelines say that Zurich has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. I've also considered the relevant overarching principles for businesses set out by the Financial Conduct Authority and the Consumer Duty.

I want to say at the outset how sorry I was to read of the circumstances which led to this claim. I have a lot of empathy with what Mr D said, particularly with what he's said about the impact of losing Mrs D and the sad circumstances of her death. I'd like to offer him my sincere condolences as I can appreciate how difficult and distressing this must have been for him.

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.

Zurich says Mrs D failed to take reasonable care not to make a misrepresentation as she failed to update them about changes to her health during the application process. The policy application took place in May 2019 but cover didn't commence until October 2019. In August 2019 Mrs D was sent a copy of the application form which included her original answers given during the application process. She was asked to carefully check the information and let Zurich know if any answers changed before the policy start date.

One of the questions that had been asked during the application process was:

> "Other than for the condition you have already told us about earlier in this application: are you aware of any symptoms that you intend to seek medical advice or treatment for, or are you waiting for any test results, appointments or investigations with your doctor or other medical professional?"

Mrs D answered 'no' to this question. However, in July 2019 she attended her GP with symptoms of palpitations, light headedness and started taking medication commonly prescribed for high blood pressure.

Zurich says that had they been made aware of this information they would have asked for more information from Mrs D's medical records and postponed the application before declining it. That's because Mrs D didn't attend the appointments for the ECG so Zurich wouldn't have offered cover until that had been completed so they could assess the risk accurately.

I'm satisfied Mrs D ought to have contacted Zurich to update them about the appointment in July and her referral for an ECG before the policy came into force in October 2019. I say that because I think it was made clear to her that she needed to check the information carefully and update Zurich. She'd had an appointment with her GP, been referred for tests and started medication and I think the documentation made it sufficiently clear that she needed to let Zurich know about this.
I've considered what Mr D has said about Mrs D feeling that her symptoms had resolved and that she didn't attend the appointments. However, in line with the information she was sent I still think she ought to have disclosed this to Zurich. Therefore, I'm satisfied that Mrs D failed to take reasonable care.

I've thought carefully about what Mr D has said about the fact that he and Mrs D moved house shortly before the correspondence was sent and so they didn't see the relevant correspondence about changes in health. I understand Mr and Mrs D moved shortly before the correspondence was sent in August 2019. However, Zurich weren't told about the change of address until after the relevant letter had been sent. It also seems likely, based on the phone call recording, that Mr and Mrs D had been able to access correspondence that

had been sent to the old address, as that's what prompted Mr D to call. During the call Mr D was told that Mrs D would need to call to update her details and they also directed him to the portal (where information about the policy was available). The information was also available via the portal and was sent to Mr and Mrs D's financial advisor. It was also Mr and Mrs D's responsibility to ensure their personal details were kept up to date. So, even I accepted that the letter wasn't received by Mr and Mrs D, I can't fairly hold Zurich responsible for that.

Zurich has provided underwriting evidence which shows that if they'd been aware of the change in health they'd have asked for more information and the case would have been passed to an underwriter for review. This would have meant the application would have been postponed until the ECG was completed and so no cover would have been offered. This means I'm satisfied Mrs D's misrepresentation was a qualifying one.

Zurich has classified Mrs D's misrepresentation as 'careless' rather than deliberate or reckless. I think that is fair and reasonable as I don't think Mrs D intended to mislead Zurich. I think it's more likely she didn't appreciate the significance of this information. And I appreciate she was in the middle of moving house so likely had other things on her mind. However, as I'm satisfied that Mrs D's misrepresentation should be treated as careless, I've looked at the actions Zurich can take in accordance with CIDRA.

In such circumstances Zurich is entitled to decline the claim, cancel the policy and refund the premiums. That's what Zurich has offered to do here so I think they've acted in line with the remedy set out in CIDRA.

I've not identified any unreasonable delays in Zurich handling the claim. I understand how upsetting and frustrating it was for Mr D. However, the time taken reflects the complexity of the claim. That includes, the information needed to be obtained and assessed in detail to decide if cover could have been provided.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 5 March 2026.

Anna Wilshaw
Ombudsman