DRN-6138119

Financial Ombudsman Service

The complaint

Mrs T says Wesleyan Assurance Society ("Wesleyan") completed medical documentation on her behalf without consultation and misled her about whether her life and critical illness policies were live. She considers the compensation offered for distress and inconvenience to be insufficient.

What happened

In December 2023, Mrs T received a quotation from the provider, Z, for life and critical illness cover arranged through Wesleyan's adviser. In January 2024, the adviser requested certain medical details by email and following this, on 22 January 2024, he emailed to say that both policies had been approved.

Mrs T did not receive formal policy documents and chased in early February 2024. On 2 February 2024, the adviser sent a Z quotation document and indicated she was covered, explaining that paperwork would follow. Mrs T chased again on 6 March 2024 as she still had not received confirmation documents.

On 15 March 2024, a "Health and Lifestyle Summary" and an AMRA consent form were generated and electronically signed. Mrs T says she was never asked the detailed medical questions shown on that form and did not authorise anyone to sign the AMRA consent on her behalf. She says that, in contrast, when renewing her income protection policy, she spoke directly with an underwriter and provided a full medical history, and she expected a similar process for the life and critical illness cover.

After receiving the completed medical form, Mrs T contacted Z, and the application was withdrawn at that time. She complained to Wesleyan. Wesleyan said it believed its adviser had gone through the medical questions with her as part of the advised process and that completing applications on a client's behalf is normal practice. It did not accept that documentation had been completed improperly, but it acknowledged shortcomings in communication and complaint handling. It initially offered £250 for distress and inconvenience and, on 27 January 2025, offered a further £150, bringing the total to £400.

The complaint was referred to this service after the initial offer of £250 had been made. The investigator concluded there was insufficient evidence to determine that the medical information had been recorded without discussion, but that communication about the policy documentation and overall handling had caused avoidable distress. The investigator considered £400 to be fair compensation in the circumstances.

Mrs T did not agree. She maintains she was never asked the relevant medical questions, that she did not consent to the AMRA form being signed, and that she experienced significant stress. She also says she was told the policies were live when they were not. The matter has therefore been referred to me for a final decision.

Wesleyan has since confirmed that, as far as it is aware, both policies were in force and remain in force.

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 want to start by acknowledging that this has clearly been a very unsettling experience for Mrs T. Protection policies are taken out to provide security. Discovering that medical information appears on a form which she does not recognise as having been discussed would understandably cause concern.

There are two key issues for me to consider: first, whether the medical and consent documentation was completed without Mrs T's knowledge or authority; and second, whether the overall handling and communication, including about the status of the policies, was fair and reasonable.

On the first point, I have carefully reviewed the "Health and Lifestyle Summary" and AMRA declaration. It is common and accepted industry practice in advised sales for an adviser to complete an insurer's online application while speaking to the client, recording the client's answers and applying an electronic signature as part of that process. The presence of an electronic signature does not, in itself, demonstrate impropriety.

However, I also note that Mrs T has consistently said she was never asked the detailed medical questions shown in the summary and that her meetings were conducted via Zoom or Teams. I have not been provided with call recordings or other independent evidence that clearly establishes what was or was not discussed. In the absence of such evidence, I must decide on the balance of probabilities.

There is insufficient evidence for me to conclude that the documentation was completed without authority. Equally, there is insufficient evidence for me to make a finding of deliberate wrongdoing.

Turning to the status of the policies, the email correspondence shows that Mrs T was told in January 2024 that the policies had been approved, yet she did not receive formal documentation for some time and continued to chase. The medical form is dated 15 March 2024, which understandably led her to question whether full underwriting had been completed when she was told the policies were live.

Wesleyan has confirmed that both policies were in force and remain in force. There is no evidence that Mrs T was uninsured at a time when a claim arose, nor that she suffered financial loss. Nonetheless, I consider that the communication around underwriting, documentation and policy inception lacked clarity. Good industry practice requires advisers to be clear about when cover starts, whether it is subject to underwriting, and what steps remain outstanding. In this case, that clarity was not achieved, and that contributed to Mrs T's distress.

I have also taken into account the time and effort Mrs T expended chasing documentation and pursuing her complaint, as well as the anxiety caused by seeing medical information she says was inaccurate.

When assessing compensation for distress and inconvenience, I must ensure any award is proportionate to the impact evidenced. While I accept this was stressful and frustrating, there was no financial loss, the policies are confirmed as in force, and I am not able to conclude that documentation was deliberately completed without authority. In those circumstances, I consider the total offer to compensate £400 to be within the range that is fair and reasonable for the level of distress and inconvenience demonstrated.

Putting things right

I appreciate that Mrs T feels strongly that the impact on her was greater and that a higher award is justified. However, I must reach a decision based on the evidence and on what is fair in comparable cases. Taking everything into account, I am satisfied that £400 appropriately recognises the shortcomings in communication and the distress caused. Should Mrs T now wish to accept and if Wesleyan hasn't already paid this sum, she should

let Wesleyan know within four weeks of this decision.

My final decision

I uphold Mrs T's complaint, but I conclude that Wesleyan Assurance Society's offer to compensate £400 for distress and inconvenience is fair and reasonable, so it need not take any further action.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs T to accept or reject my decision before 16 March 2026.

Farzana Miah
Ombudsman