

The complaint

Mr V complains that Allianz Insurance Plc declined a claim on his pet insurance policy and said the policy was void.

What happened

Mr V had insurance for his dog, which was taken out in July 2022 and renewed each year. This was a lifetime policy, with cover for vets' fees up to £3,000 per year.

In April 2025, Mr V took his dog to the vet regarding a cough. They discussed possible causes and some treatment was given. There was a follow up appointment on 20 May with further treatment and advice, though the condition hadn't been diagnosed. On 4 July the vet sent an email to Mr V with some quotes for further treatment.

The policy was due to renew on 27 July 2025. On 23 July, Mr V took his dog to the vet for a health examination and booster injections. He called Allianz the same day and asked about increasing the cover limit. Allianz agreed to increase the limit to £6,000 per year from the renewal on 27 July.

On 30 July Mr V made a claim for treatment costs relating to his dog's cough. The claim was for treatment between 11 April and 30 July. Allianz paid the costs up to 20 May under the previous policy, but declined the claim for later costs and said the policy was void as from the renewal on 23 July. Allianz said Mr V's actions amounted to fraud.

Mr V complained but Allianz didn't change its decision. Our investigator said it was fair to decline the claim and void the policy from the renewal date, because there had been a misrepresentation by Mr V when he renewed the policy. But she didn't think there was fraud. She asked Allianz to remove any fraud markers.

Neither party has accepted the investigator's view. Mr V says any misrepresentation was careless (a result of a misunderstanding) not deliberate or reckless, and a fair outcome would be to maintain the policy with the previous level of cover. Allianz still considers there was fraud and does not think the fraud markers should be removed.

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 industry rules and guidance say insurers must deal with claims promptly and fairly, and not unreasonably reject a claim. They should settle claims promptly once settlement terms are agreed.

The starting point is the policy terms and conditions as they set out the terms of the insurance contract. But I also need to take into account any relevant law, together with regulators' rules, guidance and standards.

In its submissions, Allianz has referred to a policy term that says

“If you:

- *Provide us with false information,*
- *Make a false or exaggerated claim with us, or*
- *Make any claim with us which involves your dishonesty,*

We won't pay your claim, and we can void your policy, inform the relevant authorities/other organisations and record the details on anti-fraud databases. If we pay a claim and subsequently find the claim was fraudulent, you must repay us the full amount.”

This term refers to a policyholder making a fraudulent claim.

The relevant law is the Insurance Act 2015, which says if someone makes a fraudulent claim under a contract of insurance, the insurer:

- is not liable to pay the claim,
- may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and
- may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.

As with the policy term, this is referring to fraudulent claims.

A fraudulent insurance claim is a false or exaggerated claim, where the policyholder has told a lie which either makes a claim that wouldn't normally be paid under the policy appear to be one that would be paid, or increases the amount the policyholder could claim, to more than they're entitled to.

But the courts have confirmed there are some circumstances where a claim isn't fraudulent if there is a 'collateral lie'. This is where false information is provided to support a claim the policyholder is entitled to make and, while the aim is to improve the insured's position, it doesn't in fact do that – the claim would still have been paid without the false information.

I'm satisfied that is what happened here. Mr V was entitled to claim under his old policy and the claim would have been paid in full as it was less than the previous limit of £3,000. Providing inaccurate information didn't change that.

I appreciate Allianz says the policy limit applied for the whole policy year so, after making this claim, Mr V would have had more of the limit still available. In that sense, he had improved his position. But in relation to this claim, the outcome would have been exactly the same, with the claim paid in the same way. And I think it's also relevant that the false information was provided before the renewal of the policy. At the point when that information was provided, there wasn't any claim. When making its decision, Allianz' reasoning concerned the information given in relation to renewing the policy, not in relation to a claim. In the particular circumstances here, I don't consider it fair to say this was fraud.

I do, however, agree there was a misrepresentation when the policy renewed.

The relevant law in relation to this 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 an insurance policy. The standard of care is that of a reasonable consumer.

If a consumer fails to take reasonable care and makes a misrepresentation, the insurer has certain remedies if there is a qualifying misrepresentation, as defined in CIDRA. For it to be a qualifying misrepresentation the insurer has to show it would either have offered the policy

on different terms or not offered it 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. One of these is how clear the question asked was.

In the call on 23 July 2025, Mr V was asked the following question about his dog:

'Has he ever had any symptoms of being unwell or been injured or anything that's affected him even if a vet wasn't needed?'

Mr V said his dog had been unwell a long time ago, and he thought it might have been allergy-based, though a diagnosis had not been confirmed. He had used antihistamines, as recommended by the vet, and changed his dog's food. Mr V said this would be noted in the vet's records. The call handler explained they wouldn't have the up to date records and wouldn't necessarily request them unless the underwriters wanted more information

There was then some discussion of questions about other issues. At the end of the call, Mr V was asked *"Is that everything you're aware of?"* and he confirmed it was.

I think the question asked was clear and Mr V knew if his dog had had any symptoms of illness he had to disclose those.

Mr V says he didn't know what the diagnosis was at that point, and the estimates he had received from the vet were detailed and technical; he didn't understand what the issue was and couldn't speculate about it. But he wasn't asked to give a diagnosis or technical details about the condition. He was simply asked if his dog had shown symptoms of being unwell or of something that affected him.

Mr V knew his dog had been unwell – he'd taken his dog to the vet about coughing more than once in the months leading up to July, and received advice and treatment for that. I'm satisfied he knew something was wrong, even if he didn't know what was causing it. He should have disclosed this, but he didn't say anything about the fact his dog had been unwell with a cough and had been treated for that. The information Mr V provided wasn't accurate and there was a misrepresentation.

As I've explained, I don't think it was fair to conclude this was fraud. The claim was made for an amount that would have been covered under the previous limit, so Mr V would have been covered for that. This was a collateral lie – although he gave false information, it didn't change the outcome of the claim. Allianz' underwriters have confirmed that if Mr V had disclosed the information about the cough, they would not have agreed to the policy being upgraded. But that still means if Mr V had given accurate information, the policy would have renewed with the existing policy limit of £3,000, so the claim would have been paid.

But there was a misrepresentation and the information from Allianz' underwriters shows it would have acted differently if it had been given accurate information. So this was a qualifying misrepresentation.

The remedy available to Allianz depends on whether the qualifying misrepresentation was deliberate or reckless, or careless. Mr V says any misrepresentation was careless but I don't think it was.

A qualifying misrepresentation will be deliberate or reckless if the consumer:

- knew it was untrue or misleading, or did not care whether it was untrue or misleading; and
- knew the matter to which the misrepresentation related was relevant to the insurer, or

did not care whether or not it was relevant to the insurer.

A qualifying misrepresentation is careless if it is not deliberate or reckless.

Mr V must have known the information he provided was misleading or else he did not care that it was misleading. He knew it was relevant to the insurer. If not deliberate, it was at the very least reckless. In these circumstances, CIDRA allows Allianz to void the policy and keep the premiums.

For these reasons, I'm satisfied it was fair to decline the claim and void the policy from the renewal date. But I don't think it was fair to say this was fraud, so any fraud markers should be removed.

My final decision

I uphold the complaint and direct Allianz Insurance Plc to remove any reports of Mr V on any internal or external fraud databases.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr V to accept or reject my decision before 7 May 2026.

Peter Whiteley
Ombudsman