

complaint

Mr G and Miss B are complaining about The Prudential Assurance Company Limited because it didn't pay a claim on their critical illness insurance.

background

Through an independent broker, Mr G and Miss B took out a life and critical illness insurance policy with Prudential in 2003. Sadly, Miss B was diagnosed with multiple sclerosis in 2015 and she claimed on the policy.

Prudential declined the claim. It said Miss B didn't include important information about her medical history in the application. If it had known this information, it said it wouldn't have offered critical illness cover. It gave Mr G and Miss B the option of either continuing with the policy without critical illness cover (and an increased premium for the life cover) or for it to be cancelled and their premiums refunded.

Our adjudicator recommended the complaint be upheld. He didn't think the relevant application questions were sufficiently clear or that Miss B should have answered them differently. He said any non-disclosure was innocent and that Prudential should assess the claim. He also said it should pay compensation of £750 for Miss B's trouble and upset.

Prudential disagrees. It says that Miss B's problems in 2001 and 2002 weren't normal and were the cause of some concern. It also points out they happened only a year before she took the policy. So it says she should have remembered and disclosed them. If she had done, it says it wouldn't have offered cover and it was therefore entitled to decline the claim.

Miss B says she never saw any correspondence between the doctors involved at the time. She says her problems were always referred to as *pins and needles* and that she was told everything was normal and she was at no higher a risk of developing multiple sclerosis than the average person. She feels she answered the application reasonably and to the best of her knowledge at the time.

my findings

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint. Having done so, I agree with the adjudicator's conclusions for much the same reasons. I'm upholding this complaint.

The policy application included the following questions, to both of which Miss B answered "no":

During the last 3 years, have you suffered from any anxiety, depression or any psychiatric disorder or any disease/disorder of the back or joints OR have you ever suffered from any illness or injury which has prevented you from working for a period of two weeks or more?

and:

Have you ever had any disease/disorder of the heart or kidney, high blood pressure, stroke, cancer, diabetes, paralysis/parasthesia, multiple sclerosis or any eye or ear disease/disorder OR have you ever suffered from any illness or injury which has prevented you from working for a period of two weeks or more? (Long or short sightedness and minor ear infections may be excluded)

In the margin next to the second question was the following statement:

Parasthesia is abnormal tingling sensations, including pins and needles, numbness, loss of feeling/sensation that required a visit to your doctor.

When it was assessing Miss B's claim, Prudential found she was investigated for numbness and pins and needles at the end of 2001 and the start of 2002. It also noticed she consulted her GP with anxiety at the start of 2002. It's these issues that Prudential thinks she should have mentioned in answer to the above questions.

When a consumer hasn't given the insurer relevant information in response to a clear question, this is known as *misrepresentation*. Industry guidance commonly recognises three types of misrepresentation – *deliberate/reckless*, *careless* and *innocent*. Depending on the type of misrepresentation, insurers are sometimes entitled to take action including declining a claim or reducing the amount payable.

In considering this claim, I'll address the issue of Miss B's investigations for numbness and her recorded anxiety separately.

numbness and pins and needles

The first step in considering a dispute like this is to look at the questions asked. If a question isn't sufficiently clear, guidance from the Association of British Insurers (ABI) says any ambiguity should be construed in favour of the consumer. It also says not much weight should be attributed to catch-all questions.

Looking at the second question above, this asks about a lot of different conditions and could arguably be seen as an example of what the ABI means when it refers to a *catch-all* question. But more importantly than that, I think there is ambiguity that should be construed in Miss B's favour.

Miss B underwent various investigations in 2001 and 2002, but the correspondence between the medical professionals involved suggests she was reassured about the findings. In January 2002, her consultant neurologist, Dr N, wrote the following in two separate letters.

The fact that her MRI brain scan is completely normal (including FLAIR scans) means that we are dealing with a solitary inflammatory episode of the cord, best called myelitis i.e., she does not have MS. It is possible she may have further inflammation within the central nervous system in which case she would be diagnosed with MS later on. However, it is equally possible that this will be a single episode. There is no way of telling, but the normal scan and visual evoked responses make it less likely that she will have further episodes. I cannot give statistics. I think she should be reassured along these lines.

and:

I reviewed this patient in the clinic today. I am pleased to say that her arm and abdominal symptoms have completely settled. I just reviewed the history with her again and there is no evidence of any previous episodes of nervous system disturbance and as you know, the MRI brain scan was normal. I have reassured her that she does not have MS by definition and because the brain scan was normal, and the likelihood of developing it is small although possible. I have advised her on a healthy diet and have not arranged to see her again routinely.

In my view, these comments and the fact no further action was taken at the time support Miss B's statement that she was reassured about the results and believed there was nothing out of the ordinary to worry about. Indeed, Prudential's own internal notes and correspondence indicate it can't be sure the term *paraesthesia* was used in discussions with her and it accepts she was given reassurances.

In the application question, the term *paraesthesia* was defined as *abnormal* sensations. And I understand Prudential's view that symptoms that caused Miss B to have detailed investigation and some anxiety should have been considered *abnormal*. They certainly would have been at the time she first sought medical advice. But I think the question could just as easily be interpreted differently. Once the investigations were complete and if Miss B was reassured she had nothing to worry about, I think she would have been entitled to believe everything was normal. In those circumstances, when she was later asked if she'd had *abnormal* sensations, I think it would have been reasonable for her to say "no".

The question didn't ask whether Miss B had ever sought medical advice for numbness or pins and needles. It instead asked if she'd had *abnormal* sensations. As I've explained, I think this question is ambiguous and that it should be interpreted in Miss B's favour. This would lead to the conclusion that she was entitled to answer it as she did and any misrepresentation was innocent. In cases of innocent misrepresentation, an insurer is expected to pay a valid claim in full as if no misrepresentation took place.

In its response to the adjudicator's assessment, Prudential referred to correspondence from a neurologist Miss B saw in 2015, Dr H, who said:

Going through the story again, she was under a Neurologist 14 years ago when she complained of bilateral hand and feet numbness and weakness of the hands. This spontaneously resolved after 4 months and, at the time. Was told that she had 'sclerosis' and that it would not need any further attention. Since then, in hindsight, she recalls having transient symptoms and some episodes of clumsiness but it was not until February this year when she again noticed similar symptoms of numbness and tingling in her hands and feet.

It thinks this indicates Miss B said to Dr H that was told she had sclerosis in 2002, and I understand why it's interpreted his comments in this way. But any conversation with Dr H was more than 13 years after her original investigations finished in early 2002. It's also not clear exactly when that conversation happened or what Miss B had been told beforehand. It could just as easily be that she wasn't told about sclerosis until she sought advice in 2015 and that she then passed this information onto Dr H when she met him.

I've not seen anything from the medical evidence available for 2001 and 2002 to show Miss B was told she had sclerosis at that time. As I've said above, I think the evidence instead indicates she was reassured and that she was most likely entitled to believe there was nothing out of the ordinary she needed to worry about.

anxiety

Miss B's medical notes do refer to anxiety, but this coincides with the medical investigations and there's no mention of this after her results in January 2002. I think it's understandable she would have worried for the short period while she awaited the results of her investigations and the medical notes suggest the issues were linked. Once the results indicated she had nothing to worry about and she had no further anxiety or problems with her sleep, I'm satisfied it was reasonable for her to think this was nothing unusual or that warranted disclosure in the application.

putting things right

I think Prudential acted unfairly in declining Miss B's claim for misrepresentation. For the reasons explained above, I think any misrepresentation in Miss B's application should be classed as innocent and that any valid claim should be paid in full.

To put things right, Prudential should assess Miss B's claim on the basis that there was no misrepresentation. If this shows she has a valid claim, it should pay the policy benefit in full. From this amount it could deduct any money paid to Mr G and Miss B if the policy was cancelled and the premiums refunded.

To compensate Mr G and Miss B for the delay in receiving any money, Prudential should add simple interest at 8% per year from the date it originally received Miss B's medical records in 2015 to the date of payment.

I'm also conscious Prudential's decision to decline her claim was particularly upsetting for Miss B and came at a time when she'd been diagnosed with a serious illness. This is shown by her letter to Prudential where she said she was asking her partner to deal with correspondence as the situation wasn't helping her health. I think both Mr G and Miss B have also been put to a lot of unnecessary trouble in having to pursue a complaint in these circumstances.

The amount to award consumers for their trouble and upset can be particularly difficult to assess. But in the circumstances of this case, I agree with the adjudicator that a substantial payment of £750 is fair.

my final decision

My final decision is that I uphold this complaint.

If Mr G and Miss B accept my decision, The Prudential Assurance Company Limited must assess Miss B's claim as if there was no misrepresentation. If the claim is payable, it must then add interest as outlined above. Irrespective of whether the claim is payable, Prudential must also pay them £750 for their trouble and upset.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G and Miss B to accept or reject my decision before 31 October 2016.

Jim Biles
ombudsman