complaint

Miss D has complained about Nationwide Building Society because she believes her critical illness insurance policy was mis-sold. She says she was told the exclusion of cover for total and permanent disability (TPD) from the policy only applied to accidental injury and not long-term disabling conditions. When she recently tried to claim on the policy, the insurer didn't pay because TPD cover was excluded.

background

In 2006, Miss D was arranging a new mortgage of £118,000 on a repayment basis. She already had a policy providing life and critical illness cover of £54,000 taken in 2002. To cover the rest of her new mortgage, Nationwide recommended the following two policies with Legal & General:

- level term life insurance providing cover of £64,000 at a cost of £11 per month; and
- level term critical illness insurance providing cover of £64,000 at a cost of £47 per month. Legal & General excluded TPD cover because of Miss D's medical history.

Sadly, Miss D recently became seriously ill and claimed on her two policies. While they didn't specifically cover her illness, the insurer accepted she was totally and permanently disabled and paid out the TPD benefit on the first policy. But Legal & General didn't pay out on the second policy as TPD was excluded from the start.

I previously issued my provisional decision explaining why I didn't think Miss D's complaint should be upheld. An extract is attached and forms part of this decision. Nationwide made no further comment. Miss D disagreed with my provisional decision, making the following key points:

- The policy was unsuitable for her needs. The sales documentation records she wanted TPD cover and that's further evidenced by the fact she was topping up her first policy that included it.
- She was given misleading information about the policy. She says she questioned the documentation saying TPD cover was excluded with the adviser and was specifically told the exclusion only referred to disabilities resulting from an accident.
- Her partner was also present at the meeting where she was told this. Nationwide hasn't provided any record of the conversation to show she was told otherwise.
- Because she was misled in this way, she was denied the opportunity to get cover elsewhere.

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 reconsidered the case, including Miss D's response to my provisional decision, my conclusions haven't changed. I'm not upholding this complaint.

As I've explained previously, this decision relates solely to Nationwide's role in the sale of the policy. Any complaint about the decision not to pay Miss D's claim, including whether she should be allowed to claim for a condition that wasn't covered from the start, would need to be raised separately with Legal & General.

I think the terms of the TPD exclusion are clear in the documentation. I appreciate Miss D recalls the adviser described this differently. But on their own and without any additional evidence to support what she's saying, I don't think her comments are enough to conclude she was misled in the way described. In reaching that conclusion, I've taken full account of what she says was discussed and the fact her partner was also present.

I understand why Miss D would have preferred to have a policy with TPD cover and feels she was denied the opportunity to get this elsewhere. But I don't think it's necessarily clear she would have declined the policy if she'd understood the benefit was being fully excluded. Firstly, it covered a number of other illnesses and Miss D wouldn't have known what she'd suffer from in the future. Perhaps more importantly, she was off work following an injury when the policy started. In that situation, I think it's very unlikely another insurer would have offered TPD cover either. I appreciate Miss D would have preferred a policy with TPD cover, but I don't think I can reasonably say the one she did take was unsuitable if this wasn't available.

my final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 6 November 2015.

Jim Biles
ombudsman

extract from provisional decision:

my provisional findings

To decide what's fair and reasonable, I've carefully considered everything Miss D and Nationwide have provided. Having done so, I don't currently intend to uphold this complaint.

Any complaint about the decision not to pay Miss D's claim, or to exclude TPD cover from her policy in the first place, would need to be raised with Legal & General first. It was the insurer and it made those decisions. Miss D would then be able to refer her concerns to us as a new complaint if she wasn't satisfied with its response.

I've considered what Miss D has said she was told about what was being excluded. But on their own and without additional supporting evidence, I don't believe her comments are enough for me to say she was misled about how the policy would work. I've also reviewed Legal & General's acceptance terms that should have been sent to Miss D at the time and these explain TPD cover was being excluded altogether. There's nothing to indicate the exclusion only applied to accidental injury.

I understand Miss D was off work with a serious injury in 2006 when the policy was arranged. This is almost certainly the reason Legal & General didn't offer her TPD cover, and I think it would have been difficult to find another insurer who would have done in that situation. So even if I were able to say Miss D was misled about the policy, I couldn't reasonably tell Nationwide to pay her TPD claim if she couldn't have got that cover.

This issue aside, Miss D did received advice and the adviser had a responsibility to make sure any policies sold were suitable for her circumstances and needs.

According to the documentation from the time off sale, Miss D's main aim was to make sure the additional part of her new mortgage could be paid off if she died or became seriously ill before it was due to be repaid.

In this case, Miss D took separate life and critical illness policies rather than combining the cover in a single policy. The benefit of arranging the cover in this way is that her life cover would continue if she became ill and successfully claimed on the critical illness policy. After that it would probably be difficult to get further life cover. The downside is that the monthly cost of a combined policy would have been lower. The total monthly cost of the policies Miss D took was around £59. If she'd arranged a single policy with both life and critical illness cover, she'd only have had to pay £53.

After reviewing the adviser's recommendation report from the time of sale, it appears these options were discussed with Miss D and the adviser provided information about the comparative costs. The difference in cost was quite small for the possible additional benefit gained by keeping the policies separate. And the sales documentation does indicate Miss D was able to make an informed decision about that.

The adjudicator also questioned why Miss D had level cover when she could have had decreasing cover that reduced alongside her mortgage. The benefit of level cover is that it's likely to pay out extra above the amount needed to repay the mortgage. Alternatively, decreasing cover is normally slightly cheaper.

In this case, the adviser's recommendation report also records the differences were discussed and that Miss D preferred level cover. So this again suggests she was able to make an informed decision about what type of cover to take.

I do appreciate that Miss D must have been very disappointed to find out she couldn't claim on one of her critical illness policies. While I have every sympathy with the position in which she finds herself, I don't think there's enough evidence to show she was misled about the cover she had. And I'm also satisfied the policies arranged were broadly suitable for her needs at the time.