DRN-4433938

The complaint

Mrs E is unhappy with the way in which Legal and General Assurance Society Limited handled a claim made for the critical illness benefit under a decreasing life and critical illness insurance policy ('the policy'). And its later decision to decline the critical illness claim and void the policy.

Although Mrs E is being represented in this complaint, I've referred to her throughout as she's the policyholder named on the policy booklet.

What happened

Mrs E applied for the policy in late 2020 via an insurance intermediary. When applying for the policy she was asked a number of questions – including about her health and medical history.

Towards the end of 2021, Mrs E made a claim on the policy for the critical illness benefit as she was diagnosed with multiple sclerosis (MS). Legal and General declined the claim in 2023. That's because Mrs E had experienced numbness, pins and needles and dizziness which, Legal and General says, weren't adequately disclosed when applying for the policy. It also voided the policy (including life insurance cover) but did refund Mrs E for the premiums she'd paid for the policy.

Mrs E complained to Legal and General. It maintained its decision to decline the claim and void the policy. However, it did accept that it delayed refunding the premiums as it mistakenly believed that this was a joint policy. It paid Mrs E £250 compensation. This was on top of £300 it paid Mrs E for delays in handling the claim since July 2022.

Unhappy, Mrs E asked the Financial Ombudsman Service to look into her concerns. Our investigator considered what had happened and didn't think Legal and General had to do anything more to put things right. So, she didn't uphold Mrs E's complaint. Mrs E disagreed so her complaint has been passed to me to consider everything afresh and decide.

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 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. 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 (in this case Legal and General) 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.

Legal and General says Mrs E failed to take reasonable care not to make a misrepresentation when answering a medical question about whether (in the last 5 years) she'd seen a doctor, nurse or other medical professional for numbness, persistent tingling, pins and needles or dizziness.

I know Mrs E will be very disappointed and I have a lot of empathy for her situation. But I'm satisfied Legal and General has acted fairly and reasonably by declining her claim for the critical illness benefit and voiding the policy. I've set out my reasons below.

Did Mrs E make qualifying misrepresentation?

When applying for the policy, Mrs E was a number of questions about her medical history including:

> Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for:
>
> …paralysis, numbness, persistent tingling, pins and needles, memory loss, dizziness, balance problems, tremors or facial pain (other than dental pain)?

I'm satisfied that this is a clear question and I'll refer to it as the 'medical question'. The application reflects that Mrs E answered 'no' to this question.

When reviewing Mrs E's claim, Legal and General concluded that she'd answered the medical question incorrectly. She should've have answered it 'yes'. I'm satisfied that this was fair and reasonable. That's because:

- The claims targeted report completed by Mrs E's GP in November 2021 contains the question: "when did your patient first seek advice for their condition/presenting symptoms and how long had the symptoms been present before seeking advice?" The GP answers: "first presented…2019...pins and needles left foot, left buttock numb. MRI lumbar spine arranged. MRI…2019. Referred to neurology based on results…"
- The consultant neurologist's report dated January 2020 reflects Mrs E mentioned left hand tingling in the last month. And in April 2020, the consultant neurologist reports that the numbness in Mrs E's arms had got better since the last couple of months.
- At a review with her consultant neurologist in May 2020, it's reflected that Mrs E "continues to have a different sensation in her right hand now, previously she had left arm altered sensation".
- The consultant's neurologist letter dated April 2021 confirming the diagnosis of MS reflects Mrs E had "some dizziness. This lasted for about seven days in total". A letter dated 19 November 2020 from Mrs E's consultant neurologist reflects that Mrs E had "recent transient vertigo (in) September 2020". She'd been admitted to hospital presenting with dizziness for four days when lying down or getting out of bed.

I've gone on to consider whether Legal and General has fairly concluded that Mrs E had made a qualifying misrepresentation under CIDRA by answering the medical question incorrectly. And I'm satisfied it has.

I've listened to the call Mrs E and her wife had with the insurance intermediary when applying for the policy. She does mention some tingling in her back. There's also a comment that the pins and needles wasn't persistent.

When considering whether Mrs E made a qualifying disclosure, Legal and General asked Mrs E why she answered the medical question in that way that she did. The call note dated 30 June 2022 reflects that Legal and General didn't receive a specific reply because Mrs E didn't want to discuss without legal input. Legal and General also spoke with Mrs E in September 2022 and it's reflected that she wanted Legal and General to listen to the sales call. Subsequently, Mrs E did email Legal and General with a transcript of the relevant parts of the call with the insurance intermediatory that she thought was relevant.

I asked our investigator to contact Mrs E to ask why she didn't declare the dizziness which she attended hospital for in the two months leading up to when she applied for the policy.

She said at that point she hadn't yet been diagnosed with MS and the dizziness had been diagnosed by the doctor as vertigo which is an unrelated symptom of MS. She was advised to go to hospital as she was under investigation at this stage and no matter what the symptoms were, she was asked to visit her consultant instead of her GP.

So, even if I concluded that Mrs E had taken reasonable care in the way she answered questions about seeing a doctor, nurse or other health professional about numbness, persistent tingling and pins and needles during the last 5 years, I'm satisfied that she didn't take reasonable care when not disclosing her dizziness.

Mrs E may not have known the reasons for the dizziness, or that it was connected to MS at the time. But ultimately, she had experienced and sought medical attention for the symptoms being asked about in the application.

I don't think it was reasonable of Mrs E to have overlooked the symptoms she'd experienced in the circumstances of this case, particularly given the time between the dizziness occurring and the date of applying for the policy.

Legal and General has provided underwriting guidance showing that if Mrs E had answered this question correctly, it would have offered the policy on different terms. It would've declined to offer critical illness cover at that time and the life cover would've been more expensive. So, the answer to this question mattered to Legal and General.

Declining the claim and cancelling the policy

Legal and General concluded that Mrs E's misrepresentation was deliberate or reckless.

Taking into account Mrs E's explanation about why she answered question in the way she did, when considered against the medical evidence, I don't think she's been able to give a credible explanation supported by the facts for the misrepresentation having occurred (particularly in relation to the dizziness part of the medical question). Nor do I think there are any reasonably credible mitigating circumstances to explain why she answered the medical question in the way that she did.

I'm satisfied that Legal and General has fairly concluded that Mrs E's misrepresentation was deliberately or recklessly made. And as the question was asked before agreeing to insure Mrs E, I think she knew that the questions being asked were relevant to Legal and General – or didn't take sufficient care about whether or not it was relevant to Legal and General.

I've looked at the actions Legal and General can take in line with CIDRA. Under this legislation it's entitled to cancel the policy and doesn't have to pay any claims as it can treat the policy as if it never existed. That's what Legal and General has done here, and I don't think it's acted unfairly and unreasonably in the circumstances of this complaint by doing so. Legal and General could have also chosen to keep the premiums paid for the policy. It didn't do that here; it reimbursed Mrs E for the monthly premiums she'd paid for the policy since the date it started. I think Legal and General acted fairly by doing this.

Delays

Legal and General has an obligation to handle claims fairly and promptly. It accepts that there were times when it unreasonably delayed assessing Mrs E's claim and progressing it as quickly as it should have. This led to Mrs E having to chase Legal and General for updates, not receiving call backs as requested and not having all of her emails responded to. Legal and General apologised and offered Mrs E £300 compensation in recognition of the delays since July 2022 (the date of a final response letter about delays up until that point which doesn't form part of the complaint I'm deciding). It accepts that Mrs E should've been more proactively contacted with updates.

I can see that this was a worrying time for Mrs E, which would have been exacerbated by the delays caused by Legal and General and Mrs E having to chase it up. But I think £300 fairly reflects the distress and inconvenience she's experienced.

Legal and General has also paid Mrs E further compensation in the sum of £250 to represent delays in refunding her the monthly premiums she paid for the policy. I think that's reasonable and fairly reflects the upset the delays caused.

My final decision

I don't uphold Mrs E's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs E to accept or reject my decision before 5 January 2024.

David Curtis-Johnson
Ombudsman