DRN-4281223

The complaint

Mr L complains that Vitality Life Limited avoided his life and serious illness insurance policies and refused to pay a claim. He also complains about poor service and claims handling delays.

What happened

In summary, in December 2020, Mr L took out two policies with Vitality to provide life and serious illness cover.

Most unfortunately, in January 2021, Mr L was diagnosed with cancer. In February 2021, Mr L claimed on his serious illness cover. Vitality requested medical evidence and further information from Mr L. After reviewing all the information obtained, Vitality said Mr L hadn't given full and accurate information during the application process. Vitality thought Mr L should've answered yes to questions about outstanding blood tests and unintentional or unexplained weight loss - when in fact, he answered no.

Vitality considered this to be a qualifying misrepresentation. It said that, had he answered correctly, it would've postponed cover until the results of the tests and cause of weight loss were known. Ultimately, upon Mr L's subsequent diagnosis, it would not have offered life or serious illness cover at all. Vitality treated the misrepresentation as deliberate/reckless. It refused to pay the claim and avoided Mr L's policies.

Mr L complained and asked for an appeal, but Vitality maintained its position, so Mr L brought his complaint to the Financial Ombudsman Service. Mr L explained he'd requested a repeat blood test to check on his cholesterol levels and that he'd been intentionally losing weight as part of his health and fitness regime. He said the questions had been answered correctly. But our investigator didn't uphold the complaint. She thought Vitality had acted fairly in refusing to accept the claim, avoiding the policies and retaining the premiums.

Mr L also complained about poor service and delays, but our investigator said we couldn't look at this aspect because Mr L's complaint had been brought by a representative and we can only award compensation to eligible complainants themselves, that is, Mr L.

Mr L didn't accept our investigator's opinion and asked for an ombudsman to review the complaint and issue a final decision.

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.

Having done that, I'm not upholding this complaint. I know this will be very disappointing news for Mr L and I'm sorry about that. I hope it will help if I explain the reasons for my decision.

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 (a policy). 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 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.

Vitality says Mr L failed to take reasonable care not to make a misrepresentation when he answered '*no'* to the following questions:

> *'Apart from anything you have already told us about in this form, do you have any impairment or medical complaints that you intend seeking medical advice for, or are you currently awaiting the results of any investigations?*
>
> *'In the last 6 months have you experienced any unintentional or unexplained weight loss?'*

Vitality says Mr L should've answered yes to these questions, because when he applied for the policy, Mr L had been asked to have a blood test and book a further appointment with his GP to discuss the results. And the day after he took out the policies, Mr L spoke to his GP about weight loss over the previous six weeks.

I've reviewed the medical evidence provided. On 3 June 2020 Mr L spoke to his GP about repeating bloods due to borderline cholesterol levels the previous year. His GP agreed to repeat the tests but did not authorise them immediately, due to the Covid pandemic. The GP suggested Mr L contact the surgery for a form in the next four months.

During a review consultation on 3 December 2020, Mr L was asked to collect test forms from reception that day and book a further appointment to discuss the results. Later that day he was sent a text message from the surgery to say a follow-up appointment had been booked for 17 December 2020.

On 17 December 2020 Mr L told his GP he was yet to have the blood tests done but had booked an appointment for the following week. The doctor's notes record the need for a review on completion of the investigations.

Mr L applied for the policy on 17 December 2020 and was immediately accepted on standard terms.

I'm aware that Mr L was a man who prioritised his health and fitness, training regularly and paying attention to his diet. I accept that Mr L asked for his bloods to be repeated following concern about slightly raised cholesterol in the previous year's results. I note that our investigator didn't think Mr L had misrepresented regarding the tests as he'd asked for them himself prior to application. But I don't think this matters in terms of the question he was asked. The fact is that when he took out the policy Mr L had concerns about his cholesterol levels and his GP had authorised repeat bloods, intending to discuss the results with him. This was outstanding at the time of application, so I don't think Vitality acted unfairly in concluding that Mr L failed to take reasonable care when answering this question.

On 25 November 2020, Mr L consulted his GP regarding a respiratory tract infection. From the GP record it's evident Mr L was asked about a number of potential symptoms. The notes record *'no wt loss or loss of appetite'.*

On 18 December 2020, Mr L again consulted his GP. The notes state:

> *'recent cough and spoken to GP, much better with antibiotics, almost resolved. No SOB, no CP. Goes to gym and is fine. No dyspepsia, no sinus drip/congestion. Was made redundant a month ago. Eating less, lost a stone in 6 weeks. PU normal. BO usually once a day, has been waking up approx. twice at night to open bowels. No blood in stool, no abdominal pain. No FHx.*
> *'Has blood test already on 30/12/20. Add on TTG, TSG. Do faecal calprotectin + FIT test.'*

Mr L has said that as part of his fitness regime he was intentionally losing weight and therefore answered Vitality's question correctly. But the GP record indicates there was a discussion about his weight loss and current bowel habits which resulted in the GP requesting some additional tests alongside the outstanding bloods.

I'm aware Mr L's consultant haematologist has provided a letter saying he could find no evidence in his documentation or recollections of consultations to show that Mr L's ill-health pre-dated Christmas 2020. And specifically, the consultant said it was quite clear Mr L had no symptoms suggestive of cancer prior to taking out the policy. I've thought carefully about this. But the question asked relates simply and specifically to unintended or unexplained weight loss. So I think it was reasonable for Vitality to rely on the GP record of 18 December 2020 – which suggests recent, unexplained weight loss pre-dating the start of the policy - to conclude that Mr L failed to take reasonable care when answering that question.

Vitality has provided information about its underwriting criteria to show what would have happened had Mr L answered the questions accurately. In relation to both questions, the outcome would've been the same. Vitality said it would've postponed cover, until the outcome of tests/investigations was known. The results of the tests quickly led to Mr L's diagnosis, at which point Vitality would not have offered life or serious illness cover at all. Given that the non-disclosures would've made a difference to Vitality's decision to offer Mr L cover, I'm satisfied Mr L's misrepresentation was a qualifying one.

Vitality has treated Mr L's misrepresentation as deliberate/reckless. The Association of British Insurers' Code of Practice – Misrepresentation and Treating Customers Fairly says that for a misrepresentation to be deliberate or reckless, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. Relying on the GP evidence and timeline of events, I think this was a fair categorisation.

As I'm satisfied Mr L's misrepresentation should be treated as deliberate/reckless, I've looked at the actions Vitality can take in accordance with CIDRA. In these circumstances an insurer can avoid a policy, treating it as if it had never existed, and keep the premiums. It is not obliged to pay any claim. This is what Vitality has done in respect of both Mr L's policies. These actions are in line with the law, so I don't think Vitality has acted unreasonably regarding Mr L's policies and claim.

Mr L has also complained about delays in assessing his claim and poor service from Vitality. Our investigator didn't think this was something we could comment on, but I disagree. I'm satisfied the complaint is about the impact of delays and poor service on Mr L. I've reviewed

Vitality's response to Mr L in respect of these complaint points and note that Vitality apologised for distress and inconvenience caused and provided feedback to claims management for service improvement purposes. Vitality offered Mr L £400 compensation which was later accepted by Mr L, without prejudice to this complaint.

So I've thought about whether the amount of compensation is sufficient to recognise the impact of delays and poor service on Mr L at what was a difficult time for him, following his diagnosis. Had Vitality not already acknowledged mistakes and offered compensation, I would have directed payment in this region, because the business's drop in service standards did cause considerable distress, upset and worry over a number of months as Mr L waited for his claim decision. I think the level of compensation was fair, so I'm not going to ask Vitality to pay anything more.

So in light of all the circumstances, I don't think Vitality Life Limited needs to do anything more in respect of this complaint.

My final decision

For the reasons given, I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 16 January 2024.

Jo Chilvers
Ombudsman