DRN-4128197

The complaint

Mr and Mrs W complain that Legal and General Assurance Limited avoided their life and critical illness policies, treating the policies as though they had never existed, and declining to pay out after Mr W claimed on the critical illness benefit. Mr and Mrs W also complain about delays in assessing the claim and poor customer service.

What happened

In January 2017, Mr and Mrs W applied for three policies with L&G, through a broker. They were taking out a new mortgage and looking to update their protection arrangements.

Very unfortunately, in March 2019, Mr W suffered a heart attack. He sought to claim on his policy under the critical illness benefit. But due to further health complications, the claims forms weren't submitted until June 2021. By this stage Mr W had, again most unfortunately, been diagnosed with a genetic mutation and associated cancer.

In June 2022, L&G told Mr W that his claim was being declined and all his policies cancelled from the outset. L&G thought Mr W hadn't given full and accurate information when completing a lifestyle and health questionnaire at application. Mr W was asked the following question:

> *'During the last 5 years have you seen a doctor, nurse or other health professional for raised blood pressure, raised cholesterol or condition affecting blood or blood vessels, for example anaemia, excess sugar in the blood, blood clot, deep vein thrombosis?'*

Mr W answered *yes* and disclosed raised blood pressure. He did not disclose excess sugar in the blood.

A follow-up question asked:

> *'Has your GP or practice nurse told you that your blood pressure has returned to normal?'*

Mr W answered yes, which L&G says wasn't accurate. And it considered this to be a careless qualifying misrepresentation, which entitled it to avoid his policies, decline the claim because of this, but return the premiums Mr and Mrs W had already paid.

Mr and Mrs W brought their complaint to us. Our investigator didn't think it should be upheld. She thought the £750 compensation paid for poor customer service fairly reflected the distress and inconvenience caused. And she agreed there had been a careless qualifying misrepresentation and that L&G was entitled to avoid the policies.

Mr and Mrs W disagreed. Amongst other things, Mr W said his answers were honest and justifiable. He was also unhappy that L&G had refused to consider his second claim for a

critical illness, having advised him to make it. As they remain unhappy, Mr and Mrs W have asked for an ombudsman's 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 so, I'm not upholding this complaint. I appreciate this will be significant news for Mr and Mrs W and I'm sorry about that. I'll explain my reasons, focusing on the points and evidence I consider material to my decision. So, if I don't refer to a particular point or piece of evidence, it's not because I haven't thought about it. Rather, I don't consider it changes the outcome of the complaint.

Customer service

I've reviewed the history of the claim and noted that L&G has accepted there were failings and that at times its service fell short of expected standards. L&G was entitled to make sufficient enquiries to enable it to assess the claims. But I acknowledge that the delays and lack of contact/updates did cause additional stress and upset to Mr and Mrs W at what was already a very challenging time. In general, I'd expect to see compensation of this value in a case where the impact of the business's errors had caused considerable distress, upset and worry over months. So overall, I think the £750 paid fairly reflects the distress and inconvenience caused to Mr and Mrs W.

Claim

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.

L&G thinks Mr W failed to take reasonable care not to make a misrepresentation when he said he'd been told his blood pressure had returned to normal and when he failed to disclose excess sugar in his blood.

I've reviewed the medical evidence provided. Information from Mr W's NHS GP shows that he was seen in June 2016 and that his blood pressure was discussed. He was advised to do home readings and to bring them to the surgery after two weeks. A home reading of 150/110 was subsequently reported. Mr W was given dietary and lifestyle advice, a target blood pressure and advised to come back if it remained above 145/95. The GP also confirmed that blood glucose levels were discussed in 2015 and 2016, again with dietary advice being given.

Mr W also saw a private GP in June 2016, who reported that on examination Mr W's blood pressure was 150/94 with a repeat reading of 154/96. Mr W was referred to a private cardiologist for further investigation and tests. The cardiologist met with Mr W in August 2016 to discuss the test results. In a letter back to the referring private GP - copied to Mr W - the cardiologist summarises the test results and discussion, saying he has gone over matters with Mr W in some detail. He notes the following:

> *'His ambulatory blood pressure monitor revealed no more than marginal mild hypertension with a mean daytime blood pressure of 146/90.'*

The cardiologist concludes that only very mild abnormalities metabolically had been demonstrated and mentions Mr W's long working hours and stressful existence. Dietary and lifestyle advice is given. The cardiologist also notes:

> *'I will send him a low cholesterol diet sheet but I will also send him a very simple low carbohydrate diet sheet because his fasting blood sugar was 6.2 which would suggest glucose intolerance.*
>
> *'He will adopt this lifestyle for the next three months and I will review him but with repeat biochemistry to include full biochemical profile and a glycosylated haemoglobin.'*

It's accepted that the review did not happen and Mr W's NHS GP has confirmed no further consultations regarding blood pressure prior to Mr W applying for the policies.

Mr W has said he was never sent a further appointment and heard nothing from his NHS GP so assumed all was ok and there was no cause for concern. He's also said he wasn't aware of excess sugar in his blood.

I don't accept Mr W's argument that the lack of follow-up review or absence of any further contact can reasonably be seen as evidence to support a positive answer to the question about being told his blood pressure had returned to normal. I think the question is clearly asking for a positive confirmation by a medical practitioner, not the absence a negative information.

And on balance, I think Mr W likely knew there was an issue with his blood sugar levels from the contact with both his NHS GP and private cardiologist.

So I think Mr W failed to take reasonable care to answer accurately when making his application.

L&G has provided evidence of its underwriting criteria and retro-assessment of what would have happened had Mr W answered accurately. In those circumstances, Mr W would not have been offered critical illness cover. And life cover would've been postponed, pending the outcome of the follow-up review and tests. This means I'm satisfied Mr W's misrepresentation was a qualifying one.

L&G has treated Mr W's misrepresentation as careless, rather than deliberate or reckless. I think this was a fair categorisation because I think Mr W ought reasonably to have considered that the information was relevant to L&G.

As I'm satisfied Mr W's misrepresentation should be treated as careless I've looked at the actions L&G can take in accordance with CIDRA. As L&G would not have been able to offer any cover at the time, it was entitled to avoid the policies and decline the claim, but should

return the premiums paid. I understand Mrs W did not wish to continue with the policies on her own, so just over £6000 was refunded to Mr and Mrs W.

Finally, I've considered Mr W's comments regarding L&G's failure to assess his second claim for cancer. However, it was right that L&G considered the claim for heart attack first, as this was the earlier claimable event. But as the policies have been avoided as a consequence of misrepresentation, it's also right that the second claim fails automatically, as there is now no policy against which to assess it. So I don't think L&G has acted unfairly in this respect either.

Once again, I'm sorry to be the bearer of unwelcome news.

My final decision

For the reasons set out above, I've decided not to uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W and Mr W to accept or reject my decision before 10 November 2023.

Jo Chilvers
Ombudsman