DRN-4085910

The complaint

Mr R, as trustee, complains that Scottish Equitable Plc, trading as Aegon, unfairly declined an insurance claim he made, following the death of his wife, Ms C.

What happened

The history of events is well known to the parties. In summary, on 30 May 2018, Ms C applied for life insurance, via her financial advisor. The policy commenced on 20 July 2018.

Most unfortunately, in August 2018, Ms C was diagnosed with cancer. After surgery in October 2018, she made a good recovery. But very sadly, her cancer returned in late 2020 and Ms C died shortly thereafter.

Mr R subsequently claimed on the policy, but in March 2022, Aegon declined the claim. It said Ms C hadn't accurately answered questions asked during the application process about her health - specifically, about symptoms of possible breast disorders. It considered this to be a careless qualifying misrepresentation, but said that, had it been aware of the symptoms at the time of application, ultimately it would not have offered cover. This entitled it to avoid the policy and decline the claim. It refunded the premiums Ms C had paid towards the policy.

Mr R later complained, but Aegon rejected his complaint. So he brought his complaint to the Financial Ombudsman Service. Our investigator didn't think it should be upheld. She agreed there'd been a qualifying misrepresentation. She thought Aegon had fairly categorised the misrepresentation as careless – rather than deliberate or reckless – and was satisfied Aegon had shown that, had Ms C fully disclosed, it wouldn't have offered cover at all. Given that, she thought Aegon had acted fairly in avoiding Ms C's policy and refunding the premiums paid.

Mr R didn't accept the investigator's view. Amongst other things, he questioned the reliability of the medical records which showed inconsistencies and said Ms C, as a medical professional, had no concerns about her health when she applied for the policy.

Mr R requested an ombudsman's decision, so his complaint has come to me for a final determination.

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.

Firstly, I was extremely sorry to read of Ms C's death and offer my sincere condolences to her family. But having carefully reviewed everything, I'm not upholding this complaint. I know

this will be very unwelcome news for Mr R. So I'd like to explain my reasoning, focusing on the points and evidence I consider material to my decision. 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.

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.

Aegon says Ms C failed to take reasonable care not to make a misrepresentation when she answered 'no' to the following questions on her application form:

> *'Other than previously stated, in the last five years have you had, been treated for or been advised to have follow-up for…any breast disorders, for example lumps, cysts, nipple discharge or inverted nipple, or an abnormal mammogram?'*
>
> *'Are you awaiting the results of any investigations or are you aware of any symptoms or complaints that you haven't consulted a doctor or received treatment for?'*

The medical records show that Ms C consulted her GP on 9 August 2018. The history is recorded as:

> *'R breast lump 1 month*
> *Bilateral nipple discharge, yellow, 2 months during periods.'*

Under the comment section, it's noted that Ms C was referred to the breast clinic.

Ms C was seen at the breast clinic on 21 August 2018. In a follow-up letter to her GP, the consultant records the clinical symptoms as:

> *'The patient has symptoms of nipple discharge on the bilateral side which have been present for 5 months.'*

I'm aware that any failure to disclose a lump was subsequently conceded by Aegon, but in any event, didn't make a difference to the decision to decline the claim, which was based on Ms C's specific cancer diagnosis. I also acknowledge there's some discrepancy in these records regarding the onset of symptoms. But what is consistent is that shortly after the policy commenced, Ms C spoke to her GP and then a consultant about nipple discharge, reporting symptoms of some months' duration.

The consultant's record puts the onset of symptoms as March 2018. Mr R has made detailed arguments regarding Ms C's completion of the form, in particular that she would never have intentionally misled Aegon and that, with her medical knowledge, she had self-diagnosed, concluding her symptoms were hormonal and linked to the menopause. In other words, they were not symptomatic of a *disorder*. But there's a specific warning on the application form

not to make any personal assessment about whether the information was relevant or not. That was the job of the underwriter.

In answering questions, the standard of care required is that of the reasonable consumer. I think the reasonable consumer would understand that the question regarding breast disorders is seeking to draw out any atypical or unusual events or symptoms in relation to the breasts. The question gives examples of the sorts of things the insurer is looking for under its category of breast disorder, including nipple discharge. I'm satisfied the question was clear and consequently, assuming Ms C's symptoms predated her application, that she failed to take reasonable care when answering both questions cited by Aegon.

But even if I were to take just the shorter of the two timeframes cited – that is, two months prior to 9 August 2018, Ms C should still have disclosed to Aegon a change in her health circumstances between her application at the end of May and the start of the policy on 20 July.

On page 2 of the application form there's a section called '*Important notes for the customer.'* It starts by telling the customer to read the following important information carefully before filling in the application form. Amongst other things, it says:

> *'The questions asked in this application form cover the facts that we think are important to our assessment of the application.*
>
> *'When answering a question, you're personally responsible for making sure you've given complete and accurate information. You shouldn't make any personal assessment about whether the information is relevant or not, or assume we'll write to your doctor for medical information.*
>
> *'You must tell us in writing if there's any change in your circumstances between completion of this application and the start date of the policy. In particular you must tell us if there are changes in your health, for example if you suffer symptoms that you've already seen or may need to see a doctor for, or if you're having any form of medical investigation.*
>
> *'If you don't give full and accurate information, as detailed above, all the protection provided by the policy could be lost or cancelled in the event of a claim.'*

And after the questions sections, on the declaration and consent page of the application form, at section 13.6, it says:

> *'I understand it's my personal responsibility to tell you, in writing, about any change to my health and/or circumstances which happen before this policy starts.'*

The declaration, which Ms C signed, reiterates the warning to applicants of the potential consequences of non-compliance with the disclosure requirements, including that cover may be cancelled and no claim will be payable.

And notably, there are similar statements and warnings on the documents Ms C received when terms were offered and the policy commenced. So I'm satisfied Ms C failed to take reasonable care by not disclosing any change in her health circumstances to Aegon between her application and the policy going live.

Mr R has also raised a question about missing medical evidence which, for completeness, I'd like to comment on. Mr R is concerned that Ms C attended a medical in June/July 2018, about which Aegon has not disclosed records. He was understandably keen to know if Ms C

was asked questions at this medical regarding nipple discharge. In other words, did Aegon have actual or constructive knowledge of the nipple discharge prior to offering terms.

Having reviewed all the documents, I've not seen any evidence to suggest that a medical examination took place. What I have seen is Aegon's request to Ms C's GP for a medical report, dated 1 June 2018 and noted on her GP record as received 13 June 2018. By way of explanation, this is a paper exercise where the insurer sends out a standard questionnaire for the GP to complete. The questionnaire covers, for example, current and past medical care and treatment, outstanding test results, time off work and family history. It is based on medical records only.

I also note that Ms C's last appointment with her GP, prior to 9 August 2018, was 15 December 2017, regarding travel vaccinations. The only other health contact Ms C had in that period was in relation to her participation in a longitudinal study of people the same age as her. So I'm satisfied the medical examination Mr R is understandably concerned about wasn't an *examination* but is the GP report to Aegon – completed 16 July 2018 – detailing Ms C's basic health circumstances. I'd like to reassure Mr R that I've seen that report and can confirm it contains only factual information and no negative disclosures about Ms C's health. Notably, there's no reference to nipple discharge because, at the time it was produced, Ms C had not consulted her GP about that issue.

So in respect of the nipple discharge, I think Ms C failed to take reasonable care not to make a misrepresentation, either when applying for the policy, or between application and commencement. So I now need to consider whether the misrepresentation was a qualifying one under CIDRA, that is, would Aegon have come to a different decision about cover had it been given correct information.

Aegon has provided evidence from its underwriting guidance. This shows that if Ms C had declared her symptoms it would've postponed the application pending further investigations. However, following Ms C's diagnosis, it would not have offered cover at all. So I'm satisfied Ms C's misrepresentation was a qualifying one.

Aegon has treated the misrepresentation as careless. This means Aegon didn't consider Ms C had deliberately or recklessly misrepresented, and given the possible explanation for her actions put forward by Mr R, I think this was a fair categorisation.

CIDRA sets out the actions an insurer can take where a misrepresentation is careless. Aegon has acted in line with CIDRA by avoiding Ms C's policy, declining the claim and refunding the premiums paid. I think that was reasonable in all the circumstances. I'm therefore not going to ask Aegon to do anything more in respect of this complaint.

My final decision

For the reasons set out above, I'm not upholding Mr R's complaint about Scottish Equitable Plc, trading as Aegon.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R as Trustee of the C Trust to accept or reject my decision before 26 September 2023.

Jo Chilvers

Ombudsman