DRN-4678442

The complaint

Mr R and Mrs R complain that Legal and General Assurance Society Limited (L&G) declined to pay a claim for total and permanent disability (TPD), made on their life and critical illness policy.

What happened

The background to this complaint is well known to the parties, so I won't repeat it in detail here. In brief summary, Mr R and Mrs R applied for cover in April 2002, through a broker. In August 2022, Mr R spoke to L&G about claiming on his policy, having recently been medically retired from work.

In July 2023, L&G declined the claim saying Mr R hadn't given full and accurate information during the application process, notably he hadn't disclosed he'd been diagnosed with scoliosis.

L&G said that, had full medical disclosure been made, it would have offered life and critical illness cover at a higher premium, but would have declined cover for TPD and waiver of premium (WoP) benefit. So L&G declined to pay Mr R's claim and redrew the policy.

Mr R complained but L&G maintained its stance, so Mr R and Mrs R brought their complaint to the Financial Ombudsman Service. But our investigator didn't uphold the complaint, so Mr R and Mrs R asked for an ombudsman to review everything and issue a final decision. Mr R said his broker would've been aware of his scoliosis and he'd never been sent the application, so couldn't check the information provided by the broker.

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 know this will be disappointing news for Mr R and Mrs R and I'm sorry about that. I'll explain my reasons, focusing on the points and evidence I think is material to the outcome of the complaint. So if I don't mention something specifically, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

The policy was sold before 6 April 2013, when the Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') came into force. So the relevant law here is the Marine Insurance Act 1906. This required Mr R and Mrs R to act with utmost good faith when applying for the policy and to tell L&G about anything that would be material to its decision about whether or not to offer cover. I'll consider this with regard to what's fair and reasonable, in line with our service's long-standing approach. So I've thought about whether Mr R made a misrepresentation and if so, whether that misrepresentation was innocent, careless, or reckless or deliberate. And whether L&G has applied the correct remedy for that

misrepresentation, as set out in the 'Misrepresentation and Treating Customers Fairly – ABI Code of Practice Managing Claims For Individual and Group Life, Critical Illness and Income Protection Insurance Products – September 2019' (the ABI code).

When Mr R applied for the policy he was asked the following question:

> *'Have you at any time had, or been advised to have any medical investigation or consultation, advice, operation or treatment for any of the following categories of medical condition:*
>
> > *'Arthritis, rheumatism or any form of neck, back or spinal trouble?'*

Mr R answered no to that question. L&G relied on entries in Mr R's GP record which it said indicated he should've answered the question positively. I've reviewed the medical evidence provided.

Mr R's GP record shows that he was diagnosed with scoliosis from birth. In January 2002, Mr R had an appointment with his GP. The history is recorded as, '*scoliosis – secondary right flank pain*.' On examination the GP noted a '*marked curvature – 1 yr of mvmt related pain*.' Mr R was referred for physiotherapy.

In March 2002, the record notes:

> *'Req from Physio – patient has signs of central cord compression – need for urgent referral.'*

The physiotherapist's letter to the GP notes the worsening of thoracic pain over the previous year, as well as a reported history of shortness of breath on minimal exertion. The physiotherapist further notes that the *'clinical impression is of a progressive scoliosis with neurological involvement, which required surgical review and assessment.'*

Mr R saw his GP the following day. The history was recorded as, *'discussed op for scoliosis for 1 year worsening symptoms of pain.'* The orthopaedic referral was subsequently made, with the GP acknowledging in the referral letter that Mr R had *'now conceded that surgery may be necessary to prevent future complications.'*

In October 2002, following the review and assessment appointment, the consultant orthopaedic surgeon wrote to Mr R's GP. The letter notes that Mr R has a congenital thoracolumbar scoliosis which Mr R felt had got worse in the last 2 or 3 years with some fatigue type pain from his back. Mr R is noted as '*sufficiently physically active to do his job. He has got some lower limb problems with mild bilateral wasting and degenerative changes in his NTP [sic] joints.*' The risks and potential benefits of surgery were discussed and Mr R was noted as *'very anxious about the rights and wrongs of this decision.'* The consultant suggested Mr R have time to think about the decision and discuss it with his family, concluding by saying that he would like to see Mr R again in four months' time for a review. A subsequent letter to the GP in July 2003 shows that Mr R didn't attend for review, but it was open to the GP to re-refer if needed.

I'm satisfied the question asked was clear and that, in view of the medical evidence, Mr R should have disclosed his scoliosis, which had clearly been troubling him in the months prior to applying for the policy.

Mr R was responsible for answering questions accurately and making a full disclosure. At the time, it was not L&G's process to send the completed application form to the customer to check the answers. L&G relied on the information submitted.

The application form includes a declaration which, amongst other things, requires the customer to, *'read carefully the answers you have given to our questions before accepting the following declaration.'*

It also states:

> *'I/we declare that, to the best of my/our knowledge and belief all the statements made including anything I/we may have said, are true and complete and have been recorded accurately in this application. I/we also agree these statements will form the basis of the insurance contract.'*

Finally, there's a boxed which on Mr R's and Mrs R's application is ticked to confirm they accept the declaration.

The policy was sold through a broker. I acknowledge Mr R's various comments about the sale. As our investigator has already explained, as the policy wasn't sold by L&G, those are not matters for me to comment on in this decision. Ultimately, L&G was entitled to rely on the information provided in the application to underwrite the policy. So I think it's fair for L&G to say Mr R didn't take reasonable care in answering the question asked about any back or spinal trouble. Consequently, there was a misrepresentation.

Based on the medical evidence, L&G categorised Mr R's scoliosis as severe. I think this was fair. L&G said that, had full disclosure been made, it would have offered the policy on different terms, resulting in the decline of the claim and redrawing of the policy.

L&G categorised Mr R's misrepresentation as careless. The ABI code defines this as a '*misrepresentation which resulted from insufficient care – the failure by the customer to exercise reasonable care. This includes anything from an understandable oversight, or an inadvertent mistake, to serious negligence. In the circumstances, a reasonable person would have considered that the information was relevant to the insurer.'* I think this was a fair categorisation.

The ABI code also sets out the actions an insurer can take in such cases. In its claims decline letter of July 2023, L&G explained to Mr R and Mrs R the effect the misrepresentation would have on their policy – that is, it was unable to pay the claim and the policy would be redrawn. TPD and WoP would be removed for Mr R and a higher premium would be charged for life and critical illness cover.

I've considered L&G's underwriting criteria and the actions taken. I'm satisfied that, had full disclosure been made, L&G wouldn't have offered Mr R TPD, so his policy wouldn't have had a TPD element for him to claim against. Therefore I think it's fair for L&G to decline the TPD claim Mr R made and remove that provision and WoP from his redrawn policy.

I also think it's fair for L&G to apply a proportionate remedy to the life and critical illness elements of Mr R and Mrs R's policy. That's because the ABI code says that where there has been a careless misrepresentation and the insurer would have charged more if not for that misrepresentation, the insurer can apply a proportionate remedy. In applying a proportionate remedy, in principle, no customer should be better off than any other customer who had answered all of the insurer's questions honestly and with the exercise of reasonable care. So it's fair for L&G to redraw the policy to reflect the higher premiums payable.

Overall, the action L&G's taken is in line with the ABI code, so I think it's acted fairly. Given this, I don't think L&G needs to do anything more in respect of this complaint.

My final decision

For the reasons given above, my final decision is that I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs R and Mr R to accept or reject my decision before 25 April 2024.

Jo Chilvers
Ombudsman