DRN-4189065

## The complaint

The estate of the late Mr S complains Legal and General Assurance Society Limited (L&G) unfairly turned down their claim.

Mrs S brings this complaint on behalf of the estate, and for ease I will refer to all submissions as having been made by her.

## What happened

The late Mr S held a life assurance policy underwritten by L&G. The policy was designed to pay a defined benefit in the event of Mr S's death or terminal illness, during the 20 year policy term.

L&G said Mr S's policy premium hadn't been paid since March 2021, as the direct debit had failed. Mr and Mrs S got in touch at the end of June 2021 after receiving a letter from L&G about the missed premiums. They asked to reinstate the policy and change the date the direct debit was taken from their account. L&G said it could reinstate the policy and needed Mr S to pay the missed premium payments from April, May and June 2021. It also asked for a declaration of health to be completed for the period since the premium had not been paid.

Mr S was asked the following question and answered 'no'.

> *"Since 28 March 2021 have you required any medical treatment, been referred to or seen a hospital doctor or had any medical investigations or tests?"*

Mr S was later diagnosed with cancer in August 2021. He and Mrs S began a terminal illness claim. However, Mr S very sadly passed away shortly after in September 2021, and a life claim was submitted by Mrs S.

When assessing the claim, L&G said it found information in Mr S's medical notes, which should have been declared when the policy was reinstated in June 2021. It said Mr S should have declared consultations he'd had in May and June 2021 as well as blood tests. And said these showed Mr S was having investigations for pain, which it needed to know about.

A report provided by Mr S's GP shows the following information.

17 May 2021 - Mr S reported symptoms of reflux, epigastric tenderness and nausea which had been ongoing for a few weeks. He was prescribed medication.

11 and 16 June 2021 - Mr S contacted the GP again and said his symptoms were not improving. An appointment was arranged.

18 June 2021 – Mr S saw the GP and reported the pain in his upper abdomen was radiating to his back. The GP conducted a stool test and arranged blood tests.

30 June 2021 – the blood tests were conducted.

Had Mr S declared the information about his treatment and tests in May and June 2021, L&G said it would have requested more information and wouldn't have agreed to reinstate the policy at that time. It said this was because Mr S was under investigation for a possible condition.

L&G said it thought Mr S had acted without care as to whether the answer he gave was right. And it cancelled the policy and declined the claim.

Mrs S complained to L&G about the declination of the claim. L&G said it had complied with the regulations and had been entitled to cancel the policy and refuse the claim, as it thought Mr S had made a deliberate / reckless misrepresentation.

Unhappy with L&G's response, Mrs S brought her complaint to this service. An investigator here looked into what had happened and said they didn't think L&G had acted unfairly.

L&G made no comments, however Mrs S disagreed with the investigator's view and asked for a decision from an ombudsman. In summary she said:

- the medical evidence shows it was not known that Mr S was suffering with any serious condition until July / August 2021 and Mr S did not act recklessly or try to misrepresent his information;
- it is presumptuous for L&G to say they would not have continued with the policy as the medical team had been unable to make a diagnosis based on Mr S's original symptoms;
- the policy had only lapsed due to the direct debit failing and they needed L&G to change the date the payment would be taken; and
- the family have been severely financially impacted by the declination of the claim.

**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 don't think this complaint is one which should be upheld. And I'll explain why.

The relevant law in this case is The Consumer Insurance (Disclosure and Misrepresentation) 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 has said Mr S failed to take reasonable care in answering its question when the policy was reinstated. As I've set out above, Mr S was asked if he'd had medical treatment, been referred to or had seen a hospital doctor, or had any investigations or tests since mid March 2021. Mr S answered 'no', however L&G has said he should have answered 'yes' and provided information about his visits to the GP and tests during May and June 2021.

The medical records show Mr S was prescribed medication during a GP visit on 17 May 2021. I think it's reasonable to say this was 'treatment', so I think it's fair to expect Mr S to have told L&G about this when asked. And he also had a stool test on 18 June 2021. At that appointment, blood tests were arranged, and these took place on 30 June 2021. L&G's question had asked about "any medical investigations or tests". So I think it's reasonable that Mr S should have told L&G he'd had stool and blood tests.

I think the question L&G asked was sufficiently clear, and I think based on the medical evidence, Mr S should have declared that he had been prescribed medication and had tests. Particularly as the blood tests took place on the same day as Mr and Mrs S's call to L&G to reinstate the policy.

I think it's reasonable that L&G asked Mr S about medical information since the policy premiums had stopped being paid. The policy terms say L&G has the right to cancel the policy within 30 days of a missed premium payment. So, I think it's fair that L&G said it could reinstate the policy if the premiums were brought up to date and a health declaration was made.

L&G has shared its underwriting guidelines with this service for the purpose of our investigation of the complaint. I appreciate Mrs S has said she has doubts over what L&G has said it would have done, as in June 2021, Mr S's cancer had not been diagnosed. The underwriting guidelines are commercially sensitive, so cannot be shared with the estate. However, I've reviewed them and am satisfied that had Mr S declared he was awaiting the results of investigations into the symptoms he was experiencing, L&G would have been unable to reinstate the policy at that time.

As I've explained, I'm satisfied Mr S failed to take reasonable care to answer L&G's question correctly. And I've considered what good industry practice was at the time of the claim, as set out in the Association of British Insurers (ABI) Code of Practice. The Code says reckless or deliberate misrepresentation is more likely to apply where the information concerns recent or ongoing treatment.

L&G has classed this misrepresentation as deliberate / reckless and I'm persuaded this was fair, as the medical records reflected the consultations where medication was prescribed and the stool and blood tests, had taken place very recently.

For L&G to take any action, there needs to have been a 'qualifying' misrepresentation. So I need to identify whether or not the misrepresentation made by Mr S made a difference to L&G. As I've said, L&G provided evidence from its underwriters confirming, had the additional medical information about the investigations been declared, it wouldn't have been able to reinstate the policy. And because of this, I'm satisfied the misrepresentation was a qualifying one.

L&G treated the misrepresentation as deliberate / reckless. And in these circumstances, the remedy available under CIDRA is for it to avoid the policy. And it's not obliged to refund any premiums paid. L&G avoided the policy, which I think it was entitled to do, and as this means the policy was cancelled from the start, there is no policy against which the claim for Mr S's death can be assessed. I note that L&G has refunded the policy premiums which had been paid, despite it not being required to do so, and I think this shows L&G acted fairly.

As I've explained, I'm satisfied L&G was entitled to take the action it did in the case of a deliberate / reckless misrepresentation, as this is in line with CIDRA.

## My final decision

For the reasons I've given, it's my final decision that I do not uphold this complaint and I make no award against Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mr S to accept or reject my decision before 20 September 2023.

Gemma Warner
**Ombudsman**