DRN-4416350

The complaint

Mrs T has complained that Legal and General Assurance Society Limited (L&G) declined a critical illness claim and provided poor customer service.

What happened

The details of this complaint are well known to the parties, so I won't repeat them all here. In summary following a diagnosis of cervical cancer Mrs T made a claim on her decreasing term life assurance policy in March 2022. L&G declined the claim as it said Mrs T hadn't correctly answered a question asked at application stage. It did accept that the service it provided could have been better and offered £300 in compensation.

Our investigator didn't think that L&G had done anything wrong by declining the claim. And she thought the offer of compensation was fair. Mrs T appealed.

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.

I've summarised the background to this complaint and focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. I recognise that Mrs T will be very disappointed by my decision, but I agree with the conclusion reached by our investigator. I'll explain why.

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.

Mrs T completed the application on 29 March 2022. The policy was to start on 8 April 2022. This policy was to replace two earlier policies – I'll come to that later. Mrs T was asked questions about her health, including the following:

When answering the following questions, if you're unsure whether to tell us about a medical condition, please tell us anyway.

Apart from anything you've already told us about in this application, do you have any medical condition or symptom that:

• your doctor or nurse told you to contact them about during the next 3 weeks?

Please ignore consultations for repeat prescriptions and pregnancy.

• During the last 3 months have you had any of the following?

- unexplained bleeding, weight loss, lump or growth

- any other symptom that you may contact a health professional about for the first time

Mrs T answered 'no' to the above questions. In order to assess Mrs T's claim L&G requested specific medical details from her GP surgery. I won't repeat all the sensitive medical details here, but Mrs T saw her GP in February 2022 concerned about the bleeding. Then three days after completing the application form Mrs T went back to see her GP having made an appointment a couple of weeks earlier. The GP wrote: abnormal uterine bleeding for months. This is also consistent with the account she gave L&G when she called to make her claim. Her GP advised a smear test. Having seen the medical notes and considered Mrs T's explanations, I'm satisfied that L&G's conclusion that Mrs T had failed to take reasonable care when answering this question was fair. She had experienced unexplained bleeding for which she was still under investigation.

L&G has shown that it wouldn't have provided cover to Mrs T had she correctly answered the question regarding the unexplained bleeding. It would have postposed her application. Following the diagnosis, it wouldn't have offered cover at that time. Accordingly, I'm satisfied that the misrepresentation was a qualifying one under CIDRA. L&G has said it was careless, rather than deliberate or reckless. I think that's fair in the circumstances. I say this because I accept that Mrs T didn't answer positively to the question because she thought the bleeding she was experiencing was either connected to her contraceptive or menopause.

This policy replaced earlier policies. I understand L&G is considering the claim under the earlier cover. If Mrs T remains unhappy at the conclusion of that assessment, she may refer the matter to this Service as a new complaint.

With regard to the service Mrs T experienced, L&G has accepted that there were delays. It said that although it isn't responsible for the time taken for third parties to respond to requests for information, it could have been more proactive in chasing a response. I can see that when the medical information was received L&G needed to follow up – this is usual but of course added to the time taken to assess the claim. When it had the requested information it did take L&G some time to reach a decision, although I can see that it did email and speak to Mrs T to keep her aware of the situation. But it does seem to me that Mrs T needed to do a lot of chasing. This was all against the background of Mrs T's diagnosis and her difficult personal situation – having divorced and re-located. So I can appreciate it would have been a very stressful time for her and she was anxiously awaiting an answer to her claim. L&G admitted it had not offered Mrs T the high standard of service it aims to achieve. I agree and find that compensation is merited. I find that £300 is fair.

My final decision

For the reasons given above I don't uphold Mrs T's complaint regarding the decline of her claim.

With regard to the customer service failures L&G has already made an offer of £300 to settle

this aspect of her complaint. I think that this offer is fair in all the circumstances.

My decision is that Legal and General Assurance Society Limited should pay Mrs T £300.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs T to accept or reject my decision before 17 January 2024.

Lindsey Woloski
Ombudsman