DRN-4527678

The complaint

Mrs T is unhappy that, after her husband (Mr T) died, AIG Life Limited only paid a proportion of the benefit claimed under a term assurance policy (the policy), taken out jointly by her and Mr T.

What happened

Mr and Mrs T applied for the policy in early 2021. When applying for the policy Mr T was asked a number of questions – including about his lifestyle, health and medical history.

Mr T sadly died in 2022 and Mrs T made a claim under the policy for the benefit to be paid. AIG only paid out a proportion of the benefit. That's because AIG says Mr T didn't answer some questions correctly when applying for the policy. If he'd done so, AIG says it would've still offered the policy, but the monthly premium for the policy would've been higher.

AIG proportionately settled the claim, paying the proportion of benefit in line with the percentage of the monthly premium paid for the policy.

Mrs T complained. AIG maintained that it acted fairly by proportionately settling the claim. Unhappy, Mrs T brought a complaint to the Financial Ombudsman Service. Our investigator considered what had happened and didn't uphold the complaint. Mrs T disagreed so this complaint has been passed to me to consider everything afresh and decide.

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.

That includes the relevant ABI Code of Practice for managing claims for individual and group life, critical illness and income protection insurance products.

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. 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 (in this case, AIG) must 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. AIG says Mr T failed to take reasonable care not to make a misrepresentation when applying for the policy.

I know Mrs T will be very disappointed, but I'm persuaded that AIG has acted fairly and reasonably by proportionately settling the claim in the way it has done here. I've set out my reasons below.

Did Mr T make a qualifying disclosure?

When applying for the policy, Mr T was asked a number of questions about his health and medical history including:

> Have you received or been advised to have any medical investigations, scans or blood tests in the last 5 years? (You do not need to tell us about contraception prescriptions, cold sores, ear syringing, hay fever, holiday jabs, in growing toenails, tonsillitis, wisdom teeth or regular well-man/woman checks where the results were all normal. You also do not need to tell us about normal pregnancies and childbirth, but must let us know about pregnancies with complications including but not limited to high blood pressure and sugar and/or protein in your urine.)

And:

> Have you been referred to, or been to see, any medical practitioner other than your GP in the last 5 years? (Examples can include but are not limited to all visits to a hospital doctor, consultant, psychiatrist, therapist or other visit to a clinic or Accident and Emergency.)

I'll refer to these as 'the medical questions'. I'm satisfied the medical questions are clear. And on the application form, it's reflected that Mr T answered 'no' to them.

When reviewing the claim made on the policy after Mr T's death, AIG concluded that he'd answered the medical questions incorrectly. It says, they should've been answered 'yes'.

I think AIG has acted fairly and reasonably when reaching this conclusion. That's because in 2017 (so within the five years leading up to Mr and Mrs T applying for the policy), the medical evidence reflects that Mr T had experienced heart palpitations. He was referred by urgent care to a hospital's emergency department. Medical investigations were carried out and Mr T was diagnosed with a medical condition affecting his heart.

I've gone on to consider whether AIG has fairly concluded that Mr T made a qualifying misrepresentation under CIDRA by answering the medical questions incorrectly. And I'm satisfied it has.

Mrs T says Mr T answered the medical questions in "utmost good faith", believing the walk-in centre automatically did medical processes that they would for most people. They assured him everything was ok and that he need not take any further action. She also says that the heart condition Mr T was diagnosed with is very common and not linked to a sudden heart attack.

That may be the case, but the medical questions are clear. And even if Mr T was given assurances, based on the medical evidence, I still think he reasonably ought to have answered 'yes' to the medical questions being asked. So, I'm satisfied Mr T acted without reasonable care when answering the medical questions.

I think the answers given by Mr T mattered to AIG. It's provided underwriting information showing that if he'd answered the medical questions correctly, it would have asked for further medical information and, although it would've still offered the policy to Mr and Mrs T, the premium would've been higher. The premium paid by Mr and Mrs T was just over half of

what they would've been charged if the medical questions had been answered correctly. Based, on the underwriting evidence and premium calculations provided by AIG, I'm persuaded that it's fairly and reasonably concluded this.

I know Mrs T has asked to see the evidence provided by AIG to support its position – in particular, around the additional premium which would've been charged and how it was calculated.

However, the Financial Conduct Authority's Dispute Resolution: Complaints Sourcebook ('DISP'), which sets out how complaints should be handled, says at DISP 3.5.9 (2) and 3.5.10 that The Financial Ombudsman Service can accept certain information in confidence. I'm satisfied that the information AIG has given us is genuinely commercially sensitive and can be accepted - and considered by the Financial Ombudsman Service - in confidence.

Proportionately settling the claim

AIG concluded Mr T's misrepresentation was careless. I think a reasonable person would have considered the answers to the medical questions were relevant to AIG – and that was why they were being asked. And although answering the medical questions in the way that he did, may have been due to an oversight or mistake made by Mr T, I'm satisfied AIG has fairly concluded that Mr T made a careless misrepresentation when applying for the policy in the circumstances of this case.

I've looked at the actions AIG can take in line with CIDRA. Under this legislation it's entitled to take the action it would've taken had the misrepresentation not occurred.

Because I'm satisfied that AIG has fairly calculated the higher premium which would've been changed in line with its underwriting guidance, I'm satisfied AIG has acted fairly by paying the benefit due under the policy in proportion to the share of the premium Mr and Mrs T paid for the policy (compared with the premium they should've been charged for it). Having applied that percentage to the sum assured at the time of Mr T's death, I think AIG has acted fairly and reasonably. I don't think it has to do anything more.

My final decision

I don't uphold this complaint. Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs T to accept or reject my decision before 14 February 2024.

David Curtis-Johnson
Ombudsman