DRN-4534744

The complaint

Mr and Mrs C have complained that, when Mrs C tried to make a claim on their critical illness policy, Liverpool Victoria Financial Services Limited ("LV") declined it because they said Mrs C had deliberately misrepresented her health in the application.

Mr and Mrs C appointed a claims management company (CMC) to bring their complaint to our service on their behalf. References to comments made by Mr and Mrs C in this decision include comments made by the CMC on their behalf.

What happened

In May 2021, Mr and Mrs C applied for a policy providing £265,000' worth of life and critical illness cover. The policy had a 20 year term with decreasing cover. Based on the information they provided, LV accepted Mr and Mrs C's application and the policy commenced the same day.

About eight weeks earlier, Mrs C's GP had referred her to her local hospital for investigation of pain she suffered after falling over. She was told that she had torn muscles and was given painkillers, as well as antibiotics for a chest infection.

Mrs C had a follow up appointment at some point between her hospital attendance and buying the policy. On the same day as she and Mr C bought the policy, a consultant in acute medicine wrote to her confirming the outcome of that appointment. He said Mrs C's chest infection was resolved, but advised an outpatient heart scan – for which a referral to cardiology had been made.

Following investigation, Mrs C was diagnosed with a congenital heart defect, for which surgery was required. At this point, Mrs C made a claim on the critical illness benefit of the policy.

LV declined the claim on the basis that they would have postponed cover if they'd known about the ongoing tests. And they said that she'd answered questions about her smoking, palpitations, and blood pressure inaccurately – which they said she'd done deliberately.

Mr and Mrs C complained. They said Mrs C had taken reasonable care to answer the questions accurately. In relation to her answer on smoking, she'd not smoked for over 10 years. But she'd started vaping (using a non-nicotine vape) after she'd bought the policy, in response to stress. She said this was consistent with her medical records.

In relation to the palpitations and blood pressure, Mrs C said these were the result of the stress of going to hospital. And she said she wasn't told about the referral to a cardiologist when she was at the hospital – she only found out when the consultant wrote to her in mid-May.

The complaint didn't lead LV to change their decision. So Mr and Mrs C brought their complaint to our service.

Our investigator reviewed the complaint and concluded LV didn't need to do anything differently to resolve it. In relation to the smoking question, he noted there was no medical evidence Mrs C was a smoker at the time of the application and that she'd been advised by her broker there was no need to disclose use of a non-nicotine vape. And he noted Mrs C's conclusion that her palpitations and blood pressure were linked to her hospital attendance. So, while he thought they should have been disclosed, it was fair to say each of these misrepresentations was made carelessly.

But in respect of the cardiology investigations, our investigator concluded that Mrs C had known about the referral because it was recorded in the records of her hospital attendance. So he said it was fair for LV to treat that misrepresentation as deliberate and that declining the claim and retaining the premiums was in line with the relevant legislation.

I agreed with our investigator that the complaint shouldn't be upheld – but for different reasons. So I made a provisional decision. I focused on the cardiology issue, because LV said that this alone would have led to them declining cover.

I explained I couldn't say what Mrs C was told when she attended hospital in March 2021. But I was satisfied she received a letter in May telling her she needed an ECG. That letter was dated the same day as the application for the policy.

Also on this date, LV sent Mrs C a letter asking her to check the answers she gave to the questions on the policy application and notify them of any changes. Because the two letters bore the same date, I was satisfied Mrs C would have received them within a few days of each other. And I would have expected her to notify LV she'd received the consultant's letter.

I thought that not doing so means she didn't take reasonable care not to make a misrepresentation. I was satisfied that the misrepresentation was a qualifying one and that LV had categorised it fairly and applied the appropriate remedy.

LV didn't comment on my provisional decision. The comments received from Mr and Mrs C submitted it was unfair to say the confirmation correspondence required her to disclose her referral for an ECG, because that obligation ended once the policy started. And they said Mrs C hadn't received the cardiologist's letter of May 2021 and wasn't aware she needed tests until July that year.

The matter's now been passed back to me to make a final decision.

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 that, I'm not upholding Mr and Mrs C's complaint. I'll explain why.

I won't repeat my provisional decision, which I've summarised above. Rather, I'll focus on the points made in Mr and Mrs C's reply.

I note it's now said Mrs C didn't receive a letter from the consultant in May 2021 and wasn't aware of any issue with her heart until she was invited to the ECG appointment in July 2021.

I've reviewed the available evidence again and I'm not persuaded this is the case. I can't see there was any suggestion this letter wasn't received before I issued my provisional decision. On the contrary, the initial letter of complaint sent to our service by the CMC on Mr and Mrs C's behalf says:

"…the first notification advising of a referral to cardiology was a letter written on 18 May 2021 by Dr […] at Acute Medicine Unit (AMU) […] University Hospital. We'd like to point out that had this doctor told [Mrs C] about the referral to cardiology whilst she was in SDEC, it's very unusual that the doctor would then write out later telling [Mrs C] about the referral. The letter was written on the same date as the application and posted to [Mrs C] therefore we feel that at the time of the application there is no way that [Mrs C] could ever have known she was being referred anywhere."

I understand from that statement that Mrs C didn't get the letter before she made the application – not that she didn't get it all. So I'm satisfied what I said in my provisional decision, about getting it within a few days of making the application, is reasonable.

And I don't agree with the representations made that Mrs C's obligation to notify LV she'd been advised to get an ECG ended when the policy commenced. The policy commenced immediately the application was completed – so, to agree with Mr and Mrs C's representations would give neither party any opportunity to correct anything. I don't think that's reasonable. I'm satisfied here that there was a failure to amend particulars previously given.

CIDRA says that failure can be considered a misrepresentation. I'm satisfied LV dealt with that in line with CIDRA. So I don't think LV need to do anything more to resolve Mr and Mrs C's complaint.

My final decision

For the reasons I've explained, I'm not upholding Mr and Mrs C's complaint about Liverpool Victoria Financial Services Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C and Mr C to accept or reject my decision before 29 March 2024.

Helen Stacey
Ombudsman