DRN-4600397

The complaint

The estate of Mr D complains that AIG Life Limited avoided Mr D's life insurance policy and refused to pay a claim.

What happened

The background to this complaint is well known to the parties, so I'll give just a brief summary here.

In March 2018, Mr D took out a life insurance policy with AIG. The policy was to run until age 75 and, in the event of Mr D's death, would pay a benefit of £200,000.

Sadly, Mr D died in July 2021. His estate claimed on the policy. But after assessing the claim, AIG said Mr D hadn't given full and accurate information during the application process. AIG thought Mr D should've answered yes to a question about medical investigations, scans or blood tests in the last five years - when in fact, he answered no.

AIG considered this to be a qualifying misrepresentation. It said that, had he answered correctly, it would've requested a full GP report. And in light of the medical evidence and what subsequently happened regarding the repeat test, ultimately would not have offered cover. AIG treated the misrepresentation as careless. But as cover wouldn't have been offered, it refused the estate's claim, avoided the policy and refunded the premiums paid.

The estate of Mr D complained but AIG maintained its position, so the estate brought the complaint to the Financial Ombudsman Service. Our investigator thought AIG had acted fairly, so didn't uphold the complaint. The estate didn't accept this and asked for an ombudsman's decision.

In November 2023, I issued a provisional decision. In it I explained why I was intending to uphold the complaint and made the following findings:

- Mr D failed to take reasonable care to answer questions fully and accurately when applying for the policy.
- AIG provided its underwriting criteria which showed the undisclosed information would've made a difference to its decision to offer cover when Mr D applied for the policy. So I was satisfied Mr D's misrepresentation was a qualifying one.
- I thought AIG's decision to treat the misrepresentation as careless was fair, because Mr D ought reasonably to have considered the information was relevant to AIG.
- AIG's underwriters showed their ultimate underwriting decision would've been to rate Mr D's policy, once the outcome of further tests was known. The results of further tests were not available until February 2020, some 23 months after Mr D applied for the policy.
- I was not satisfied that, in line with the Association of British Insurers (ABI) Code of Practice: Misrepresentation and Treating Customers Fairly, AIG had shown

reapplication would've been required, thus allowing it to treat Mr D's application as having been declined, meaning there would've been no policy at all and so the claim would result in no payment.

- In view of this, I didn't think AIG had acted fairly and in line with the relevant law – the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA).
- I intended to uphold the complaint and require AIG to reinstate Mr D's policy and settle the claim on a proportionate basis, as set out in CIDRA, deducting the value of premiums refunded to the estate and adding 8% simple interest to the final settlement figure from the date the medical evidence used to assess the claim was received until the date of settlement.

The estate responded to my provisional decision indicating general agreement to my analyses and that it had no further representations to make at that time. AIG provided further information confirming that as a repeat blood glucose reading wasn't available until February 2020 – more than six months after postponement - reapplication would have been required.

In light of the additional information provided by AIG, I issued a second provisional decision in January 2024. In it I explained I was no longer intending to uphold the complaint. My provisional thoughts in respect of the misrepresentation itself remained the same. But given AIG's confirmed approach to reapplication, I thought AIG acted fairly and in line with CIDRA in avoiding Mr D's policy, not paying the claim, but returning the premiums paid.

AIG did not respond to my provisional decision. The estate of Mr D provided further comment and argument regarding, in summary, the likely evolution of events, had full disclosure been made on application, the likely ultimate underwriting decision and AIG's position on reapplication.

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 appreciate this will be significant news for Mr D's family and I'm sorry about that. I've paid particular attention to the estate's most recent submissions, following my second provisional decision. I'll explain my reasoning, focusing on the issues and evidence I consider relevant to my decision.

The ABI Code of Practice – Misrepresentation and Treating Customers Fairly says that in cases of careless misrepresentation, the insurer must apply a proportionate remedy. Where the underwriting decision would've been deferred or where the decision to defer the cover would've been made, insurers should, as far as possible, try to determine what the ultimate underwriting decision would've been (that is, at the end of the deferred period or when the investigation was complete) and apply the appropriate remedy, as detailed further in the code. If it is not possible to work out whether the insurer would have offered any cover, or if the deferral decision would have required the customer to re-apply at a future date, then this should be treated as a decline. Treating as a decline means that, had the misrepresentation not occurred, there would have been no policy at all so the claim will result in no payment, but premiums will be returned.

AIG provided underwriting information which showed it would've applied a combined rating of +125, taking into account Mr D's diabetes – diagnosed in February 2020 - BMI and liver

function. So in these circumstances, AIG could only treat the application as a decline and not pay the claim if reapplication would have been required.

I can appreciate the estate's concerns regarding AIG's confirmation of its reapplication position after my first provisional decision. It's unfortunate this confirmation wasn't given at the earliest opportunity.

In November 2017, shortly before taking out the policy in March 2018, Mr D had two test results that showed impaired glucose regulation. Lifestyle advice was given and a repeat of the test in three months agreed. But this repeat didn't take place until April 2018, after Mr D's policy had commenced, and the result was slightly higher. Mr D's medical records show the next test result wasn't until February 2020. None of these tests was disclosed to AIG.

The estate has argued it's unfair to base a decision on what AIG might've done, had full disclosure been made, without taking into account what Mr D might also have done. It said that, had Mr D's cover been deferred due to his readings in November 2017 and April 2018, he would've retested within the deferment period at which point AIG would've offered cover with the rating applied.

But I don't agree. I don't think it's necessary to speculate on what Mr D might've done had he disclosed fully, because the fact is he didn't. Had he done so, the situation would've been quite different. The ABI Code of Practice simply requires the insurer to determine, as far as possible, the ultimate underwriting decision. I don't think it would be reasonable to ask AIG to assume that Mr D would've retested sooner and therefore reapplication wouldn't have been necessary.

AIG has shown that, had Mr D disclosed his recent tests, it would've requested a report from his GP. It would also have sought guidance from its reinsurers in terms of his other conditions – raised blood pressure and cholesterol, both disclosed – and the application would've been postponed for further investigation, effectively until the next glucose reading. Mr D's April 2018 reading was higher than his pre-application readings, which AIG considered to be suggestive of full diabetes. The guidance would then have been to postpone for a further six months to allow for Mr D's condition to respond to initial treatment and fully evaluate the course of the disease. No further test result was recorded within six months of April 2018.

The estate has argued that AIG would've offered cover based on the April 2018 reading being suggestive of full diabetes. But that's not what AIG has said throughout the life of the claim and subsequent complaint. The rating AIG determined was always indicative, based on trying to determine the ultimate underwriting decision. In its further clarification to me, after my first provisional decision, AIG confirmed that the underwriting decision remained the same. But it also acknowledged the earlier lack of clarification and clearly confirmed reapplication would've been required six months after any deferment. In Mr D's case, the six months elapsed without any updated test results.

Given this, I'm satisfied reapplication would've been required, so in line with the ABI code of practice, Mr D's application can be treated as having been declined. This means I think AIG's decision to treat the policy as never having existed, not pay the claim but return the premiums, is in line with CIDRA and reasonable. It follows I'm not going to ask AIG to do anything more in respect of this complaint.

My final decision

For the reasons set out above, I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mr D to accept or reject my decision before 7 March 2024.

Jo Chilvers
Ombudsman