DRN-4646293

The complaint

Mrs R is unhappy with the way in which Zurich Assurance Limited handled a claim made for the critical illness and total permanent disability (TPD) benefits under a decreasing life and critical illness insurance policy ('the policy') which included TPD. That includes its decision to decline the claim and void the policy.

What happened

Mrs R applied for the policy in 2019. When applying for the policy she was asked a number of questions – including about her lifestyle, health and medical history.

Towards the end of 2022, Mrs R made a claim on the policy for the critical illness benefit (deafness) and for total permanent disability benefit.

Zurich declined the claim in June 2023. That's because it said certain questions weren't answered correctly when Mrs R applied for the policy and had it been, Zurich wouldn't have offered the policy to Mrs R at that time. Zurich also voided the policy but did agree to refund Mrs R the premiums she'd paid for the policy since it started.

Mrs R complained to Zurich. It maintained its decision to decline the claim and void the policy. However, it did accept that it delayed reaching an outcome and offered £150 compensation.

Unhappy, Mrs R asked the Financial Ombudsman Service to look into her concerns. Our investigator considered what had happened and didn't uphold her complaint. He didn't think Zurich had to do anything more to put things right.

Mrs R disagreed so her 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 Zurich) 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.

Zurich says Mrs R failed to take reasonable care not to make a misrepresentation when answering certain questions. In particular, it says she didn't answer questions correctly about, within the last five years, having anxiety, stress, depression or any other mental illness or any tremor, numbness, loss of feeling or tingling in the limbs. It also says she didn't declare that she was waiting for appointments or investigations with her doctor or other medical professional.

I know Mrs R will be very disappointed and I have a lot of empathy for the situation she finds herself in. But, overall, I think Zurich has acted fairly and reasonably by declining her claim and voiding the policy. My reasons are set out below.

Questions on the application form for the policy

When applying for the policy, Mrs R was asked a number of questions including:

> In the last 5 years, unless you have already told us earlier in this application, have you had, or been advised to take any medication or have any treatment for:
> Raised blood pressure or raised cholesterol?

Mrs R declared raised blood pressure. One of the follow up questions included:

> Was your raised blood pressure reading a one off that did not require treatment?

I'll refer to this as 'the follow up blood pressure question'. Mrs R answered 'yes'.

Mrs R was also asked:

> In the last 5 years, unless you have already told us earlier in this application, have you had, or been advised to take any medication or have any treatment for:
> Anxiety stress, depression, chronic fatigue, obsessive compulsive disorder, or other mental illness?

I'll refer to this as the 'the anxiety question'. Mrs R answered 'no'.

Mrs R was also asked:

> In the last 5 years, unless you have already told us earlier in this application, have you had, or been advised to take any medication or have any treatment for:
> Any tremor, numbness, loss of feeling or tingling in the limbs or face, blurred vision, loss of balance or co-ordination, epilepsy, seizure, or loss of muscle power?

I'll refer to this as 'the numbness question'. Mrs R answered 'no'.

Mrs R was also asked:

> Other than for the conditions you have already told us about earlier in this application:

> Are you aware of any symptoms that you intend to seek medical advice or treatment for, or are you waiting for any test results, appointments or investigations with your doctor or other medical professional?

I'll refer to this as 'the investigations question'. Mrs R answered 'no'.

It's also reflected that Mrs R answered 'never used' in reply to tobacco and nicotine usage. And she answered 'no' to whether her natural parents, brothers or sisters had been diagnosed with a list of medical conditions before their 65th birthday which included multiple sclerosis (MS).

I don't think Zurich was under any obligation to request Mrs R's medical records at that stage and by not doing so, I don't think it acted unreasonably. I'm satisfied that Zurich is entitled to rely on the answers to the questions when applying for the policy.

Did Mrs R make qualifying misrepresentation?

It is Zurich's position that Mrs R answered the follow up blood pressure question, the anxiety question, the numbness question and the investigations question – as well as the family history question – incorrectly.

However, when considering what's fair and reasonable in the circumstances of this complaint, I'm satisfied that I need to make findings on whether Mrs R did make a qualifying representation in respect of all those questions.

Instead, I'm going to focus on whether it has fairly and reasonably concluded that Mrs R made a qualifying misrepresentation when answering the numbness and investigations questions. That's because, for the following reasons, I'm satisfied that Zurich has fairly concluded that Mrs R did make a qualifying misrepresentation under CIDRA when answering those two questions.

I'm satisfied that both questions are clear and when reviewing Mrs R's claim, I'm satisfied Zurich has fairly and reasonably concluded that she'd answered them incorrectly. And she should've answered them 'yes' because:

- there's an entry in Mrs R's GP notes dated December 2018 – so around nine months before applying for the policy – which reflects that there was a neurology referral and that Mrs R was increasingly worried about the possibility of having multiple sclerosis ('MS'). Part of the referral reflects: "she has a constant tremor in her left hand, that is there throughout day and night. She describes it being severe enough to wake he [sic] up at night. She often gets shooting pains in her left arm. She describes that there is a delay with her eyes following and this is more pronounced in recent months. She has also noticed a change in sensation in her lower right leg".
- there's an entry dated early September 2019 – so shortly after the date of the application - which reflects that she was awaiting a neurology review for unusual symptoms and that she thinks she has MS because her mum had MS.
- Mrs R's GP records reflect that in July 2015 she consulted her GP about "intermittent pins and needles and numb sensation in hands and feet, pains in legs" and she was waiting to see a neurologist. A few months later the GP notes reflect: "ongoing unusual lower limb and upper limb intermittent tingling sensation" and she was still waiting to see a neurologist.

So, I'm persuaded that within the five years leading to the application Mrs R had experienced a tremor in her left hand and a numbness sensation in her hands and feet as

well as tingling in her lower and upper limbs. And a further neurology referral had been made by her GP in late 2022. At the time of applying for the policy she was still awaiting a neurology review. So, she was awaiting an appointment with a medical professional as the investigations question asks.

As I would reasonably expect, when considering whether Mrs R made a qualifying disclosure, Zurich asked her why she answered some of the medical questions in the way that she did - including the numbness question. I've listened to the recording of that call. Mrs R says that she answered all questions to best of her knowledge and that if something was a "one-off" she wouldn't have thought much about it if it wasn't ongoing.

That may be the case, but the numbness question is clear. At the time of applying for the policy, Mrs R was waiting to see a neurologist in respect of tremors in her hand that she'd been to see her GP about around nine months before. So, I'm satisfied she had a tremor in her limb within the five years leading up to the date of her application, which is what the numbness question asks.

I don't think it was reasonable of Mrs R to have overlooked the symptoms she'd experienced in the circumstances of this case, particularly given the time between those symptoms occurring (which her GP notes reflect as being a constant tremor) and the date of applying for the policy.

I think she reasonably ought to have answered 'yes' to numbness and investigations questions being asked. So, I'm satisfied Zurich has fairly concluded Mrs R acted without reasonable care when answering those questions.

Zurich has provided underwriting information showing that if Mrs R had answered the numbness and investigations questions correctly, it wouldn't have offered her the policy at that stage.

I'm persuaded by that information in this case and it's not uncommon for insurers to not offer cover for a life and critical illness policy whilst medical investigations are ongoing or awaited at the time of application. So, I'm satisfied the answer to these questions mattered to Zurich.

Declining the claim and cancelling the policy

Zurich concluded that Mrs R's misrepresentation was deliberate or reckless. Taking into account her explanation about why she answered questions in the way she did, when considered against the medical evidence, I don't think she's been able to give a credible explanation supported by the facts for the misrepresentation having occurred. Nor do I think there are any reasonably credible mitigating circumstances to explain why she answered the numbness and investigations questions in the way that she did.

I'm satisfied that Zurich has fairly concluded that Mrs R's misrepresentation was deliberately or recklessly made. And as the question was asked before agreeing to insure her, I think she knew that the questions being asked were relevant to Zurich – or didn't take sufficient care about whether or not they were relevant to Zurich.

I've looked at the actions Zurich can take in line with CIDRA. It's entitled to cancel the policy and doesn't have to pay any claims as it can treat the policy as if it never existed. That's what Zurich has done here, and I don't think it's acted unfairly and unreasonably in the circumstances of this complaint by doing so.

Zurich could have also chosen to keep the premiums paid for the policy. It didn't do that; it said it would reimburse Mrs R for the monthly premiums she'd paid for the policy since the date it started. I think that's fair and reasonable.

When making this finding, I've taken on board all of Mrs R's comments including what she says about Zurich offering her the same policy shortly after declining the claim and cancelling the policy. However, I'm not persuaded that this did happen. I think it's more likely that Mrs R had clicked on the "not registered link" for the customer portal which regenerates the original welcome email with a new registration link as Zurich says. I think that's more likely than Mrs R having personal protection cover – which is what the email says – even though she hadn't re-applied for it.

Delays

Zurich has an obligation to handle claims fairly and promptly.

It took around eight months for Zurich to decline Mrs R's claim. That's a long time. Zurich has said that most of the delay was outside of its control, and I'm satisfied that's the case.

Zurich requested a medical report from Mrs R's GP at the start of January 2023. And her GP completed a claims medical report for Zurich in March 2023. I'm satisfied that Zurich chased the GP surgery for the report in the meantime, as I would reasonably expect.

I'm satisfied Zurich promptly consider the medical report which reflects that Mrs R had depression and anxiety "on and off" for 12 years. The form also reflects that she's "listed as no [sic] smoking and ex-smoker".

Given that Mrs R had said in her application for the policy that she'd 'never used' tobacco and nicotine and had answered 'no' to the anxiety question, I think it was fair and reasonable of Zurich to want to obtain Mrs R's medical records from the GP. That's because, given the differing information, I think it was reasonable for it to want to check whether Mrs R had made a qualifying misrepresentation when taking out the policy. I'm also satisfied that it promptly requested this information from the GP. It looks like it took the GP surgery a few weeks to provide the further information Zurich requested.

I'm satisfied that Zurich updated Mrs R at the end of March 2023, and again in mid-April 2023, that it had requested further medical evidence from her GP. I think that was reasonable.

In its final response letter, Zurich however accepts that there were times when it unreasonably delayed progressing Mrs R's claim. Zurich apologised and offered Mrs R £150 compensation in recognition of the delays.

I can see that this was a worrying time for Mrs R, which would have been exacerbated by the delays caused by Zurich. But I think £150 fairly reflects the distress and inconvenience she's experienced because of the delays caused by Zurich – which I'm satisfied were comparatively short compared with the delays outside of its control.

Without the delays caused by Zurich it's likely Mrs R would've received an outcome to her claim sooner. However, that wouldn't have avoided the ultimate disappointment of the decision to decline her claim and void the policy, which I'm persuaded is the main reason for her distress and upset (and, for reasons set out above, I think was fair and reasonable).

My final decision

I don't uphold Mrs R's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs R to accept or reject my decision before 8 April 2024.

David Curtis-Johnson
Ombudsman