DRN-4717722

The complaint

Ms R and her brother have complained, on behalf of their late father's (Mr R's) estate that Vitality Life Limited have unfairly obtained and reviewed their late father's medical records when assessing the claim on his life insurance. And Vitality won't progress the claim any further without getting more medical evidence.

What happened

Mr R bought a life policy from Vitality at the start of 2018. As part of the application process, he completed a health and lifestyle questionnaire. Based on the answers he gave, Vitality offered Mr R a life policy providing £100,000 of cover.

Mr R sadly died at the end of 2022. His death certificate recorded the cause of death as colon cancer. Ms R and her brother made a claim on the policy.

As part of their assessment process, Vitality requested information from Mr R's doctors. The doctors provided more than was requested. Based on what they received, Vitality noted conditions Mr R hadn't disclosed and sought further disclosure. That further information also raised questions about Mr R's health. After several months, Ms R revoked the consent she'd provided to obtain medical records, as she said that Vitality were deliberately looking for reasons to decline the claim.

Vitality told Ms R that, unless they could get further medical evidence, they would have to reach a decision on the basis of the information they had. And, based on that, Vitality concluded they wouldn't have offered Mr R a policy when he made his application, but would have postponed a decision until they had more information about his health.

Ms R initially complained about the time it was taking to assess the claim. Vitality accepted they had delayed and offered £250 compensation, which Ms R accepted.

Ms R subsequently made another complaint about Vitality requesting more and more medical information from different doctors. Vitality explained their process and offered her a further £100 for delays caused by the claim having to be reallocated and not addressing correspondence. But they maintained they couldn't assess the claim on the basis of what they had.

Ms R wasn't satisfied with Vitality's response and brought the estate's complaint to our service. She told us that Vitality had deliberately sought information from doctors to decline the claim and that they'd tricked the doctors into providing more information than they were entitled to. And she said Vitality shouldn't be reviewing the application information because the two year "contestability period" had passed.

Our investigator reviewed all the information provided and concluded Vitality didn't need to do any more to resolve the complaint. She explained the relevant law when considering whether a customer has made a misrepresentation is the Consumer Information (Disclosure and Representations) Act 2012 – known as CIDRA. She was satisfied that Mr R's medical records meant it was reasonable for Vitality to request more information to assess the

complaint. And it was fair for them to say they couldn't complete their assessment of the claim.

Ms R didn't agree with the investigator's view. So I've been asked to make a final decision on the complaint.

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 upholding this complaint. But I'm not asking Vitality to do more than they've already offered to resolve it. I know this will be unwelcome news for Ms R and her brother and I'm sorry about that. I hope it will help if I explain the reasons for my decision.

I understand Ms R's frustrations with the claim process. But it's not the role of the Financial Ombudsman Service to direct businesses how to decide claims. Rather, we consider whether they've considered a claim fairly and reasonably, in line with the applicable law and rules.

Ms R has referred throughout the complaint to Vitality requesting information about Mr R's health outside "the contestability period". In many jurisdictions around the world, this term refers to a period outside of which a business cannot request information about a customer's health. Such periods – where they exist – are most usually around two years after a policy is purchased. Mr R died almost five years after he bought his policy. So Ms R says Vitality can't now review the information he provided on his application.

I understand why Ms R would suggest this is the case, particularly as contestability periods are mentioned on Vitality's website. But, as our investigator explained, the relevant law in this country relating to disclosure is CIDRA. And neither CIDRA, nor the Code of Practice issued by the Association of British Insurers (ABI) on how to apply CIDRA, limits the time in which an insurer can investigate. So I'm satisfied Vitality didn't act unfairly by investigating five years after the policy was purchased.

It's the usual practice of insurers to request and review medical records as part of their assessment of a claim – and to ask questions where they identify inconsistencies with the information provided to them on application. Ms R is unhappy about what she views as a deliberate attempt by Vitality to obtain comprehensive medical information about Mr R to justify not paying the claim. She says they should only be asking about information relating to his cause of death.

It is the case that an insurer should only ask for relevant information. But I'm satisfied that's what Vitality did. I've seen they asked Mr R's doctors for information dating back to 2013 (ie, five years before his application) about colon and bowel issues and raised blood pressure – which Mr R had declared on his application.

But, in response, the doctor provided Vitality with more extensive information. That indicated Mr R had other health issues at the time of his application, which he hadn't disclosed. Having received that information, it wasn't in my view unreasonable for Vitality to review it and seek clarification on the additional matters they were made aware of, to establish if Mr R had misrepresented his health at the time he bought the policy.

As explained, the relevant law in relation to misrepresentation is 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.

I'm satisfied from the information I've seen that it was reasonable for Vitality to request further medical information to establish if Mr R had accurately answered the questions in the application. While I note Ms R has said her father was elderly and would likely have forgotten some of the details, CIDRA did impose a duty on him to take reasonable care to be accurate in his answers – and it's reasonable for Vitality to assess whether he was.

While Vitality have written to Ms R indicating they believe Mr R misrepresented his health in his application, they say they can't complete their assessment of whether this is a qualifying misrepresentation because Ms R has revoked the authority to obtain any more medical records.

While I can appreciate why Ms R had done that, I'm satisfied it does mean it's reasonable for the claim not to progress any further. If Ms R changes her mind and provides further authority, I'd expect Vitality to review the information against their underwriting criteria to determine whether they would have offered Mr R cover on other terms or not at all. And I'd expect them to categorise the misrepresentation and apply the appropriate remedy.

I understand Vitality's investigations have taken some time and it's been frustrating for Ms R and her brother that more evidence has been requested. But I think it's reasonable for Vitality to investigate the issues they've become aware of during their assessment. They've paid £250 compensation for delays and have offered a further £100 which I think they should now pay. But I don't think they need to do more than that to resolve this complaint.

My final decision

For the reasons I've explained, I'm upholding the complaint Ms R and her brother have made about Vitality Life Limited on behalf of the late Mr R's estate and directing Vitality to pay the estate the £100 they've previously offered.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mr R to accept or reject my decision before 26 July 2024.

Helen Stacey
Ombudsman