DRN-5012249

Financial Ombudsman Service

The complaint

Mrs G is unhappy with the way Legal and General Assurance Society Limited (L&G) handled a claim made on a life insurance policy (which included terminal illness cover) she jointly held with her husband, Mr G.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

Mr G died shortly after the claim for the terminal illness benefit was declined by L&G. I wish to pass on my condolences to Mrs G and her family at a continuingly difficult time. I know Mrs G feels very strongly that L&G hasn't acted fairly but for reasons I'll go on to explain, I don't uphold this complaint.

Relevant law and industry guidance

I've considered The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I'm satisfied this is relevant law.

I've also taken into account the relevant ABI Code of Practice for managing claims for individual and group life, critical illness and income protection insurance products.

CIDRA 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 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 several 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.

Did Mr G make a misrepresentation when applying for the policy?

L&G has concluded that Mr G didn't take reasonable care when completing his part of the application for the policy and didn't answer some questions accurately. Had these questions been answered correctly, it says it wouldn't have offered a joint policy at the time. It therefore concluded that Mr G should be removed from the policy, and – if Mrs G wanted - it could

continue with the policy in Mrs G's name only (refunding the premiums Mr G's share of the policy). It also declined the claim for terminal illness benefit.

When applying for policy Mr G was asked a number of questions about his health and medical history. That included:

> Apart from anything you've already told us about in this application, during the last 2 years have you seen a doctor, nurse or other health professional for:
>
> Any condition affecting your gall bladder, liver or pancreas for example, hepatitis, fatty liver?

I'll refer to this as 'the pancreas question'. It's reflected that Mr G answered 'no' to this question.

He was also asked:

> Apart from anything you've already told us about in this application, during the last 2 years have you seen a doctor, nurse or other health professional for:
>
> A growth, lump, polyp or tumour?

I'll refer to this as 'the polyp question'. It's reflected that Mr G answered 'yes' to this question. He was then asked further sub-questions and amongst other answers he said he'd had a polyp, selected 'other site' from a drop-down list of options and that he'd had it for "2 years, 0 months".

He was then asked:

> Have you another condition or illness to tell us about under this heading.

It's reflected he answered: 'no'.

Mr G's medical records reflect that within the two years before applying for the policy he'd had a number of investigations. A duodenal polyp had been identified and so had adenomatous lesions in the duodenal bulb (benign appearance).

A letter from a consultant physician dated March 2018 also referenced Mr G having iron deficiency anaemia and that the adenomatous lesions in duodenum was the likely cause.

A further letter from Mr G's consultant surgeon dated May 2018 also reflects that a small lesion had incidentally been found in the pancreatic neck and an ultrasound/MRI was suggested. The subsequent medical records reflect that they couldn't identify the exact nature of this lesion from the MRI scan, and he was referred to a specialised pancreatic team.

The consultant gastroenterologist's letter dated January 2019 refers to the CT colonoscopy in May 2018 and MRI scan of pancreas dated September 2018 and it was concluded that Mr G had a side branch of intraductal papillary mucinous neoplasm ('IPMN') with no concerning features. It was recommended that a MRI scan is repeated in two years.

Mr G didn't disclose the lesion that had been found in his pancreas under the pancreas question, which I'm satisfied he reasonably ought to have by answering 'yes' to this question. When making this finding, I've taken into account the point made about the lesion not being a 'condition'. However, I'm satisfied that the question is reasonably clear and that a

reasonable person would've reasonably considered the lesion identified in Mr G's pancreas (which the consultant describes as a side branch of intraductal papillary mucinous neoplasm) as a condition affecting the pancreas even if at that stage it had no concerning features.

Based on a conversation with Mr and Mrs G during the assessment of the claim, L&G has concluded that Mr G tried to disclose the pancreatic lesion under the polyp question. That's because Mr and Mrs G said they weren't aware of the duodenal polyp until after the policy had started.

However, even if that's the case, I'm satisfied that L&G has fairly concluded that Mr G answered the question about how long he'd had the pancreatic lesion for. He said two years, but the medical records reflect that this was discovered around 18 months before he applied for the policy.

I'm therefore satisfied that L&G has fairly and reasonably concluded that Mr G misrepresented some of his answers to the questions asked of him when applying for the policy.

Mrs G has pointed out that L&G had a pending request for post completion specific medical records. If a request had been made, then L&G would've been able to review Mr G's medical history shortly after he and Mrs G applied for the policy. However, L&G has explained why this request was never made.

I'm satisfied that there was no requirement for L&G to request this information although it might be its internal process to do so for one in ten applications. I don't think it had any knowledge at the time that Mr G had answered some questions on the application incorrectly or had affirmed the insurance contract by accepting that the questions had been answered wrongly.

I think L&G was reasonably entitled to rely on the answers Mr G gave in the application without obtaining any further medical records. So, this doesn't change my conclusion about Mr G making misrepresentations when answering the questions identified above.

Were these misrepresentations 'qualifying' misrepresentations?

Looking at the underwriting information provided by L&G – along with the relevant medical evidence from the time – I'm satisfied on the balance of probabilities that if Mr G had accurately answered the pancreatic question accurately and / or declared that the lesion in his pancreas had been identified less than two years before applying for the policy when answering the sub-questions under the polyp question, L&G wouldn't have ended up offering a joint policy at the time. That's because the lesion was diagnosed as being a side branch of IPMN and was still being monitored at the time.

I'm therefore satisfied that the misrepresentation made by Mr G is what CIDRA refers to as 'qualifying' misrepresentations.

Has L&G fairly declined the claim?

L&G has concluded that the misrepresentations were careless (as opposed to deliberately or recklessly made). Taking into account the relevant ABI Code of Practice for managing claims for individual and group life, critical illness and income protection insurance products (and what it says about classing misrepresentations as careless) I find that L&G has acted fairly and reasonably by reaching that conclusion.

I’ve looked at the actions L&G can take in line with CIDRA if a qualifying misrepresentation is careless. I’m satisfied it can do what it would’ve done if the questions had been answered correctly.

Because I’m satisfied that the policy wouldn’t have been offered to Mr G at the time, I’m satisfied L&G has acted fairly and reasonably by removing him from the policy, declining the terminal illness claim (on the basis that the policy wouldn’t have been in place for Mr G to have made a claim on) and offering to refund the premiums paid for Mr G’s share of the policy if Mrs G wanted to continue with the policy in her sole name.

The handling of the claim

L&G has an obligation to handle claims fairly and promptly.

L&G accepts there were delays in handling the claim and responding to the subsequent complaint. It offered £400 to reflect the impact of this.

Mrs G says L&G lacked compassion when considering the claim and asking Mr G questions. In principle, I’m satisfied that it was fair and reasonable for L&G to have wanted to ask Mr G questions about why he answered some of the questions in the way he did when applying for the policy in light of the medical evidence it had obtained. I’m also satisfied that’s good industry practice.

L&G’s contact notes reflect that when calling Mr G, he was unable to speak and most of the call was conducted with Mrs G with Mr G being present. I appreciate that this would’ve been upsetting, and I haven’t seen anything to suggest that other methods of communication were considered to try to obtain this information – for example, in writing.

However, even if that’s the case, I’m satisfied that total compensation in the sum of £400 fairly and reasonably reflects the overall impact on Mr and Mrs G for the distress and inconvenience they experienced when handling the claim and subsequent complaint.

My final decision

I don’t uphold this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs G to accept or reject my decision before 13 January 2025.

David Curtis-Johnson
Ombudsman