DRN-5041860

The complaint

Miss C complains that Aviva Life & Pensions UK Limited avoided her life and critical illness insurance policies and refused to pay a claim.

What happened

The background to this complaint is well known to the parties, so I won't repeat all the details here. In brief summary, in September 2022, Miss C took out life and critical illness cover with Aviva. I understand the policies were sold through a broker and were to protect a mortgage.

Most unfortunately, in May 2023, Miss C was diagnosed with multiple sclerosis. Miss C subsequently made a claim for critical illness benefit, but Aviva declined the claim, saying she hadn't given full and accurate information during the application process.

Aviva considered this to be a qualifying misrepresentation. It said that, had Miss C answered correctly, it wouldn't have offered cover, postponing the application until the results of outstanding investigations were known. The outstanding investigations ultimately led to Miss C's diagnosis.

Aviva refused to pay Miss C's claim, saying she had deliberately or recklessly misrepresented her circumstances on application. It cancelled her policies, but refunded the premiums paid.

Miss C complained, but Aviva maintained its stance, so Miss C came to the Financial Ombudsman Service. But our investigator didn't uphold the complaint, so Miss C asked for an ombudsman to review everything and issue 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 so, I'm not upholding this complaint. I know this will be disappointing and unwelcome news for Miss C and I'm sorry about that. I'll explain my reasons, focusing on the points and evidence I think is material to the outcome of the complaint. So if I don't mention something specifically, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

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 (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.

When applying for the policy, Aviva said Miss C failed to take reasonable care not to make a misrepresentation when she answered no to the following questions:

> *Have you ever had blurred or double vision, numbness, loss of feeling or muscle power, balance problems, tremor, or persistent pins and needles, dizziness, or facial pain serious enough to seek medical advice?*
>
> *Within the last four years have you had, or have you taken medication for, or been advised to take medication or have treatment for any problems with your eyes or ears which haven't been fully corrected by glasses, contact lenses, laser treatment or by hearing aids?*
>
> *Apart from anything you've already told us about, within the last two years have you:*
>
> - *been referred to a specialist (even if you didn't attend, or haven't attended yet)?*
> - *been under follow-up with your GP surgery, a specialist, hospital, or clinic, including reviews or check-ups you have been asked to attend even if you didn't?*
> - *had, or been advised to have, any medical investigations (even if you didn't attend, or haven't attended yet)? This includes a blood test, biopsy, Ultrasound, x-ray, CT, MRI, other scan, or a scope (internal camera).*

Aviva relied on entries in Miss C's medical records – obtained for the purposes of assessing her claim – which it says show she should've answered these questions positively.

I've reviewed the medical evidence provided. I can see that Miss C attended A&E on 13 June 2022. In a follow-up letter to Miss C's GP the complaint is recorded as *pain in/around eye*. Under diagnosis it states;

> *Direct admit to a speciality. Suspected diagnosis – rt eye heaviness and slightly droopy UL on waking up today morning, no previous eye problems or similar episodes.*

The Discharge Outcome is recorded as Eye Clinic.

Miss C also attended A&E on 1 September 2022. The complaint was listed as *eye review*. In the diagnosis section it's recorded that Miss C was *'extremely anxious, wants MRI head. Has appointment with neuro-ophthalmology already in less than two weeks. To keep.'*

Miss C attended A&E again on 2 September 2022. The complaint was again listed as *eye review*. Under diagnosis it states:

> *Seen again today. Symptoms largely the same. Reviewed with [consultant ophthalmologist] and recent bloods – for MRI head urgently to r/o SOL. Has neuro-ophthalmology appointment already.*

The Discharge Outcome is recorded as Outpatient Clinic.

Miss C was seen by a consultant in neuro-ophthalmology on 15 September 2022. From there she was referred to the neurology clinic. The referral letter from the consultant notes:

> *This patient was seen in eye casualty and an urgent MRI was requested.*
> *She reports that she had blurred vision in both eyes since June and was seen in A&E June and then again in September. The appearance of disc fullness and slight swelling worsened between June and September so when she was seen in September, the MRI was requested. This was reported yesterday and the appointment was already in place so I therefore saw her in clinic today.*
> *The person who requested the scan communicated with the Neurology team and was told that an urgent neurology assessment, ideally, would happen within the next few weeks which, hopefully, is being put in place now.*
> *I'd be grateful if you could arrange to see her promptly (this is booked for 26 September).*

After the initial neurology appointment on 26 September 2022, consultant neurologist, Dr B, wrote to Miss C's GP. She said:

> *[Miss C] reports difficulties with her vision, with both of her eyes, that she experienced back in June 2022 that improved after a couple days. Then by the end of August 2022 she had difficulties with her right eye vision namely difficulties with her vision field where she did not see the upper field at all. She also did have a couple of short lasting of feeling numbness in the lateral side of her left thigh.*

Miss C has argued that she did not have blurred vision and that references to this in her medical records are generic and therefore misleading. I can understand Miss C's focus on the terminology used. But even if I were to discount her answers to the questions about neurological symptoms - including blurred vision - and eye treatment/medication, the question about referrals, follow-ups and investigations remains.

In this respect, Miss C has argued that she was ignorant of what her eye condition was, or when the MRI appointment was, until after she took out the policy, having not seen any letters or internal documents. However, I'm mindful that Miss C was sufficiently worried about her eyes to attend A&E on three occasions. On the first occasion she was referred to the Eye Clinic and on the second occasion she said she wanted an MRI and her forthcoming appointment with neuro-ophthalmology was referred to. So I'm satisfied that, at the least, Miss C ought to have answered yes to the question about referrals, follow-ups and investigations.

Miss C was subsequently sent a personal details confirmation document. This documents shows the questions Miss C was asked on application and her answers. The cover letter tells Miss C it's really important to check through the document to make sure the information shown is correct. It gives 14 days to let Aviva know of any changes that need to be made. Ultimately, Miss C was responsible for answering questions accurately.

I'm satisfied the questions asked were clear and unambiguous. And that when Miss C applied for the policy, she should've disclosed her recent hospital attendances which led to specialist referral and further investigation. So I'm satisfied Miss C failed to take reasonable care when taking out the policy.

Aviva has provided information about its underwriting criteria to show what would've happened, had Miss C answered the questions accurately. A positive answer to any one of the questions Aviva identified concern with would have resulted in follow-up questions. This would've led to Aviva being told that no diagnosis had been made – meaning there would've

been investigations outstanding at application. This would've resulted in a manual under writing process. Aviva has also provided evidence and a statement from a senior underwriter confirming that the application would've been deferred until the results of further investigations or any diagnosis was known.

This shows that full medical disclosure would've made a difference to Aviva's decision, so I'm satisfied Miss C's misrepresentation was a qualifying one.

Aviva considered Miss C's misrepresentation to be deliberate or reckless, meaning she either knew, or must have known, that the information given was both incorrect and relevant to the insurer, or she acted without any care as to whether it was either correct or relevant to the insurer. In view of the proximity of Miss C's hospital attendances to her taking out cover, I think this was a fair categorisation.

CIDRA sets out the actions an insurer can take in cases of misrepresentation. In the circumstances of Miss C's misrepresentation, Aviva was entitled to cancel the policies and keep the premiums. However, I understand it refunded Miss C the premiums she paid. The action Aviva's taken is more than is required under CIDRA, so I think Aviva has acted fairly here. Given this, I don't think Aviva needs to do anything more in respect of this complaint. Once again, I'm sorry to send what I know will be difficult news to Miss C.

My final decision

For the reasons given above, my final decision is that I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss C to accept or reject my decision before 25 October 2024.

Jo Chilvers
Ombudsman