DRN-5042479

The complaint

Mrs J is unhappy that Liverpool Victoria Friendly Society Limited (LV) declined her claim and cancelled her income protection policy.

Mrs J would like the policy re-instated, and her claim paid.

What happened

Mrs J took out a 'Flexible Protection' plan in January 2020. The policy started on 25 January 2020 and in the event of Mrs J not being able to work due to sickness or accident, the policy would pay out a monthly benefit after a one week waiting period. The policy underwriter is Liverpool Victoria Friendly Society Limited.

On 26 July 2022, Mrs J contacted LV that she had been unwell and submitted a claim for the benefit to start from 7 July 2022. Mrs J went to see her GP on 30 June 2022 because of low back pain and had taken time off work due to the pain.

LV requested Mrs J's medical records in September 2022 and reviewed the questionnaire she completed when she took out the policy in 2020. The GP information wasn't received until 29 March 2023. The records referred to low back pain in 2015 and further information needed to be requested from the GP. At the time, in 2015, Mrs J was referred to a physiotherapist. This caused a further delay, and the information was received in August 2023.

Mrs J was referred to a gynaecology and orthopaedics. She had an ultrasound scan which showed a small fibroid. There was no diagnosis of any illness and was again referred to a physiotherapist. In February 2023, she went to the gynaecology department and a decision was made to have a hysterectomy and eventually Mrs J had the procedure in November 2023. Mrs J said her back pain was due to her gynaecological issues.

Having received Mrs J's medical records, LV says it was clear she should have answered 'Yes' to the questions about her back, knee and neck history. LV said Mrs J had a responsibility to ensure the information she provided on her application was accurate. But as the questions weren't accurately completed, exclusions relating to back, knee and neck would be applied to Mrs J's policy from the outset. So, as Mrs J's claim was for back pain, the claim was declined.

LV wrote to Mrs J on 23 October 2023 and asked her how she wishes to proceed with her policy. It provided her with the option of continuing with her policy with the exclusions it applied or having it cancelled and the premiums refunded. As it didn't hear back from her, LV cancelled the policy in November 2023 and refunded the premiums for £659.40. It said premiums were waived as per her policy terms for February 2023 and March 2023. Mrs J then had a payment break from April 2023 to July 2023.

LV refunded £659.40 from January 2020 to December 2022. LV said the policy cancellation had nothing to do with the claim decline, but it was due to non-payment of the premium in November 2023. It wrote to Mrs J on 27 November 2023 that the policy had lapsed and if

she wanted it reinstated, it provided her a telephone number to call. LV says if the policy is to be re-instated, Mrs J would need to accept the exclusions it would need to apply and complete a re-instatement questionnaire due to the time that's passed.

Mrs J made a complaint to LV about the claim being declined and the policy being cancelled. It issued a final response on 22 March 2024. It said Mrs J made a qualifying misrepresentation on her application in 2020 and so it declined her claim. LV said if Mrs J wanted the policy re-instated, she would have to accept that the exclusions would be applied and that she would need to complete a reinstatement questionnaire.

Unhappy with LV's response, Mrs J brought her complaint to this service. Our investigator upheld the complaint. She thought LV had unfairly declined Mrs J's claim because the claim itself doesn't relate to 'the disease or disorder of the back' and that she was claiming for a gynaecological condition. She recommended that LV should settle the claim, add 8% simple interest and for the policy to be re-instated. And she said LV should pay Mrs J £300 compensation for the delays and subsequent decision to decline the claim.

LV disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me to decide.

In summary, LV said:

- We have confused LV's position. It declined the claim due to Mrs J not being able to work because of back pain which is excluded. It's not being declined due to not meeting the definition of incapacity.

- It disagrees that Mrs J's back pain was due to gynaecological issues. While the issues may have been exacerbated by the back pain, it was simply the back pain that was the cause of Mrs J not being able to work.

- Mrs J returned to work in January 2023 and her procedure didn't take place until November 2023.

- The gynaecological issues were fully considered but it was determined that these issues alone wouldn't have prevented Mrs J from working. This was referred to its Medical Officer for a second medical opinion and he said it was the back pain, not the gynaecological issues that caused Mrs J to be off work.

I issued a provisional decision on 20 September 2024. I said the following:

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

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 must 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 note that LV has said it would be placing an exclusion on the policy for Mrs J's back and left knee. However, this complaint is about Mrs J's claim for back pain in 2022. It's not my role to comment on whether the exclusion LV proposes for claims made about Mrs J's left knee is fair. I'm only looking at the issue about the back pain claim here.

LV thinks Mrs J failed to take reasonable care not to make a misrepresentation when she didn't disclose Mrs J's condition. So, I've looked at the evidence provided.

I've considered the health questionnaire within the application Mrs J completed in 2020. When she made the application, she was asked the following questions:

'In the last 5 years, regardless of whether you've seen a doctor, required treatment or had time off work, have you had:

- *Back pain, sciatica, whiplash, or anything else affecting your neck or back?*
- *Joint or muscle pain, or any type of arthritis, gout or anything else affecting your bones, joints, muscles or limbs?*

Other than for things you've already told us about, in the last 3 years have you:

- *Requested any or been advised to have any medical investigations?'*

Mrs J answered 'No' to the above questions.

I'm satisfied that the above questions were answered incorrectly. The medical evidence provided shows Mrs J had lower back pain in 2015 and I think this information should have been disclosed to LV when taking out the policy.

Mrs J's claim in 2022 was for back pain and she was off work for this reason. Whilst I can see later, she had a consultation with a gynaecologist which resulted in a hysterectomy in November 2023, I don't think the reason for her being unable to work was because of the gynaecology issues. But I think it was the back pain.

Mrs J says she tried to tell her broker when she took out the policy, but they told her this information wasn't relevant. I appreciate this. But ultimately the responsibility was with Mrs J to check that she's provided accurate information. I note that LV also sent out information to Mrs J after the paperwork had been completed to check the accuracy of what she'd completed.

LV has classified the qualifying misrepresentation as a careless one (as opposed to deliberate or reckless).

I've gone on to think about whether failing to take reasonable care makes a difference in this case.

LV has provided evidence which shows what would have happened if the correct information was entered at the time of taking out the policy. This shows that had Mrs J completed the question correctly about her back pain at the start of the policy in 2020, LV would have excluded this condition. This means, I'm satisfied Ms J's misrepresentation was a qualifying one.

CIDRA sets out the remedies available to an insurer in the case of careless

misrepresentation. CIDRA is concerned with disclosure and representations made by a consumer to an insurer before a consumer contract is entered into or varied.

In this case, LV has said an exclusion would have to be placed on Mrs J's policy:

> *'disease or disorder of the back, neck or spine including the supporting muscles, ligaments, joints or discs of the spinal column or related nerves including sciatica.'*

This means Mrs J wouldn't be covered under the policy if she needed to make a claim for anything related to the exclusion. And Mrs J can ask LV to review the situation two years after this date if she is symptom and treatment free for that period and it would consider removing the exclusion.

I do understand that Mrs J will be disappointed. But LV has followed the law as set out in CIDRA and applied an exclusion for Mrs J's back pain and declined the claim she made in 2022. Overall, therefore, I'm satisfied this is fair and reasonable, taking everything into account.

My understanding is that LV cancelled Mrs J's policy in November 2023. It wrote to her and said she did not respond so the policy lapsed and was cancelled. Mrs J said she was unhappy about LV's decision to decline the claim and she had wanted to take this further.

So, whilst LV has refunded the premiums Mrs J had paid, and the policy was cancelled, this happened at a time when Mrs J had just had her hysterectomy procedure and when the claim was declined.

Should Mrs J want the policy re-instated, she should contact LV directly. This would be on the basis that the exclusion referred to above would be added to the policy and a medical questionnaire would have to be completed. I leave this to the two parties to communicate directly with each other to discuss any next steps.

Overall, based on the available evidence, I don't think LV declined Mrs J's claim unfairly or unreasonably. And I'm satisfied this was in line with the policy terms and conditions and was done fairly.

Both parties responded to my provisional decision.

Mrs J responded and said she had nothing further to add.

LV also said it had nothing further to add.

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, as neither party had any further points or comments to add, I see no reason to depart from the provisional decision I issued.

Overall, therefore, I'm sorry to disappoint Mrs J I don't think LV declined her claim unfairly or unreasonably. I'm satisfied this was in line with the policy terms and conditions and was done so fairly.

My final decision

For the reasons given above, I don't uphold Mrs J's complaint about Liverpool Victoria

Friendly Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs J to accept or reject my decision before 23 October 2024.

Nimisha Radia
Ombudsman