DRN-5049396

The complaint

The estate of Mrs C is unhappy with the way Legal and General Assurance Society Limited ('L&G') handled two claims made on two separate life insurance policies held by Mrs C, after she sadly died.

What happened

Mrs C successfully applied for two life insurance policies; the first in 2014 (policy number ending 711) – which I'll refer to as "the first policy" - and the second in 2021 (policy number ending 173), which I'll refer to as "the second policy".

After Mrs C sadly died, claims were made on both policies.

L&G ended up paying a proportionate life benefit under the first policy. That's because it said Mrs C failed to answer questions correctly about her medical history when applying for the first policy. And had she done so, the first policy would've cost 50% more than she was paying each month.

L&G ended up voiding the second policy and declining the claim made under it. It again concluded that Mrs C hadn't answered a medical question correctly when applying for the second policy. Had she done so, it says it wouldn't have offered the second policy to her.

As well as complaining about L&G claims' decisions, the estate of Mrs C raised several concerns about the way in which the claims were handled including delays in progressing and assessing the claims.

L&G accepted that there had been some unnecessary delays and the service received fell below the standard expected. In total, it's paid the estate of Mrs C £750 compensation to acknowledge this.

After the complaint was brought to the Financial Ombudsman Service, our investigator looked into what happened. He concluded that L&G had acted fairly by paying a proportionate benefit under the first policy and voiding the second policy (and declining the claim made under it). He also felt that total compensation in the sum of £750 was fair and reasonable so he didn't uphold the estate's complaint.

The estate of Mrs C didn't agree. So, this complaint has been passed to me to consider everything afresh to 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.

I've considered The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA') as I'm satisfied this was relevant law at the time Mrs C applied for both policies.

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.

L&G has concluded that Mrs C didn't take reasonable care when applying for both policies and didn't answer some questions accurately. Had these questions been answered correctly, it says the first policy would've cost more and it wouldn't have offered the second policy.

The first policy

Did Mrs C make a misrepresentation when applying for the first policy?

It isn't disputed that Mrs C applied for the first policy via a third-party intermediary.

Mrs C signed and returned a 'checking your details' form dated June 2014. A box is ticked confirming that the details contained in the application are right.

The form also says:

> If the answers on your application are not correct, are incomplete, or are out of date it may mean that a claim will be declined, and the policy or policies cancelled…please tell us straight away if you need to change any of your answers before the policy starts.

The declaration signed by Mrs C says:

> By signing and dating this form you declare that to the best of your knowledge and belief the information provided on your application and, where necessary, on this form is true and complete.

The application form contains a number of questions about Mrs C's medical history and lifestyle including:

> Have you ever:
>
> Had diabetes…

I'll refer to this as 'the diabetes question' and I think it's clear. It's reflected that Mrs C answered 'no' to this question.

And:

> Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for:

> Raised blood pressure, raised cholesterol or condition affecting blood or blood vessels, for example anaemia, excess sugar in the blood, blood clot, deep vein thrombosis?

I'll refer to this as 'the blood question' and, again, I think this question is clear. It's reflected that Mrs C answered 'no' to the blood question.

CIDRA says that it's the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer. And that a failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation.

I'm satisfied L&G has fairly and reasonably concluded that the answers given to the questions set out above were incorrect. And that Mrs C made a misrepresentation when applying for the first policy.

Mrs C's medical records reflect that before applying for the first policy she had been diagnosed with diabetes and within the five years before applying for the first policy her blood sugar level was found to be raised.

I've taken into account what Mrs C's husband (Mr C) has said about Mrs C being in denial about having diabetes at the time and that she was looking to manging her condition.

However, I'm satisfied that L&G has fairly concluded that she didn't take reasonable care when answering the diabetes and blood questions above.

When making this finding, I've taken into account that Mrs C gave her permission for L&G to obtain her medical records and it didn't do this around the time of accepting her application for the first policy. But I don't think it was under any obligation to request medical evidence at the time. It was reasonably entitled to rely on the information Mrs C gave in her application and assume that the answers she gave were correct.

Did Mrs C make a 'qualifying' misrepresentation?

Looking at the underwriting information provided by L&G - in light of the relevant medical evidence from the time - I'm persuaded that had Mrs C answered the diabetes and blood questions correctly, it would've still offered the policy to her, but it would've cost more.
So, as the answers to those two questions mattered to L&G, I'm satisfied that by answering them incorrectly Mrs C made a 'qualifying' misrepresentation.

L&G has concluded that Mrs C was careless when answering the blood and diabetes questions incorrectly (as opposed to acting recklessly or that she deliberately didn't answer the questions correctly). I think that's reasonable.

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 would've cost more, I think it's fair and reasonable for L&G to pay the life benefit under the first policy in proportion to the premium Mrs C paid for the policy (compared with what she ought to have paid). That's what it's done here, and I'm satisfied that's reasonable.

The second policy

Did Mrs C make a misrepresentation when applying for the second policy?

Again, it isn't disputed that Mrs C applied for the second policy via a third-party intermediary.

The application for the second policy contains a declaration which says:

> The information given in this application has been provided truthfully and accurately.
>
> I am aware that the information provided will form part of the legal relationship between us and if any of it is found to be incorrect it may mean that a claim is not paid or the policy(ies) is amended or cancelled.

The application form again contains a number of questions about Mrs C's medical history and lifestyle. Mrs C declared that she had diabetes and was asked a number of follow up questions about this condition including:

> Which of the following most closely describes your latest HbA1e result?

I think that's a clear question. It's reflected that Mrs C answered: "normal or low".

I'm satisfied L&G has fairly and reasonably concluded that the answer given to this question was incorrect. And that Mrs C made a misrepresentation when applying for the second policy. That's because Mrs C's medical records reflect that Mrs C's most recent HbA1e result before applying for the second policy was 'high', which was consistent with previous results.

The estate of Mrs C says that L&G said it would access Mrs C's medical records when considering her application for the second policy. I've seen evidence that it did contact Mrs C after the application to say that one in ten applications will be checked by obtaining information from the policyholder's doctor and that a report had been requested in this case.

However, I'm satisfied that L&G didn't end up receiving the information from Mrs C's GP and there's a letter from L&G to the GP dated May 2021 saying it no longer requires this information and for the request to be destroyed.

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 Mrs C hadn't answered the question about her latest HbA1e result correctly or had affirmed the insurance contract by accepting that this question had been answered wrongly.

I think it was reasonably entitled to rely on the answers Mrs C gave in her application without the information from the GP. So, this doesn't change my conclusion about Mrs C making a misrepresentation when answering the question about her latest HbA1e result when applying for the second policy.

Did Mrs C make a 'qualifying' misrepresentation?

Looking at the underwriting information provided by L&G I'm persuaded that had Mrs C answered this question correctly, it would've declined offering the second policy to Mrs C. So, by answering it incorrectly, I'm satisfied Mrs C made a 'qualifying' misrepresentation.

L&G has concluded that Mrs C was careless when answering this question incorrectly and, again, I think that's reasonable. As set out above, CIDRA says if a qualifying

misrepresentation is careless, an insurer can do what it would've done if the misrepresentation hadn't occurred.

As I'm satisfied that L&G wouldn't have offered the second policy at the time, I'm satisfied it's acted fairly and reasonably by voiding the policy. And as the policy wouldn't have been in place, I'm satisfied that it's fairly declined the claim and offered to refund the premiums paid for the second policy.

The handling of the claim

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

L&G accept that there were some delays in assessing the claim and it ought to have provided better service on occasions. It's paid £750 compensation in total. I think that sum fairly reflects the impact of its errors in this case, including the frustration, upset and trouble caused chasing for updates.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mrs C to accept or reject my decision before 19 December 2024.

David Curtis-Johnson
Ombudsman