DRN-5205610

Financial Ombudsman Service

The complaint

Mr M's complained that Legal and General Assurance Society Limited ("L&G") cancelled his and his late wife's joint life insurance policy from the outset and refused to pay the claim he made following his wife's death.

What happened

Mr and Mrs M bought a joint life policy from L&G in 2005. In 2016, they were contacted by a financial adviser who offered to help them assess whether that policy still met their needs. Following this, Mr and Mrs M completed an application for a new joint policy to replace their previous one. Their application was accepted and the term started in summer 2016.

Mrs M had had several ongoing medical conditions for a number of years. Sadly, these progressed and she died in autumn 2022. Mr M made a claim on the policy.

L&G assessed the claim and declined it. They said that Mrs M hadn't answered the medical questions - which formed part of the application – accurately. If she'd done so they wouldn't have offered cover. L&G said this entitled them to decline the claim and retain the premiums Mr and Mrs M had paid. But they offered to refund the premiums.

Mr M complained about L&G's decision. He said Mrs M hadn't answered any questions inaccurately. L&G didn't uphold his complaint. So Mr M brought it to our service.

Our investigator reviewed all the information provided by both parties and concluded L&G didn't need to do any more to resolve the complaint. She was satisfied that L&G had dealt with the matter in line with the Consumer Information (Disclosure and Representations) Act 2012 (CIDRA) – which sets out how insurers should deal with policies and claims in cases where a customer makes a misrepresentation.

Mr M didn't agree with the investigator's view. And he said L&G had shared his and Mrs M's personal information with the financial adviser, but later denied it, hadn't followed guidance set out by the Association of British Insurers (ABI) about genetic testing and hadn't properly checked the application when it was made in 2016.

Because Mr M didn't agree with the investigator's view, the matter's been passed to me to make 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 that, I'm not upholding Mr M's complaint. I know that will be unwelcome news and I'm sorry about that. I hope it will help if I explain the reasons for my decision.

Misrepresentation

L&G declined the claim and offered to refund Mr M the policy premiums because they said Mrs M had made misrepresentations about her health when she applied for the policy. I know Mr M feels she didn't do that. My role here is to consider whether L&G's conclusions about misrepresentation were reasonable, and in line with the relevant law.

As our investigator explained, the relevant law in this case 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.

At the time of the application in 2016, Mrs M was suffering from both coeliac disease and chronic obstructive pulmonary disease (COPD). And she had Alpha 1 antitrypsin deficiency - a genetic condition which affected her lungs.

L&G say Mrs M misrepresented her health because she didn't disclose she had coeliac disease. She did disclose she had COPD – but L&G say she didn't disclose the extent of the impact this had on her. Nor did she disclose the Alpha 1 antitrypsin deficiency.

I've considered the medical questionnaire which formed part of the application. In relation to coeliac disease, L&G say Mrs M should have answered "yes" to the question:

"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 stomach, oesophagus or bowel, for example Crohn's disease, ulcerative colitis?"*

Mr M has said that Mrs M had suffered from coeliac disease for many years and it was well controlled. I accept that was the case. But that wasn't what the question asked – it asked if Mrs M suffered from any condition in this category. I'm satisfied that she didn't answer that question accurately.

Nor do I think she answered the questions around her respiratory health accurately. Mrs M did disclose she had COPD. As is common in this type of application form, answering "yes" generated a number of follow-up questions. One of these was:

"Has your doctor ever told you that you have Cystic Fibrosis or Alpha1-antitrypsin deficiency?"

Mrs M answered "no" to this question, even though her medical records show she'd been told she had Alpha 1 antitrypsin deficiency several years earlier.

Mr M has said his wife was diagnosed with the deficiency as a result of genetic testing. And the information at the start of the form says the only genetic test result L&G need to know about is a test for Huntington's disease. He's also referred to information contained in the ABI's Code on Genetic Testing.

I've thought carefully about this, but I'm not persuaded this means Mrs M didn't make a misrepresentation. I've looked at the ABI's Code and the notes about it on their website. These make clear that an insurer should not take into account predictive genetic tests (with the exception of Huntington's disease). But it distinguishes predictive tests from diagnostic tests and says of the latter:

"The Code recognises that a diagnostic genetic test is the same as any other diagnostic medical test (such as a blood test). This means you might need to tell the insurance company about the results of a diagnostic genetic test when you apply for insurance."

I'm satisfied Mrs M's notes show her test was diagnostic – and that means it was fair for L&G to ask specifically about it. And I'm satisfied that, by answering "no" to the question about Alpha 1 antitrypsin deficiency, she made a misrepresentation.

In order for a misrepresentation to be a qualifying one within the meaning set out in CIDRA, I need to be satisfied that, had the questions been answered accurately, L&G either wouldn't have offered cover, or would only have offered it on other terms.

I'm not persuaded Mrs M's coeliac disease would have made any difference to L&G's offer of cover. The underwriting information shows that they may have referred the issue to their Chief Medical Officer for review but, given Mrs M had had the condition for many years and Mr M says it was well controlled, cover may have been offered on standard terms.

But I am satisfied that Mrs M's answer to the question about Alpha 1 antitrypsin deficiency would have led to L&G declining cover, irrespective of any other answers. So I don't think it's necessary to consider the questions about the severity of her COPD in more detail. And the fact that L&G would have made a different decision on offering cover means that misrepresentation was a qualifying one within the meaning set out in CIDRA.

Finally, I've thought about it was fair for L&G to categorise Mrs M's misrepresentation as deliberate or reckless. I've concluded it was, because she answered a very specific question (about the Alpha 1 antitrypsin deficiency) incorrectly. This was a test she'd had in relation to ongoing treatment and management of her COPD – so I think it's unlikely she would have forgotten about it.

Where a customer makes a deliberate or reckless misrepresentation, CIDRA permits an insurer to decline any claim made and retain the premiums paid. In this case, L&G offered to refund the premiums. While I hope they'd honour that offer if Mr M asks them to, it's more than I can require them to do, having decided their categorisation of the misrepresentation was fair.

Other issues

Mr M has suggested L&G didn't process the 2016 application diligently because they didn't cross check their answers with his and Mrs M's previous application. I've considered this. But not every condition results in an insurer declining cover. When she bought her previous policy, Mrs M only disclosed coeliac disease – which, as I've said above, doesn't mean she wouldn't have been offered cover. She was diagnosed with COPD after she bought the first policy and before she bought the second.

And, while I understand what Mr M has said, it's not reasonable for me to say L&G should check every new policy against any previous policies a customer has. They make clear a customer should take care the information they provide in an application should be accurate and the potential consequences of not doing so. I can't say they should do more.

During our investigation, Mr M has said that L&G misled him when they said they didn't share his details with third parties, as the financial adviser he and Mrs M dealt with in 2016 had got their details from L&G. I've thought about this. But I don't think L&G have done anything wrong here.

The investigator ascertained from L&G that they write to all customers who have policies with them, and whose financial adviser has ceased trading, to introduce them to the financial adviser who contacted Mr and Mrs M. I've seen the detail of the letter L&G sent about this. It introduces the adviser, provides their contact details and tells the customer that, if they don't want to be contacted or have their details shared, they can opt out by letting L&G know.

Mr M has asked how the adviser got his details. But he's not suggested he opted out and his details were passed on anyway. So I don't think L&G did anything wrong here. I can see Mr M has suggested he and Mrs M didn't get appropriate advice before switching their policy, but that's not something L&G are responsible for. Concerns about that would need to be raised with the adviser. But, for the reasons I've set out, I don't think L&G need to do any more to resolve the complaint Mr M's made about them.

My final decision

For the reasons I've explained, I'm not upholding Mr M's complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 21 January 2025.

Helen Stacey
Ombudsman