DRN-5348590

The complaint

H, a limited company and Mrs A, as trustees of the A Trust, complain about the way that Aviva Protection UK Limited (formerly AIG Life Limited) handled a terminal illness claim made by Mr S on the A Trust's life insurance policy.

While Aviva Protection UK Limited is now responsible for complaints about AIG Life Limited, for ease of reading, I've still referred to AIG throughout.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

In February 2020, Mr S, a director of H, took out a life insurance policy through a broker to protect his own life. The contract was underwritten in trust by AIG. The broker passed on details of H's application to AIG. Mr S had declared that he suffered from migraines and took prophylactic medication. Based on the application information given by the broker, AIG offered life insurance cover on standard terms. The policy sum assured was set at £400,000 and AIG charged a monthly premium of £33.23.

Sadly, in 2023, Mr S made a terminal illness benefit claim on the policy after he'd been diagnosed with motor neurone disease (MND).

AIG asked for medical information so it could assess the claim. Based on the evidence available, it didn't think Mr S' condition met the definition of a terminal illness at that particular point. It told Mr S that it would continue to review the claim and the evidence.

And AIG noted that in 2019, Mr S had been diagnosed with a lesion on his brain following an MRI scan and that he was under neurological follow-up. It said that if it had been told about Mr S' brain lesion when he applied for the policy, it would have charged more for the cover. So it concluded Mr S had made a careless misrepresentation under the relevant law. It said Mr S could either opt to obtain a refund of premiums for the policy or it could proportionately reduce the policy sum assured to reflect the price it would have charged for the cover.

Mr S was unhappy with AIG's decision and so he and the trustees of the A Trust asked us to look into this complaint. Mr S said that he'd applied for the policy through the broker alongside another type of insurance contract underwritten by a different insurer. He said he'd amended the medical information for the other policy with the broker to include details of his brain lesion so he'd believed this information would also be passed on to AIG.

Our investigator didn't think AIG had handled this claim unfairly. In summary, she explained that the broker had been acting on Mr S' and H's behalf – the broker hadn't been working on AIG's behalf. She said it had been the broker and Mr S' responsibility to check AIG had the right medical information at application and to check the medical information set out in the policy paperwork. Based on the evidence AIG had provided, the investigator thought it had shown Mr S had made a qualifying careless misrepresentation under the relevant law. So

she thought it was entitled to either proportionately reduce the policy sum assured or to cancel the policy and refund the premiums Mr S and H had paid for the cover.

The investigator also felt that it had been fair for AIG to conclude that Mr S' claim hadn't met the policy definition of a terminal illness at the point Mr S complained. So she didn't think AIG needed to do anything more.

Mr S didn't agree and I've summarised what he said. He didn't think AIG had sent him the policy paperwork after the policy had been sold. He maintained he'd given his broker the correct information and that he hadn't provided any inaccurate details. He felt it would be fairer for AIG to agree to H paying the correct backdated premiums while maintaining the original policy sum assured. He asked for an ombudsman to look at this complaint.

Subsequently, in December 2024, following a further review of Mr S' claim, AIG let us know it was now satisfied that the claim met the policy definition of a terminal illness. And it paid H a proportionate benefit payment of around £273,330.

The complaint was passed to me to decide.

I issued a provisional decision on 5 February 2025, which explained the reasons why I didn't think AIG had handled this claim unfairly. I said:

'First, I'd like to say how sorry I was to hear about Mr S' diagnosis and the impact this has had on him. It's clear this has been a very worrying and upsetting time for Mr S and his family.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst relevant considerations, such as regulatory principles, the law, the available medical evidence and the policy documentation, to decide whether I think AIG handled this claim fairly.

Admission of the terminal illness benefit claim

I've first considered the terms and conditions of the policy, as these form the basis of H's contract with AIG. The policy provides cover for terminal illness claims. But in order for a terminal illness benefit claim to be paid, the claim must meet the definition of a terminal illness. This states:

'Terminal illness - where life expectancy is less than 12 months

A definite diagnosis by the attending consultant of an illness which satisfies both of the following:

- *The illness either has no known cure or has progressed to the point where it cannot be cured; And*
- *In the opinion of the attending consultant, the illness is expected to lead to death within 12 months.*

A claim will be considered where terminal illness is diagnosed and this definition is met at any time up to the day cover ends.'

The policy also defines a consultant as:

'A consultant doctor who:

• specialises in an area of medicine appropriate to the cause of the claim;
• is employed at a hospital in an eligible country,
and
• is treating the person covered for their condition.

All diagnoses made by a consultant must be confirmed by our Consultant Medical Officer.'

In October 2023, Mr S' treating consultant completed a medical report. The form specifically asked what, in the consultant's opinion, Mr S' life expectancy was likely to be and on what basis their opinion had been reached. The consultant answered: 'Variable. Mean survival 2-5 years.' AIG's Chief Medical Officer (CMO) reviewed the evidence and didn't think Mr S' claim met the relevant definition. Given the consultant's evidence, I don't think it was unreasonable for AIG to conclude that Mr S' claim didn't meet the definition of a terminal illness because it didn't seem he had a life expectancy of less than 12 months.

Subsequently, after the terminal illness claim was initially turned down, the treating consultant completed a new form, dated January 2024. The consultant stated that Mr S' life expectancy was less than 12 months. They said: 'Symptoms started 2021. Progressive.' AIG didn't think the report went far enough to explain why the consultant's opinion of Mr S' prognosis had changed, so it asked the consultant for more information. In the circumstances, I think this was fair, given I think there was a marked change in the consultant's view of Mr S' condition.

The consultant responded to say: 'median survival is less than 12 months. Progressive weakness of his arms and legs and has PEG inserted in Dec 2023.'

AIG's CMO went on to re-review the claim. They felt the consultant's evidence was more generic than patient specific. And they didn't think there was enough evidence of markers of severe disease progression - such as loss of bulbar tone or the need for non-invasive ventilation - to show that Mr S' illness met the definition of a terminal illness at that point.

In my view, the evidence indicates that AIG did assess the claim in line with the policy terms and it sought the opinion of its CMO. Based on the CMO's comments, in addition to the consultant's evidence, I don't think it was unfair for AIG to conclude that Mr S hadn't shown the definition of terminal illness had been met. Nonetheless, AIG agreed to keep the claim under review, as I'd reasonably expect it to do and it continued to assess medical evidence.

As I set out above, in December 2024, AIG accepted the terminal illness definition had been met. And so it settled Mr S' claim proportionately. Mr S thinks the claim should be paid in full though, so I've next considered whether I think the claim has been settled fairly.

Was it fair for AIG to pay the claim proportionately?

When assessing this case, AIG applied the provisions of The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). 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 CIDRA says that 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.

While AIG applied CIDRA to the circumstances of this claim, strictly, this wasn't a consumer insurance contract as it was taken out by H – a limited company. So the relevant law in this case would be the Insurance Act 2015. The Insurance Act 2015 states that before a contract of insurance is entered into, the insured must make a 'fair presentation of the risk' to an insurer.' The Act says:

'A fair presentation of the risk is one—

> *(a) which makes the disclosure required by subsection (4),*
> *(b) which makes that disclosure in a manner which would be reasonably clear and accessible to a prudent insurer, and*
> *(c) in which every material representation as to a matter of fact is substantially correct, and every material representation as to a matter of expectation or belief is made in good faith.*

(4) The disclosure required is as follows, except as provided in subsection (5) —

> *(a) disclosure of every material circumstance which the insured knows or ought to know, or*
> *(b) failing that, disclosure which gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances.'*

In my view, the Insurance Act 2015 places more onerous obligations on a potential insured than CIDRA. And strictly, AIG was legally entitled to apply the provisions of the Insurance Act 2015 when it considered this claim. However, as I explained above, AIG has applied what I consider to be the more generous legal principles set out in CIDRA when it settled this claim. So, based on the very specific facts of this complaint, I think it's fair and reasonable for me to apply the principles set out in CIDRA to the circumstances of Mr S' claim, taking into account the stricter obligations on H set out in the Insurance Act.

When Mr S took out the policy through a broker, he was asked a number of questions about his health and his circumstances. AIG used this information to decide whether or not to offer H a life policy and if so, on what terms. AIG says that Mr S didn't correctly answer some of the questions he was asked during the application process. This means AIG thinks Mr S failed to take reasonable care not to make a misrepresentation when he applied for H's policy. So I've considered the available evidence to decide whether I think this was a fair conclusion for AIG to reach.

I've looked closely at the application form Mr S' broker sent to AIG to understand the questions Mr S was asked during the sales process. AIG considers the following questions were answered incorrectly:

- *'Have you received or been advised to have any medical investigations, scans or blood tests in the last 5 years? (You do not need to tell us about common colds, contraception prescriptions, cold sores, ear syringing, hayfever, holiday jabs, ingrowing toenails, influenza, tonsillitis, wisdom teeth or regular well-man/woman checks where the results were all normal. You also do not need to tell us about normal pregnancies and childbirth, but must let us know about pregnancies with complications including but not limited to high blood pressure and sugar and/or protein in your urine.)*

- *Are you under routine medical review or awaiting a consultation with a specialist for any medical condition? (Examples can include but are not limited to all expected visits to your GP, a hospital doctor, consultant, psychiatrist, therapist or other visit to a clinic.)*

- *Have you ever had a brain scan? (for example an MRI or CT scan)'*

In my view, these questions are worded in a clear, specific and understandable way and ought to have prompted Mr S to understand what information AIG wanted to know. The application form shows that the answer given to each of these questions was no. AIG considers that the answers to each of these questions should have been yes. So I've gone on to look at Mr S' medical records to consider whether I think these answers were inaccurate.

From those medical records, it's clear that in 2019, Mr S was diagnosed with a brain lesion, following a referral to neurology and an MRI scan of his brain. He was under the care of neurology and he did have some follow-up, although this was impacted by the Covid-19 pandemic. It seems to me then that Mr S was fully aware of his diagnosis and the medical treatment he'd received. As such, I'm satisfied that the answers given to the questions I've set out above were incorrect and that there was non-disclosure of medical information.

Mr S says that he did give the broker accurate information about his health. He's provided evidence of information about his conditions which he gave the broker. But this information relates to a separate contract of insurance he took out at the same time as this policy with an entirely different insurer. I understand Mr S may have believed the broker had passed on this information to AIG when it sent the updated information on to the other insurer. But there's no evidence that the broker did provide AIG with any updated information about Mr S' health or that the broker told AIG about Mr S' brain lesion and MRI scans. And as the broker wasn't acting on behalf of AIG, AIG isn't responsible for any acts or omissions on the broker's part. In this case, the broker was acting as Mr S' and H's agent. So any complaints about anything the broker may or may not have done when the policy was taken out and any resulting consequential losses would need to be made directly to the broker.

I've next gone on to consider whether AIG has shown that under the principles set out in CIDRA, Mr S' misrepresentation was a 'qualifying' one. The Insurance Act requires there to be a 'qualifying breach'.

AIG has provided us with confidential underwriting evidence which shows that if it had known about Mr S' brain lesion and MRI scan, it would have charged significantly more for the policy. Instead of £33.23 per month, it would have charged H £48.63 per month. As such then, I find that the failure to answer AIG's medical questions correctly did impact upon its view of the risk insuring Mr S' life posed to it. I'm therefore satisfied the misrepresentation was a qualifying one.

Under both CIDRA and the Insurance Act, an insurer may categorise a misrepresentation as careless or deliberate or reckless. AIG categorised Mr S' misrepresentation as careless. In my view, this was a fair categorisation by AIG, in the circumstances. Both the Insurance Act and CIDRA say that in cases of careless misrepresentation, an insurer may rewrite the policy as if it had all of the information it needed to know at the outset. If the insurer would have entered into the contract, but would have charged a higher premium, the insurer can proportionately reduce the amount to be paid on a claim. Both Acts say:

'Reduce proportionately means that the insurer need pay on the claim only X% of what it would otherwise have been under an obligation to pay under the terms of the contract… where X = Premium actually charged / higher premium x 100.'

In this case, now AIG is satisfied that Mr S has shown he has a valid terminal illness benefit claim, it's settled the claim proportionately. It's provided me with its settlement calculation, and I find it's settled the claim in line with the methodology I've set out above. On that basis, I think AIG has already settled Mr S' terminal illness claim fairly and reasonably. And so I'm not intending to direct it to pay anything more.

Did AIG send H relevant information?

Mr S says that following the sale, he didn't receive the relevant policy paperwork from AIG which would have shown him that his medical information was wrong. I've considered this point carefully.

AIG has provided us with evidence from its systems that shows copies of H's policy pack, including the application details and an amendment form to complete if anything was wrong, were sent to Mr S at the address we hold for him, as well as to H on 20 February 2020, when the policy was taken out. The application details set out the questions Mr S had been asked and the answers the broker had recorded. So I do think AIG has shown us it sent H the policy paperwork to the correct address details and that therefore, it gave Mr S a fair opportunity to check the application details were correct. And I don't think I could fairly hold it responsible if this information wasn't received.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

Neither party responded by the deadline I gave.

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.

As neither party has provided me with any new evidence or comments to consider, I see no reason to change my provisional findings.

So my final decision is the same as my provisional decision and for the same reasons.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask H and Mrs A as trustee of the A Trust to accept or reject my decision before 28 March 2025.

Lisa Barham
Ombudsman