complaint

Mr T is complaining about IMC Financial Services Ltd ("IMC") because he says it didn't give him appropriate advice when he arranged a life and critical illness insurance policy to cover his new mortgage in 2013. Because of existing health problems that led to some aspects of cover being excluded from his new policy, Mr T says he should have been advised to keep his existing policy and arrange top up cover for the additional borrowing. Instead, he cancelled his first policy and took a new one covering the full amount of his new mortgage.

background

In 2010, Mr T took a life and critical illness insurance policy with PruProtect (now Vitality Life) to cover his mortgage. It started in December 2010 and provided cover (starting at £160,000) that decreased each year through the term of 25 years. The policy started on 23 December 2010, cost £25.22 per month, and didn't have special conditions or exclusions.

In 2013/14, Mr T increased his mortgage borrowing to £300,000 over a fresh term of 25 years. Following discussions with an adviser representing IMC, he took a new decreasing life and critical illness policy (also with Vitality) providing cover starting at £300,000 for a term of 25 years. The original quote estimated this would cost £54.97 per month on normal terms.

By the time the policy started on 24 January 2014, and as a result of health issues Mr T disclosed in his application, the cost of life cover was rated, increasing the monthly premium to £65.64. Also, a special exclusion was added to the critical illness cover, which said:

> *No Serious Illness Cover will be payable under this Plan for any illness or incapacity arising directly or indirectly from:*
>
> *- Any disease or disorder of the urogenital tract or kidney or any complications thereof.*

The policy continued despite these changes and replaced Mr T's original 2010 policy, which Vitality has confirmed was cancelled in January 2014.

I issued my first provisional decision, an extract of which is attached, on 17 December 2018. This set out the reasons I was proposing to uphold the complaint and some initial thoughts on how IMC should put things right. IMC responded to say it didn't agree with my provisional decision, but made an offer of £35,000 to settle the complaint.

I issued my second provisional decision, an extract of which is also attached on 1 February 2019. I addressed the concerns IMC had raised about my decision to uphold the complaint. I also said I felt, based on the medical evidence available at the time, that its offer seemed fair.

IMC said it accepted the outcome proposed in my second provisional decision, but also made the following key points:

- How can Mr T, years later and with the benefit of hindsight, pursue a claim against any of the parties involved in the decision-making when he had the ability and time to make a fully informed decision but chose to ignore the advice provided?

- The adviser, the product provider, the GP and most importantly, the customer are all involved in the decision-making process and it's unfair that I'm proceeding in the way I am. IMC's role was to provide advice, not make decisions for Mr T. The original advice was suitable based on what was known at the time the application was made. The adviser also discussed the different options with Mr T after Vitality applied the exclusion. Mr T has disputed this because it suits his complaint, which has been brought solely with the benefit of hindsight.

- Once Vitality decided to amend the terms of the policy, it wrote to Mr T with details and suggested he speak to his GP. Mr T failed to do so, despite IMC advising him to and having 71 days before the policy started to do so. At best this was irresponsible. For confidentiality reasons, the adviser couldn't contact his GP to discuss his condition directly, so responsibility should rest with Mr T in this situation.

- There are a number of points where I've taken Mr T's side in interpreting the facts or where there's no written evidence. If I choose to change my decision or find further in Mr T's favour, it planned to request an oral hearing of the case so it has the opportunity to question Mr T and highlight the inconsistencies in his position.

- This is an incorrect decision that could have serious repercussions in the future, every time a customer dislikes a decision they previously made. I've shown an extremely unjustified level of deference to Mr T, at the expense of honest professionals.

Mr T didn't accept my second provisional decision and obtained a report from a consultant nephrologist, Professor C, to support his view that the compensation payment should be higher.

After reviewing Professor C's report, I felt it indicated Mr T's condition is deteriorating more quickly and he's likely to reach the point where he would have been able to claim on his 2010 policy much sooner than previously suggested. As a result, I wrote to IMC (with a copy to Mr T) on 14 March 2019 setting out a different proposal for resolving the complaint. An extract from this email is attached.

In summary, I proposed IMC place money equivalent to the current critical illness benefit on the 2010 policy - if it was still in force - into an escrow account or similar arrangement overseen by an independent third party. That third party would then be able to pay the appropriate amount to Mr T if and when he reaches the point where he would have been able to successfully claim on the 2010 policy for something that isn't cover by the policy that replaced it in 2014. Any money that isn't claimed by Mr T could then be repaid to IMC in line with the reductions in the policy sum assured and at the end of the term if applicable.

I also provided IMC with details of the procedure for oral hearings. I invited it to request a hearing if it wanted to and to explain why it felt this would be beneficial and the issues it would want to raise, so I could consider whether it's appropriate to hold one.

IMC responded to say it no longer wishes to pursue an oral hearing due to the further delay and inconvenience this would cause Mr T. It said it had considered my suggestion of an escrow account, but foresees a number of practical impediments, in particular finding a suitable custodian and then agreeing the complexities of the arrangement to determine who receives what and when, and also the onerous administrative costs.

IMC said it would prefer to agree a lump sum settlement now and is now willing to offer Mr T £50,000. If he doesn't accept this, I should make a final decision essentially saying IMC will pay out if he reaches the point where he would have been able to claim on the 2010 policy for something he's not now covered for, provided the 2014 policy is maintained. IMC confirmed the claim has been notified to and acknowledged by its professional indemnity (PI) insurer, meaning the decision would be enforceable against it in the event IMC is no longer trading at the time.

Mr T said he felt my latest proposals were fair and the he didn't accept IMC's increased offer of £50,000.

my findings

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, it remains my view the complaint should be upheld for essentially the reasons I've outlined previously.

I accept that the advice Mr T received from IMC was suitable up to the point the application was made at the end of 2013 and Vitality made the decision to apply an exclusion to the new policy. This is the point at which I think Mr T should have reassessed the advice and considered the other options available. I accept the adviser didn't have full details of Mr T's health problems. But he knew from the application that he was having tests for issues that could involve his kidneys and from the exclusion, he also knew Vitality thought this was potentially serious enough it didn't want to provide cover. That should have been enough to prompt further discussion. IMC doesn't appear to dispute this.

While IMC hasn't been able to provide any documentary evidence to support the adviser's recollection, I am conscious he says he did contact Mr T to discuss his options, including keeping the 2010 policy. But Mr T disputes this. In a situation where the evidence is contradictory, I need to base my decision on what I think is most likely to have happened.

The ideal outcome in 2014 would have been for Mr T to end up with a policy with no exclusion or rating and that covered him for the full term of his mortgage. This wasn't possible because of his health, so there was a choice to make. Either he could have full cover, including for health problems he'd developed since 2010, for some of his mortgage and a potential shortfall in the last three years. Or he could have partial cover, with claims resulting from his existing health issues excluded, for the full term of his mortgage.

If the adviser had discussed the options in this way, I think Mr T would have chosen to continue his original policy and arrange a top-up for the increased amount of his new mortgage. I say this because he had a potentially serious kidney problem, as confirmed in Vitality's letter to his GP, and the policy still had 22 years to run. I think the prospect of being covered if this condition deteriorated would have been more pressing than the desire to have cover for the last three years of his new mortgage, a potential problem that wouldn't arise for another 22 years, and when the outstanding balance would have been expected to have decreased significantly.

On balance, and taking everything into account, I still think it's more likely the adviser *didn't* discuss the possibility of Mr T keeping his original policy. If he had done, I think that's the option he would most likely have chosen.

The letter Mr T received from Vitality dated 15 October 2013 told him his policy had been offered on *"special terms"* and said:

> *We have written to your GP to explain the reason for our decision. Please contact your GP to discuss this further.*

So I don't think it implied the urgency IMC is now trying to suggest and it certainly didn't say he should contact his GP *"as soon as possible"* as it said in its letter of 1 March 2019.

It's unfortunate Mr T didn't contact his GP at the time. But that doesn't change the fact he was receiving advice and the adviser should have discussed his options with him once the situation changed. If the adviser felt Mr T should speak to his doctor urgently so he could make an informed decision, he should have told him that. But no evidence has been provided from the time to show he did.

I note IMC's comments about the complaint being made with the benefit of hindsight. But the key issue with hindsight is that I mustn't rely on it when making my decision and I'm satisfied I haven't. My view that the advice given to Mr T wasn't suitable is based on information that was available to the adviser at the time.

I don't think this decision has wider consequences in the way IMC has suggested. Each complaint has to be assessed on its own merits and this decision isn't intended as any sort of precedent for other complaints we may receive in future. If I felt the evidence demonstrated the adviser had given suitable advice, which would have involved reconsidering his original recommendation after Vitality's underwriting decision and discussing Mr T's options with him so he could make an informed decision about how to proceed, the outcome would likely be very different.

putting things right

The aim of any award I make is to put Mr T in the position he'd be in if he'd received suitable advice in 2013/14. In this case, I think he would have opted to continue with his 2010 policy and take a second policy for the difference between the cover it provided and the amount of his new mortgage. As discussed before, it's now not possible to set up policies on these terms because of his health. Since Mr T has rejected IMC's offer of a cash sum to settle the complaint now, I'm looking to find a practical alternative that makes sure he receives any money he may have become entitled to on his 2010 policy at the correct time.

I thank IMC for the comments in its most recent letter of 31 March 2019. But after serious consideration, I don't think the alternative suggestion made is appropriate in the circumstances. This is because I can't be certain IMC will still be trading and in a position to pay out if and when Mr T needs to claim. I note what it's said about its PI insurer. But the ombudsman service doesn't have jurisdiction over that business and we wouldn't be able to do anything to ensure it met Mr T's claim should that become necessary in future. Further, my decision is only enforceable against IMC. While I'm sure this proposal was made with the best of intentions, I can foresee that its application could prove problematic for Mr T at a time when he will presumably be seriously unwell.

On balance, I still believe the best way to resolve this complaint is for IMC to pay an amount equal to the current sum assured on Mr T's 2010 policy (if it was still in force) into an escrow account or similar custody arrangement. This would mean an independent third party held the money and paid Mr T at the correct point in the future if certain conditions are met.

I believe the escrow account or similar custody arrangement should be set up on the following terms:

- With money to be paid to Mr T if and when his kidney condition deteriorates to the point where he would have been able to claim on the 2010 policy. This would be determined by Vitality as it has offered to do, and the amount payable would be equal to what Vitality would have paid on that policy. I'd only expect this arrangement to pay out for a critical illness claim that's excluded by Mr T's new policy but that would have been covered under the 2010 policy.

- The 2010 policy had a decreasing sum assured, so the amount Mr T would have been able to claim will decrease over time. To account for this, the arrangement could be set up to facilitate a payment back to IMC each time the sum assured would have decreased, equal to the amount it would have decreased by. That way the third party would never be holding more money than it would need to pay Mr T if he qualified for the full benefit.

- If there's money remaining with the third party when the policy would have ended (either at the end of the term in 2035 or on his earlier death) and there's no outstanding claim, the remaining money deposited with the third party should be returned to IMC in full.

- The 2010 policy was a severity-based plan, so claims don't automatically lead to payment of the entire sum assured. To accommodate this, the arrangement should be set up to only pay the part of the sum assured Mr T would have been eligible to receive. In the event of a partial claim, the policy was structured so the remaining sum assured would be retained to be paid in the event of a future claim. To replicate this situation, in the case of a partial claim the third party would simply need to retain any money not paid to Mr T. The balance would either then become payable if his kidney condition deteriorates further leading to another claimable event, or be returned to IMC when the policy would have ended.

- IMC would be entitled to any interest payments due on the money held by the independent third party.

It would be for IMC to pay all costs involved in setting up and administering the escrow account or similar arrangement.

I'm not recommending a particular third party to run the escrow account or similar arrangement, but clearly that party needs to be entirely independent from IMC and Mr T. Preliminary searches show there are a number of companies offering escrow accounts in the UK and that at least some of these are registered with the Financial Conduct Authority. I think the third party used should be appropriately authorised to provide security for both IMC and Mr T.

For this type of arrangement to work effectively, it will be helpful to obtain assistance from Vitality. Both to confirm how the sum assured would reduce to determine the amount of any payments IMC will be entitled to reclaim from the third party over time. Also, to assess a hypothetical future claim and confirm whether it would have been paid if the 2010 policy was still in place and what proportion of the sum assured would have been due. Fortunately,

Vitality has confirmed it's willing to assist with this. If things change and it ultimately proves unwilling or unable to do that, we may be able to help further at the time.

This is the best solution I can currently think of that will mean Mr T isn't disadvantaged and that IMC doesn't pay more than it needs to. As a result I think it represents a fair and reasonable outcome.

additional compensation

As I've set out previously, I also think IMC should:

- compensate Mr T for the fact he's been overpaying by £5.08 per month by refunding each monthly overpayment in full between the date the 2014 policy started and the date compensation is paid. It should add simple interest at 8% per year to each amount being refunded from the date of the overpayment to the date compensation is paid. Income tax may be payable on the interest; and

- pay an additional sum of £750 to compensate Mr T for the significant and unnecessary trouble and upset he's been caused at an already difficult time.

my final decision

My final decision is that I uphold this complaint.

If Mr T accepts my decision, IMC Financial Services Ltd must put things right using the method set out above. It should make sure it engages positively with Mr T in arranging the escrow account or similar custody arrangement and make sure he has full details so he can check it's set up on the terms I've proposed and knows who he needs to contact to make a claim in future.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 14 June 2019.

Jim Biles
ombudsman

extract from email dated 14 March 2019:

As you seem to be already aware, Mr T rejected my provisional decision and made further submissions. I've enclosed this information for your reference, which includes:

- an email from Mr T dated 5 February;
- a further email dated 22 February; and
- the attached report from a consultant nephrologist he recently consulted, Professor C, dated 20 February.

I've noted the comments in your recent letter, but it remains my view the complaint should be upheld for the reasons I've explained previously. I will specifically address your latest comments and any further submissions you wish to make subsequently, most likely in my final decision.

The purpose of this letter is to propose an alternative method for resolving the complaint. I felt the solution I recently proposed was broadly fair based on the information I had at the time. But after reading Professor C's report, it seems a situation where Mr T would likely to be able to claim on his originally policy if it was still in force is now more likely and imminent than the medical evidence that was submitted previously suggested. Professor C's comments actually indicate a claimable event is quite likely at some point in 2020, at which time the sum assured on the policy would have been in excess of £120,000.

With this information in mind, I now feel a settlement figure of £35,000 is likely to prove inadequate and I've given the matter further thought. The ideal solution here is one that makes sure Mr T receives all money he would have been entitled to on his original policy at the correct time. I think the following alternative could effectively achieve that.

My proposal is for IMC to pay amount equal to the current sum assured on Mr T's 2010 policy if it was still in force. According to the figures Vitality provided previously, that would be somewhere in the region of £130,000. But rather than pay that direct to Mr T, to instead pay it into an escrow account or similar arrangement. An escrow account is essentially an arrangement where an independent third party holds money on behalf of the donor (IMC in this case) to be paid to the recipient (Mr T) in the future when certain conditions are met.

In this case, an agreement could presumably be set up so the third party paid the money to Mr T if and when his kidney condition deteriorates to the point where he would have been able to claim on the original policy. If this doesn't happen before the policy would have ended (either at the end of the term in 2035 or on his earlier death), the money deposited with the third party would be returned to IMC.

I'm conscious the 2010 policy had a decreasing sum assured so the amount Mr T would have been able to claim will decrease over time. To account for this, it would make sense for the escrow or similar arrangement to facilitate a payment back to IMC each time the sum assured would have decreased, equal to the amount it would have decreased by. That way the third party would never be holding more money than it would need to pay Mr T if he qualified for the full benefit.

I'm also conscious the 2010 policy was a severity-based plan so all claims don't lead to payment of the entire sum assured. To accommodate this, the arrangement would need to be set up to only pay out the amount Mr T would have been eligible to receive. If he does qualify for part of the sum assured, the policy was structured so the remaining balance would be retained to be paid in the event of a future valid claim. To replicate this situation, in the case of a partial claim the third party would simply need to retain any money not paid to Mr T. The balance would either then become payable if his kidney condition deteriorates further leading to another claimable event, or be returned to IMC when the policy would have ended.

To be clear, I'd only expect this arrangement to pay out for a critical illness claim that's excluded by Mr T's new policy but that would have been covered under the 2010 policy. As far as I can see, he's

covered for broadly the same other illnesses under the replacement policy he took in 2014. By way of a reminder, the exclusion in the replacement policy read as follows:

> *No Serious Illness Cover will be payable under this Plan for any illness or incapacity arising directly or indirectly from:*
>
> *- Any disease or disorder of the urogenital tract or kidney or any complications thereof.*

It's my understanding that escrow account holders sometimes pay interest on money they hold for the parties and I'm satisfied IMC would be entitled to any and all such interest payments in this case.

For this type of arrangement to work effectively, it will be necessary to obtain assistance from Vitality. Both to confirm how the sum assured would reduce to determine the amount of any payments IMC will be entitled to reclaim from the third party over time. Also, to assess a hypothetical future claim and confirm whether it would have been paid if the 2010 policy was still in place and what proportion of the sum assured would have been due. Fortunately, Vitality has confirmed it's willing to assist with this.

It's not my place to recommend a particular third party to administer the escrow account or similar arrangement. But preliminary internet searches show there are a number of companies offering this service in the UK and that at least some of these are registered with the Financial Conduct Authority. I think it would be correct to use an appropriately authorised third party to provide security for both IMC and Mr T.

I assume there would be a cost for setting up and administering the kind of arrangement I'm talking about. If so, I think it's reasonable to expect that cost to be paid in full by IMC.

As I've said before, I'm happy to consider any alternative proposals the parties put forward. I'm also particularly interested to hear if IMC anticipates it won't be possible to set up an arrangement on the terms I've described. And of course the reasons it thinks that.

This is the best solution I can currently think of that will mean Mr T isn't disadvantaged and that IMC doesn't pay more than it needs to. Subject to any further submissions I receive, this is what I'm currently planning to tell IMC it needs to do when I issue my final decision.

I'm conscious that if a claim was paid through an escrow account in the way I've described, Mr T will still have life and critical illness cover for his whole mortgage under the policy he took in 2014 and may ultimately be able to claim more than he would have done if he'd kept his original policy and only taken top-up cover. But I can't currently think of a sensible way to account for that fully. That said, I think limiting an escrow account to pay out only for conditions that were excluded in 2014 minimises the risk of that situation occurring. And assuming Mr T continues paying premiums for his 2014 policy, he will actually be paying the premiums required to entitle him to a future benefit.

In my previous provisional decision, I recommended additional compensation for the additional premiums Mr T has paid because he took a new policy plus an additional £750 for his trouble and upset. My views on these issues haven't changed and I currently anticipate also telling IMC to pay these amounts in my final decision.

Finally, I note your most recent letter also refers to the possibility of requesting an oral hearing if I'm minded to change the outcome I've proposed previously. It's ultimately for me to decide whether a hearing is appropriate in this case and I've attached a leaflet explaining more about the process. If, after reading my comments above, you wish to request a hearing you should let us know that *as soon as possible*. So I can consider the merits of such a request, I'd also ask that you please explain:

- why you believe a hearing would be beneficial; and
- the particular issues you feel should be explored at a hearing.

To summarise, my current plan is to issue a final decision upholding the complaint for the reasons I've previously explained and that requires IMC to resolve it on the terms I've set out in this letter. If you have any further comments on this, including alternative suggestions or reasons why you think what I'm proposing won't be achievable, please let me know so I can consider things further. Please also let me know *as soon as possible* if you would like to request a hearing as that would need to take place before I issue a final decision.

I would be grateful if you could please let the investigator, Tony Hall, have any further comments, including a hearing request if appropriate, by 12 April 2019 at the latest. If we haven't heard anything from you by that date, I may take that to mean you have nothing further to add and proceed to issue my final decision. If you won't be able to reply by this date, please contact Tony as soon as possible to explain the reasons and we can consider whether an extension is appropriate.

extract from second provisional decision dated 1 February 2019:

I previously issued my first provisional decision explaining why I thought this complaint should be upheld and invited both parties to make suggestions on how it should be resolved. An extract is attached and forms part of this decision.

IMC didn't agree with my view the complaint should be upheld and made the following key points:

- It doesn't agree the advantages of Mr T keeping his original policy and arranging a top-up outweigh the disadvantages of replacing it with a new policy covering the full mortgage amount. It points out that selecting that option would have meant he wouldn't have been covered for the final three years of his mortgage.

- It thinks the complaint has been made with the benefit of hindsight. It says the adviser discussed the options with Mr T so he was able to make an informed decision and he had some time to consider his options. He also had the opportunity to talk to his GP about the reasons for the exclusion applied to his policy and I haven't commented on this.

Nevertheless, IMC said it's willing to offer Mr T £35,000 to settle the complaint. It thinks this is reasonable given the lack of certainty in Dr B's latest comments about when a claim might be necessary and about the exact condition to be claimed for, and therefore the percentage of the policy benefit that could be due.

Mr T has now seen this offer and didn't accept it. He says his kidney function is continuing to deteriorate and that medication hasn't helped. He thinks he'll need a kidney transplant by 2021 at the latest and that IMC should pay him £120,000, based on the benefit that would have been payable on his original policy in that year.

my provisional findings

I note IMC doesn't agree with my reasons for upholding this complaint. It doesn't seem to dispute my view the adviser should have reconsidered his advice after Vitality decided to offer cover on non-standard terms. The adviser says he did discuss the option of Mr T keeping his original policy but, as I've explained before, Mr T disputes this and I haven't seen any documentary or other evidence to support the adviser's account.

The ideal outcome for Mr T in 2014 would have been that he ended up with a policy with no exclusion or rating that covered him for the full term of his mortgage. This wasn't possible because of his health, so a choice had to be made. He could either have full cover, including for health problems he'd developed since 2010, for some of his mortgage and a potential shortfall in the last three years. Or he could have partial cover, with claims resulting from his existing health issues excluded, for the full term of his mortgage.

If the adviser had discussed the options in this way, I don't think Mr T would have chosen to cancel his original policy. I say this because he had a potentially serious kidney problem, as confirmed in Vitality's letter to his GP, and the policy still had 22 years to run. I think the prospect of being covered if this condition deteriorated would have been more pressing than the desire to have cover for the last three years of his new mortgage, a potential problem that wouldn't arise for another 22 years.

Mr T has told us he didn't discuss Vitality's underwriting decision with his doctor and with the benefit of hindsight, it might have been better if he had. But that doesn't change the fact he was receiving advice and the adviser should have discussed his options with him. If the adviser felt Mr T should speak to his doctor so he could make an informed decision, he could have suggested that. But I've seen nothing to indicate he did.

On balance, taking account of all the evidence and other submissions received, it remains my view the complaint should be upheld. The remainder of this provisional decision will now focus on how I think IMC should put things right.

putting things right

The principal aim of any award I make is to put Mr T back into the position he'd be in if he'd received appropriate advice. The circumstances of this case mean it's probably not going to be possible to achieve this as Vitality won't allow Mr T to reinstate the cancelled policy.

For the reasons I explained previously, I think the best way to resolve this is for IMC to pay a lump sum now that's designed to compensate Mr T for the fact he won't have cover on the terms he should have and for the additional worry that causes. It's possible any award on this basis could over or under-compensate Mr T. That depends on whether he develops a condition that would have been covered by the 2010 policy before it was due to end in 2035, although the latest information from his nephrologist does indicate this is likely, and the benefit that would have been left on the policy at that time.

Mr T believes he'd have been making a claim by 2021 at the latest and that settlement should be based on the benefit his original policy would have paid at this time. But after reviewing Dr B's comments, I note she only says it's *"likely"* he'll need a transplant or dialysis in the future. She also says it's difficult to say when that might happen, but that this *"could be within the next few years"*. As his treating specialist, I think Dr B is in the best position to comment on Mr T's condition and I think her prognosis is more positive than his. Given the apparent lack of certainty about how his condition will develop and when a claim might be payable, I don't think it would be fair for me to base a settlement on the 2021 benefit.

Even if we did know the date when Mr T is likely to develop a claimable condition, I don't think the answer is necessarily as simple as awarding the amount his original policy would have paid in that year. There are a number of other factors I also need to take into account and that would have the effect of reducing the compensation due. These include:

- The cover provided by the policy was severity based. That means the amount of the benefit paid for a condition depends on its severity and for many illnesses it pays out less than 100%. In the context of this complaint, this includes acute renal dialysis for example, which qualifies for a 25% payout.

- Because Mr T cancelled the policy and took a new one, he'll still have full cover for the full amount of his mortgage. So if he develops another condition that's covered by his new policy, he'll receive a much higher payout than he would have done if he'd kept his original policy and taken a top-up for the shortfall in 2013/14.

- Mr T will also still have full cover for the full mortgage term, including the last three years. He wouldn't have had that if he'd kept the original policy and arranged a top-up.

- Mr T will be receiving payment in advance of when he might otherwise qualify for it and will have the use of that money in the meantime. For example, it could be used to reduce his outstanding mortgage, thereby saving interest payments, or invested to generate a return. These are not the only options and Mr T should consider taking financial advice before deciding what to do if he accepts my award.

I think it bears repeating that it's not possible to know the extent of any loss Mr T might suffer as a result of the shortcomings in the advice he received. So it could turn out in the future that any award I make ends up either over or under-compensating him. But in view of Dr B's comments, and taking account of the other factors I've listed above, I think the £35,000 IMC has offered is broadly fair based on the information that's currently available.

additional compensation

In my first provisional decision, I also set out that I think additional compensation is due. IMC hasn't commented directly on these issues and I still think the following amounts should be paid.

To compensate Mr T for the fact he's been overpaying by £5.08 per month, IMC should refund each monthly overpayment in full between the date the 2014 policy started and the date compensation is paid. To compensate Mr T for not having the use of this money in the interim, it should add simple interest at 8% per year to each overpayment from the date it was paid to the date compensation is paid. Income tax may be payable on the interest.

To compensate Mr T for the substantial unnecessary trouble and upset he's been caused, IMC should pay an additional sum of £750.

finally

I appreciate neither party will be totally satisfied with the outcome I've proposed. While I currently think it's fair for the reasons I've explained, I am of course happy to consider any further comments or evidence the parties wish to provide before I make my final decision.

I note Mr T recently asked about whether he should be seeking legal advice at this stage. To clarify, my final decision - when it's issued - will only become binding if he accepts it. If he chooses not to accept it, he's free to pursue his complaint by any other means, including through the courts. It's unlikely he'll be able accept my decision and then go to court seeking further redress. So he may want to consider getting independent legal advice before deciding whether to accept my decision.

my provisional decision

My provisional decision is that I intend to uphold this complaint. I currently think IMC Financial Services Ltd should pay Mr T £35,000 plus additional compensation for his overpayments to date, calculated as I've set out above, and a further £750 for his trouble and upset.

extract from first provisional decision dated 17 December 2018:

my provisional findings

When Mr T first discussed his requirements with the adviser and according to IMC, it was assumed a new policy application would be accepted on standard terms. Based on that assumption, I think it was reasonable to recommend he cancel his existing policy and replace it. This ensured he had cover for the full amount of his mortgage for the full term. To have recommended keeping his existing policy and taking a top-up plan for the difference would have meant Mr T didn't have cover for the full amount in the last three years.

But once Vitality had considered the application, the terms of the deal changed. Vitality wrote to Mr T's GP on 15 November 2013 to say the policy had been offered on special terms due to *Glomerulonephritis*. This is a potentially serious kidney problem that can be associated with serious conditions, including chronic kidney disease. The fact Vitality felt it was necessary to exclude critical illness claims relating to kidney issues and charge a higher premium for life cover indicates it felt it was something that at least had the potential to become much more serious.

I realise IMC's adviser didn't see Vitality's letter to Mr T's GP and only knew what had been disclosed in the application – that he'd had protein in his urine and the last time that had occurred was three months earlier. But he would have been aware the terms of the deal had changed and I would have expected him to reconsider the merits of the original advice at that point. It seems clear from his statements and the other evidence provided that the adviser contacted Mr T to discuss the terms on which cover was now being offered. But contrary to IMC's view, I don't think the evidence supports the adviser's recollection, which is disputed by Mr T, that he discussed the possibility of keeping the original policy (issued on standard terms) and topping it up with a new one for the additional amount of the new borrowing only.

The advantage of changing to this approach would be that Mr T had full critical illness cover for at least part of his mortgage and only paid a loaded premium for part of his life cover. I think the adviser should have discussed this option with Mr T in those terms. I don't think the fact he didn't have full details of Mr T's medical issues should have stopped him considering this option and he could have advised Mr T to contact his GP for more information to help him make an informed decision. But given Mr T had a condition that could become more serious and lead to a claim, I think it's most likely he would have opted to keep his original policy if his options had been discussed and he'd been in a position to make an informed decision.

IMC and its adviser have put forward various suggestions about why Mr T might have felt it was better to follow the original advice and replace his policy even after Vitality had made its underwriting decision, but I don't find these persuasive.

First, I accept the option I've said should have been discussed would have meant Mr T didn't have cover for the final three years of his new mortgage. But given he had a repayment mortgage and decreasing cover, the amount of any shortfall in those final three years would have been very low compared to the starting amount of the mortgage. If he'd been able to make an informed decision, I don't think this potential advantage of sticking to the original advice would have outweighed the potential disadvantage of giving up a policy that covered his existing health issues.

Second, IMC has suggested Mr T made his decision partly on price. This appears to be based on the assumption that the new policy, even after the premium was increased, was less than it would have cost to continue with the 2010 policy and arrange a top-up. But according to information we requested from Vitality this assumption isn't correct.

Vitality has said the amount of cover left on the 2010 policy when the second policy started in 2014 was £151,617. That means a top-up policy would have been needed for £148,383 and, taking account of the loading that would have applied, Vitality says the premium for a policy providing this amount of cover would have been £35.34. When added to the 2010 policy premium, that would have

meant Mr T paying a total monthly premium of £60.56 – less than the £65.64 he ended up paying. So if price was a factor as IMC suggests, that would have been another reason for him not to follow the adviser's original recommendation.

Third, the adviser recalls the decision not to continue with the 2010 policy and top it up was partly motivated by Mr T being *"happy with paying just one premium"*. In the context of the decision that needed to be made, I don't think the advantages of paying one direct debit rather than two would have been a particularly important factor.

In conclusion, the evidence shows the adviser and Mr T were aware the policy wasn't offered on standard terms. Once that was established, I think the adviser should have reconsidered his original advice and discussed alternative options, including for Mr T to keep the 2010 policy and arrange a top-up for the additional amount of his new mortgage. Aside from the adviser's recollections, which are directly contradicted by Mr T's account, I don't think there's any evidence to show that happened. If the adviser had discussed Mr T's options in these terms, I think it's most likely he'd have chosen to keep the 2010 policy and would now be in a different position. This is the reason I'm upholding this complaint.

putting things right

There's nothing to suggest Mr T would have had a valid critical illness claim right now if he'd kept his original policy. But I think there's a strong likelihood he'll reach the point where he would have had a payable claim before it was due to end in 2035. The terms and conditions for the 2010 policy show it included cover for a number of kidney-related conditions, including acute renal dialysis, chronic renal impairment, kidney failure and surgical repair of a kidney. And for major organ transplant, including kidneys. In a recent letter dated 12 November 2018, Mr T's consultant nephrologist, Dr B, said:

> *Mr T is a patient under the care of the kidney clinic at XXXX Hospital He has renal failure and nephrotic syndrome, and is likely to require a renal transplant or dialysis at some point in the future*
>
> *It is very difficult to say with certainty the time scale of him requiring either dialysis or a transplant, but given the current rate of decline in his renal function, this could be within the next few years.*

The principal aim of any award I make is to put Mr T back into the position he'd be in if he'd received appropriate advice. The circumstances of this case mean it's probably not going to be possible to achieve this as Vitality won't allow Mr T to reinstate the cancelled policy.

My preferred way to resolve this situation would be for Mr T to have a policy with a different insurer that would fully replicate the cover he should have if he'd kept his 2010 policy with IMC covering the additional cost over and above what he was paying before. Unfortunately, I don't think it's likely other insurers will offer this cover to Mr T in his current state of health. But I'm conscious IMC is an independent adviser with extensive knowledge of different insurers and what they can offer. If it can find an insurer willing to offer comparable cover and provide evidence of this, I'm happy to consider a solution along these lines.

Assuming he can't now get comparable cover, Mr T will probably have to continue with his current arrangements. But that means he won't have any cover for kidney-related problems and isn't the position I think he'd he'd be in if the adviser had discussed the merits of keeping his original cover and taking a top-up policy.

One possible solution to this problem would be for IMC to provide a formal, written undertaking to pay any claim Mr T may have in future that isn't covered by his current policy, but that would have been covered by the one he took in 2010. But I don't favour this as there's no way of knowing IMC will still be trading and in financial a position where it can honour this if and when it needs to do so.

Instead, the only possibility I can currently see is to make an award telling IMC to pay a lump sum compensation amount now that's designed to compensate Mr T for the fact he won't have cover on the terms he should have and for the additional worry that causes.

It's possible any award on this basis could over or under-compensate Mr T. That depends on whether he develops a condition that would have led to a valid claim on the 2010 policy before it was due to end - although the latest information from his nephrologist does indicate this is likely. Because the policy had a decreasing benefit, it also depends on the date when this position is reached. To illustrate, Vitality has confirmed the current benefit on the 2010 policy if still in force would be £134,045. And that for the remainder of the term, this would have been set to reduce as follows:

2019	£129,699.49
2020	£125,048.77
2021	£120,072.50
2022	£114,747.89
2023	£109,050.56
2024	£102,954.42
2025	£96,431.55
2026	£89,452.07
2027	£81,984.03
2028	£73,993.23
2029	£65,443.08
2030	£56,294.41
2031	£46,505.34
2032	£36,031.03
2033	£24,823.52
2034	£12,831.48
2035	£0.00

On balance, I think the evidence shows it's likely Mr T will end up missing out on a significant claim payment that would have become due if the adviser had truly discussed the merits of keeping his 2010 policy as I believe he should have. To reflect that, the compensation IMC needs to pay would also have to be significant.

In deciding how much to award, I'd also need to take account of the following issues that would have the effect of reducing the compensation payment to some extent:

- assuming Mr T does reach the point he would have had a valid claim on the 2010 policy, settling the complaint now means he'll receive payment for this sooner than he would otherwise have done.

- also, Mr T will be left with a policy providing more cover than he'd have if he'd taken a smaller top-up policy as I've suggested. So in the unfortunate event he suffers another illness that's not related to his kidney problem before the policy ends that leads to a successful claim, he'll actually end up receiving more than he would have done otherwise from the policy he still has.

additional compensation

As I've explained above, Vitality has confirmed the total monthly cost of Mr T's current arrangements is more than he would be paying if he'd kept his original policy and taken a difference to cover the shortfall - £65.64 compared to £60.56. So he's been overpaying by £5.08 per month.

To compensate for this, I currently think IMC should refund each monthly overpayment in full between the date the 2014 policy started and the date compensation is paid. To compensate Mr T for not having the use of this money in the interim, it should add simple interest at 8% per year to each overpayment from the date it was paid to the date compensation is paid. Income tax may be payable on the interest.

I'm conscious Mr T will continue overpaying into the future. But it's not certain for how long this will happen. Rather than try to directly compensate for future overpayments, I think it makes sense to take this point into account when deciding on the final settlement figure I've described above.

Finally, I do think the failure of IMC's adviser to provide suitable advice has caused Mr T to suffer considerable and unnecessary trouble and upset. I think the impact of this would have been particularly severe given the health problems he's facing, the amount of money involved and the continued uncertainty he will face. I currently think IMC should make a substantial compensation payment of £750 to reflect this. That's in addition to the lump sum settlement and partial premium refund I've described above.

finally

At this stage, I haven't finalised my view on how much compensation should be paid to reflect the fact Mr T won't now be able to make a claim the medical evidence suggests he probably would be able to make at some point if he'd kept his original policy. I'm interested to hear the views of both parties on the subject, including the amount of compensation they think is appropriate at this stage. I'm also very interested to hear of any alternatives I haven't thought of that might put Mr T back in the right position, particularly if IMC is able to find him appropriate cover elsewhere.

my provisional decision

My provisional decision is that I intend to uphold this complaint. To put things right, I currently believe IMC Financial Services Ltd should pay Mr T substantial compensation because he won't be able to make a claim for future kidney-related issues. I also plan to make a further award for the additional premiums he's paid and the unnecessary trouble and upset he's suffered. I'll finalise my award after both parties have responded to my initial thoughts outlined above.