ABI Code of Practice

Managing Claims Involving Misrepresentation For Individual and Group Life, Critical Illness and Income Protection Insurance Products

July 2023

1 Scope

1.1 This ABI Code of Practice: Managing Claims Involving Misrepresentation for Individual and Group Life, Critical Illness and Income Protection Insurance Products (‘the Code’) covers the continuing appropriate treatment of claims involving a non-disclosure or misrepresentation for UK individual and group life, critical illness, income protection and other long-term protection insurance contracts in the light of evolving industry practice, FCA regulations, the treating customers fairly (‘TCF’) or Consumer Duty regime (whichever is applicable at the time), the approach of the Financial Ombudsman Service (‘FOS’) and the Consumer Insurance (Disclosure and Representations) Act 2012 (‘CIDRA 2012’).

1.2 This Code applies to individual policies and individually underwritten benefits within group schemes, but does not apply to any misrepresentation by employers, trustees or other group scheme owners.

1.3 For the purposes of this Code, any reference to misrepresentation includes the omission of material information that the insurer has asked for.

1.4 This Code covers the appropriate treatment of misrepresentation occurring during the application process and discovered at the point of claim.

1.5 This updated Code was published on 21 July 2023 and is effective from 31 July 2023, and replaces its September 2019 predecessor. This Code replicates most of what was in the September 2019 version, with the majority of changes made to bring it in line with the Consumer Duty which comes into effect on 31 July 2023 for new and existing products that are open to sale or renewal. As the Duty only comes into effect for closed products on 31 July 2024, there will be a period of 12 months during which the TCF regime will remain in force for the customers of these closed products.

1.6 This Code goes beyond the current legal position in a number of material aspects. Compliance with those aspects is voluntary, although firms should be aware that the FOS may determine whether a firm has acted fairly by reference to this Code or its predecessors.

1.7 Insurers should note that this Code does not purport in any way to replace the law or regulations; they must always comply with relevant legal and regulatory obligations when applying this Code, including but not limited to those obligations set out in CIDRA 2012, the General Data Protection Regulation and the Data Protection Act 2018, the Access to Medical Reports Act 1988 (‘AMRA’) and the Access to Health Records Act 1990 (‘the 1990 Act’). The AMRA sets out how insurers obtain medical reports from a treating medical professional for insurance purposes in respect of a living person, and the person’s rights. Where the person has died, the 1990 Act sets out the rights of a Personal Representative and any person who may have a claim arising out of the person’s death, to ask to inspect/have copies of relevant medical records from the holder of the medical records.

1.8 A full review of this Code will take place within three years of its publication. Intermediate reviews may be conducted if a compelling issue is raised, for example a change to relevant law or regulation that affects the current version.

2 The three categories of misrepresentation and associated outcomes

2.1 The three high level categories of misrepresentation and outcomes are set out in the table below.

Category	Explanation	Outcome
Innocent	• The customer has acted honestly and reasonably in all of the circumstances, including the customer's individual circumstances, but only where and to the extent these were known to the insurer. • In the circumstances, a reasonable person would have considered that the information was not relevant to the insurer. • The misrepresentation would have resulted in a different underwriting outcome.	Pay the claim in full
Careless	• Applies where the misrepresentation resulted from insufficient care – the failure by the customer to exercise reasonable care. This includes anything from an understandable oversight, or an inadvertent mistake, to serious negligence. • In the circumstances, a reasonable person would have considered that the information was relevant to the insurer. • The misrepresentation would have resulted in a different underwriting outcome.	Apply a proportionate remedy
Deliberate or reckless	• Only applies where the misrepresentation was deliberate or reckless. • In the circumstances, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. • The misrepresentation would have resulted in a different underwriting outcome.	May avoid the policy (decline the claim and cancel the policy from inception)

3 Assessing Claims

3.1 Customers cannot be expected to provide information that they are not asked for.

3.2 In assessing claims, insurers should consider all of the circumstances, including:

3.2.1 How clear and concise the relevant questions were. Where the insurer has asked a clear question, there will be a presumption that the customer realised that it would be relevant to the insurer. Insurers can expect customers to answer clear questions carefully, accurately and to the best of their knowledge and belief. However, not much weight should be given to 'catch all' or 'memory test questions'.

3.2.2 The sales process and its effect on the customer – for example:

3.2.2.1 Whether or not an intermediary was involved (see 3.4 below).

3.2.2.2 Whether or not the customer had the opportunity to check their answers.

3.2.3 The warnings given and whether these are adequately prominent.

3.3 As far as possible, insurers should always try to understand the reasons for misrepresentation. Where possible, insurers should ask the customer (or the potential beneficiary) about the reasons why the information was incomplete or incorrect before making any judgement about the category of misrepresentation.

Intermediated sales

3.4 Insurers should always try to establish the facts and credibility of allegations that misrepresentation arose as a consequence of failures during the sales process and their effect on the customer, paying special regard to those parts of the process for which the insurer, or those acting for the insurer, is responsible. In particular, where the allegations are supported by credible evidence:

3.4.1 If the intermediary was acting on behalf of the insurer, and information was properly disclosed to that intermediary, then the insurer cannot claim that the information was not disclosed to it.

3.4.2 Whether an intermediary was acting as an insurer's agent in a transaction will depend on the facts and circumstances in each case.

3.4.3 The insurer will always benefit from being able to provide an audit trail – regardless of whether the sale was intermediated – to show that clear questions were asked and understood, and that the customer had the opportunity to check and confirm the accuracy of their answers.

3.4.4 If the intermediary was clearly acting on behalf of the customer, for example, an independent financial adviser, the intermediary (as opposed to the insurer) should be accountable for any misrepresentation resulting directly from the intermediary's action or omission.

Collecting medical information

3.5 Insurers may ask for relevant medical or other information needed to properly assess a claim.

3.6 However, insurers should have a justifiable reason for requesting medical information at the point of claim.

3.7 Accordingly, insurers should only ask for medical information beyond that needed to assess whether the insured event has occurred, or to case manage a disability claim, if and to the extent that the circumstances of the claim reasonably prompt the insurer to believe that there might have been misrepresentation by the customer. In particular, insurers should:

3.7.1 Keep an audit trail of the reasons for requesting medical information (the FOS and the Information Commissioner's Office ('ICO') are likely to be concerned at the use of medical information clearly obtained without a justifiable reason).

3.7.2 Note that an early claim is not a reason by itself (although it may be a relevant supporting factor).

3.7.3 Carefully consider the time period for which it is appropriate to request medical information and the relevant areas that should be investigated and keep an audit trail of the reasons for that time period.

3.7.4 Ensure that claims investigations are consistent with the timely collation of medical information and the need to make claims decisions promptly.

See Annex, example cases 1 to 5 – asking for appropriate medical information

4 Notes on innocent misrepresentation

4.1 Typical characteristics:

4.1.1 The question was not clear enough – any ambiguous wording should be construed in favour of the customer.

4.1.2 The question did not apply clearly to the facts in question.

4.1.3 It was reasonable for the customer to have overlooked omitted information – for example, a minor childhood ailment.

4.2 It is irrelevant whether or not there is a link between the misrepresentation and the cause of the claim.

5 Misrepresentation and inducement

5.1 For the purposes of this section, section 1.2 above and for the rest of this Code, a relevant misrepresentation is one that is made carelessly, or deliberately or recklessly at the time the customer took out the policy and which would have induced the insurer at that time to have applied a different underwriting outcome. For example:

5.1.1 A higher premium would have applied to the policy for the same sum assured;

5.1.2 A lower sum assured would have applied to the policy for the same premium;

5.1.3 Part of the cover would have been excluded for the relevant life assured;

5.1.4 The term of the policy would have been restricted;

5.1.5 The application would have been deferred, for example, pending the outcome of a medical investigation; or

5.1.6 The application would have been declined.

6 Notes on careless misrepresentation

6.1 Includes all cases between innocent and deliberate or reckless.

7 Notes on misrepresentation that is deliberate or reckless

7.1 The overall principle is that the remedy of avoiding a policy from the outset should be confined to the most serious cases of misrepresentation.

7.2 The insurer has the initial burden of establishing whether any case falls into this category on the balance of probabilities. Accordingly, insurers need clear evidence to show this applies.

7.3 This category does not apply where:

7.3.1 Having investigated the matter, the customer has a credible explanation supported by the facts for the misrepresentation having occurred and/or there are other credible mitigating circumstances.

7.3.2 The degree of relevance associated with the misrepresentation is relatively low and, in cases where a premium rating would have applied, the underlying risk premium rating resulting from that misrepresentation would not have been more than +50% (or £1/mil) for the applicable life assured.

7.4 Typical characteristics:

7.4.1 **Deliberate** – in the circumstances, the customer knew, or must have known, that the representation they made in answer to a question was incorrect and knew, or must have known, that the information was relevant to the insurer.

7.4.2 **Reckless** – it is clear that the customer had a complete disregard for the question or the accuracy of the answer when completing the application and must have understood that the information was relevant to the insurer.

7.4.3 **Medical information** – in cases where the misrepresentation was about the customer's medical history or family medical history (as opposed to, for example, about occupation, time spent abroad, the use of tobacco products, alcohol or drugs) insurers should take into account that in some circumstances consumers may not have a full understanding of their or their family's medical history. Accordingly, this category is more likely to apply in the following situations where:

7.4.3.1 misrepresented information is widely known by consumers to be important to the risk of a claim being made (for example, cancer, heart disease, diabetes or, for income protection, periods of time off work as a result of incapacity).

7.4.3.2 misrepresented information concerns recent or ongoing treatment, specialist consultations and/or medical investigations about matters that a reasonable consumer would have understood to be important to their health.

7.4.3.3 the customer has specialist knowledge – for example, someone in the medical profession or relevant parts of the insurance industry.

See Annex, example cases 12 & 13 – misrepresentation of medical information

7.4.4 **Lifestyle information** – since lifestyle information is usually more familiar and easier for customers to understand, it follows that customers should give a particularly credible and convincing explanation for clearly evidenced misrepresentation not to be classified as deliberate or reckless.

See Annex, example cases 14 & 15 – where smoking is not disclosed

7.4.5 **Continuing duty to take reasonable care not to make a misrepresentation** – insurers will need to have a particularly robust case for classifying misrepresentation occurring after the application was completed as deliberate or reckless (that is, when the misrepresentation results from a change of health or other circumstances after the application was completed but before the cover starts).

7.5 **Returning premiums** – when avoiding a policy, insurers will normally return the premiums paid. Insurers may only keep the premiums in cases where there is clear evidence of deliberate or reckless misrepresentation.

8 Menu multi-benefit policies – severable benefits and misrepresentation

8.1 Insurers may not decline a claim as a result of misrepresentation if the misrepresented information was only relevant for the purposes of a severable benefit which is not the subject of the claim.

8.2 For this purpose, for combinations of critical illness and/or income protection and/or life cover benefits in a single policy, the severable benefit types are limited to Total Permanent Disability and Waiver of Premium Benefit.

> See Annex, example case 11 – a claim with misrepresentation that relates only to a severable benefit

8.3 When considering misrepresentation, insurers should take into account the risk warnings given and whether these were adequately prominent – see section 3.2.3 above.

9 A proportionate remedy

9.1 An insurer must apply a proportionate remedy where the misrepresentation is careless.

9.2 The outcome will depend on what the underwriting decision would have been had the misrepresentation not occurred at the time the customer took out the policy, as follows:

9.2.1 **The premium would have been rated** – where the insurer would have offered the same cover but charged the customer a higher premium, the insurer will pay the claim in proportion to the premium that was actually charged. Where the policy was entered into or varied on or after 6 April 2013, the insurer will use the formula set out at Schedule 1, paragraph 8 of CIDRA 2012 or a formula no less generous than this.

> See Annex, example case 6 – applying a proportionate remedy where the premium would have been rated

9.2.2 **An exclusion would have been applied to the cover** – in this case, the insurer will assess the claim as though the exclusion had been applied when the cover started. If the exclusion applies to the claim, no payment will be made. If the exclusion does not apply to the claim, a payment will be made (note: the amount paid may still be less than the full sum assured in cases where a premium rating would also have applied, as above).

9.2.3 **The term would have been restricted** – in this case, the claim will be paid only if it arose within the restricted term (note: the amount paid may still be less than the full sum assured in cases where a premium rating would also have applied, as above).

9.2.4 **The application would have been declined** – in this case, had the misrepresentation not occurred, there would have been no policy at all so the claim will result in no payment. However, the premiums will be returned.

9.2.5 **The underwriting decision would have been deferred or where the decision to defer the cover would have been made** – in this case, insurers should, as far as possible, try to determine what the ultimate underwriting decision would have been (that is, at the end of the deferred period or when the investigation was complete) and apply the appropriate remedy, as above. If it is not possible to work out whether the insurer would have offered any cover, or if the deferral decision would have required the customer to re-apply at a future date, then this should be treated as a decline in 9.2.4 above.

See Annex, example cases 7 to 9 – deferred decisions

9.3 Important considerations:

9.3.1 In applying a proportionate remedy, in principle, no customer should be better off than any other customer who had answered all of the insurer’s questions honestly and with the exercise of reasonable care.

9.3.2 For the purpose of determining the appropriate amount to pay when a higher premium would have applied, proportionality applies at the policy level, for example, where the policy covers more than one person or multiple types of benefit.

See Annex, example case 10 – applying a proportionate remedy to a multi-benefit policy For a joint life policy see Annex, example case 6 – applying a proportionate remedy where the premium would have been rated

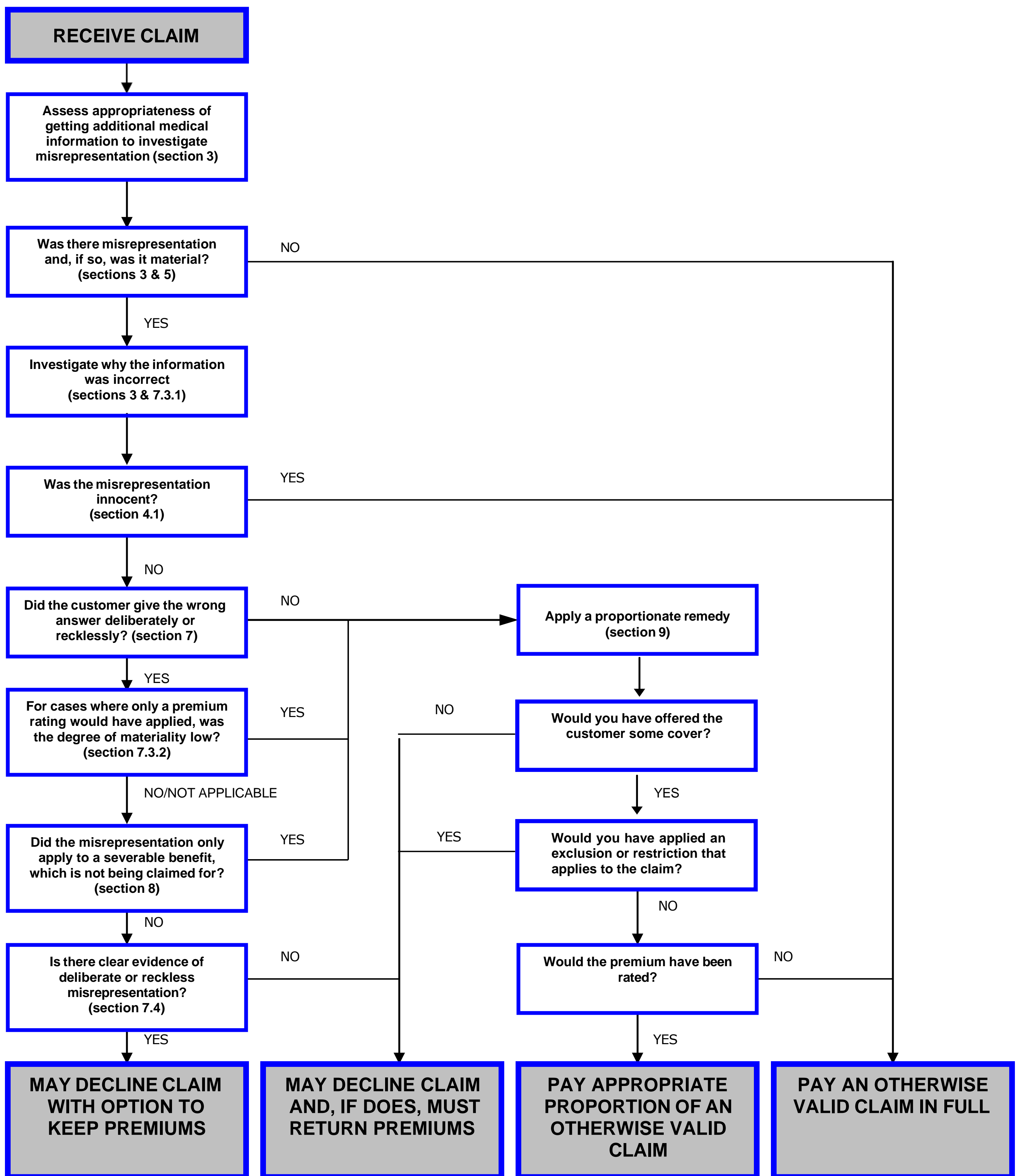
10 Notes on the application of this code for group schemes

10.1 This code only applies to any misrepresentation by individual members of group schemes. It does not apply to any misrepresentation by employers, trustees or other group scheme owners.

10.2 Any misrepresentation by an individual group scheme member should not affect that member’s entitlement to benefits up to the amount of any free cover limit applicable to that member at the time of joining the scheme.

10.3 Any misrepresentation by an individual scheme member should not affect any other scheme member’s entitlement to receive benefits from the scheme.

11 Flowchart for assessing misrepresentation discovered at the point of claim



Appendix – Illustrative Examples

These examples, including the individuals, their policies and the premiums paid, are entirely illustrative to show how an insurer may investigate and treat a misrepresentation, in accordance with this Code. It is unlikely that an insurer will receive a claim that is identical to any of the illustrative examples below. Insurers must therefore arrive at their own conclusions as to whether a misrepresentation has been made, the type of misrepresentation and take their own view on which of the remedies to apply, having regard to this Code, and relevant law and regulatory standards governing their conduct.

Case 1 – asking for appropriate medical information for a benign brain tumour claim

A 42 year old woman makes a critical illness insurance claim for a benign brain tumour after her policy has been in force for a year. The insurer's medical advice is that there is a reasonable likelihood that the woman experienced related symptoms before the policy started.

In addition to asking for all the details relating to the need to assess whether the benign brain tumour definition is met, the insurer, relying on the applicable legislation (see 1.7 above of this Code) asks her GP for a report that includes details of all consultations concerning neurological and related symptoms in the two years before the woman took out the policy. Having considered what symptoms or impairments could be relevant to benign brain tumour, the insurer explains that it is interested in all relevant symptoms regarding development of a benign brain tumour such as loss of coordination or motor control, hemiparesis, numbness, speech difficulties, hearing loss, impairment of vision, intellectual impairment, headache, epilepsy, vomiting. The insurer asks the GP to conduct a review of her medical records, for example, referral letters, etc that relate to any such consultations for the purposes of producing the report and to provide a copy of the key medical records the medical professional referred to (with the woman's informed consent to supply copies of these). This is so that it can get the most accurate picture of what underwriting terms, if any, it would have offered.

If the claim had been for cancer, depending on the site, the potential early symptoms might be too wide in scope for the insurer to list for the GP. The insurer (with the woman's informed consent) asks for a copy of the original medical records over a time period appropriate to the likely onset of the cancer when asking for the GP report.

Case 2 – asking for appropriate medical information in an accidental death claim

A man takes out life insurance and dies less than two years later. The information on the interim certificate of the fact of death leaves the insurer with reason to believe that the customer might have committed suicide, been the victim of an unlawful killing, suffered an accident with no contributory medical factor or suffered an accident with a contributory medical factor. The insurer is at first unable to get further credible information from the Coroner or other sources.

The insurer is keen to avoid delaying settlement of the claim. It wishes to avoid repeated requests for additional information; especially for information that the customer could reasonably say that the insurer was able to ask for earlier in its consideration of the claim.

In some of the potential scenarios, it is likely that the customer would have experienced undisclosed symptoms of a contributing medical condition before the policy started. However, this could involve a wide range of relevant medical conditions or symptoms. In these circumstances, the insurer considers that it is reasonable to request sight of the medical records of the deceased over a time period appropriate to the medical conditions that it has reason to believe may have existed. The insurer relies on the applicable legislation (see 1.7 above of this Code) when it requests sight of the medical records with the agreement of the Personal Representative/person who may have a claim for the insurance monies arising out of the man's death. The insurer also limits the request for sight of the medical records that are directly relevant to the insurance policy claim (including misrepresentation on the application).

Before receiving this medical information, and before the Inquest has been held, the Coroner is able to inform the insurer that there is no evidence to suggest anything other than the customer was the innocent victim of a road

traffic collision and the customer had no contributory medical condition. The insurer should pay the claim and

inform the GP that it no longer needs sight of the medical information.

Case 3 – asking for appropriate medical information in an accidental death claim with an underlying medical cause

A man takes out life insurance and dies less than a year later. The circumstances of his death are such that the insurer believes that he has died in a road traffic collision. The Coroner and post-mortem indicate that the man suffered a heart attack at the wheel of his car.

The insurer therefore has reason to believe that not all questions about the customer's cardiovascular history, and related factors such as family history, weight and smoking history were correctly answered. This includes coronary heart disease, congenital and valvular heart disease, cardiac arrhythmias, hypertension and other circulatory disorders, and their related symptoms, tests and treatment. Relying on the applicable legislation (see 1.7 above of this Code), the insurer requests sight of medical records with the agreement of the Personal Representatives or person who may have a claim for the life insurance monies and writes accordingly to the GP/medical records holder.

The information received from the GP shows that the customer did not disclose a history of angina, related treatment and a relevant family history. However, the information does not enable the insurer to determine whether the misrepresentation was deliberate or precisely what terms it might have offered if there had been full disclosure at the outset. Accordingly, the insurer asks for further clarification of the matters that were not disclosed.

Case 4 – asking for appropriate additional medical information for an income protection claim

A 40 year old woman makes a claim for chronic fatigue syndrome under her income protection policy which she took out six years ago. The insurer asks her GP and her Consultant Neurologist to each produce a report (relying on the applicable legislation referred to at 1.7 above of this Code) on the presentation, functional effects, investigations and effectiveness of treatment regarding her current condition.

The GP report confirms that in the GP's view she is currently incapacitated. The Consultant's report suggests that a neurological investigation revealed no adverse findings. However, this report also refers to episodes of anxiety and depression when she was in her late 20's and early 30's, indicating that the Consultant regarded this as relevant. These episodes were not disclosed when she took out the policy, despite being the subject of clear questions in the application.

The insurer sends a copy of the Consultant's report to the GP and asks the GP for a further report after the GP had conducted a review of her medical records since the age of 25. The insurer (with the woman's informed consent) also requests copies of the medical records relevant to anxiety and depression and symptoms relevant to a later manifestation of chronic fatigue syndrome. The GP's further report shows recurrent episodes of depression, irritable bowel syndrome, stress at work, reports of being tired all the time, treatment with fluoxetine and prozac, as well as time off work for depression in the year before she took out the policy.

Accordingly, the insurer asks her why she did not disclose this information as the next step in assessing her claim.

Case 5 – asking for appropriate medical information for a death claim caused by liver failure

A man dies of liver failure three years after taking out life insurance. The circumstances are such that the insurer has reason to suspect that the claim could reasonably be related to a history of heavy alcohol consumption or drug use that started before the policy was taken out, but was not disclosed.

Accordingly, relying on the applicable legislation (see 1.7 above of this Code) and with the agreement of the customer's Personal Representatives or person who may have a claim for the life insurance monies, the insurer asks the customer's GP/medical records holder for a copy of any medical records relating to the use of alcohol and drugs in the period the insurer had asked application questions before the policy started, together with details of any history of liver disorder such as hepatitis or cirrhosis, or of any metabolic disorder as those symptoms and

disorders were regarded as relevant. The time period asked about is appropriate to the development of the conditions that the insurer has reason to be concerned about.

Case 6 – applying a proportionate remedy where the premium would have been rated

When assessing a man's critical illness claim, an insurer finds that he had incorrectly answered a question about his medical history when he took out the policy, jointly with his wife, several years before. They paid a premium of £50 a month for joint cover of £100,000. The insurer assesses the misrepresentation in accordance with the relevant legal requirements and this Code, and concludes that he had been careless.

If he had given the correct information, the insurer works out that the premium for joint cover of £100,000 would have been £75 a month.

As the claim is otherwise valid and a proportionate remedy is appropriate, the insurer reduces proportionately the amount to be paid on the claim. Using the formula set out at Schedule 1, paragraph 8 of CIDRA 2012, the insurer pays out £66,666.67 (£50.00 / £75.00 x £100,000 = £66,666.67).

Case 7 – where the underwriting decision would have been deferred pending an investigation

A man takes out critical illness insurance and subsequently claims for cancer. In assessing the claim, the insurer discovers that when he took out the policy he failed to disclose that he was waiting for the results of a test for the malignancy of a mole. The insurer assesses the misrepresentation in accordance with the relevant legal requirements and this Code, and concludes that he had been careless.

If the insurer had known about this, it could have deferred the underwriting decision until the result of the test was known. However, on this occasion the test showed that the mole was perfectly normal with no signs of malignancy. In these circumstances, the insurer would have accepted the application on standard terms. Accordingly, in applying a proportionate remedy, the insurer pays the claim in full.

Case 8 – where the underwriting decision would have been deferred subject to a fresh application at an unspecified time in the future

A woman takes out life insurance and subsequently dies of a heart attack. In assessing the claim, the insurer discovers that she failed to disclose that, shortly before she took out the policy, she had made a failed suicide attempt after a significant life event and she was taking treatment for depression. The insurer assesses the misrepresentation in accordance with the relevant legal requirements and this Code, and concludes that she had been careless.

If the insurer had known this, it could have deferred the underwriting decision indefinitely, but would have been prepared to consider a new application for life insurance when she has been free from treatment for at least a year.

In these circumstances, the insurer may argue that it would not have offered any cover at all at the time of her application, nor in the foreseeable future. If it could prove this, the insurer would be able to decline the claim, cancel the policy from inception and, if it did, must return her premiums in full.

Case 9 – where the insurer would have asked for specific tests

A man takes out life insurance and subsequently dies in the early years of the policy. In assessing the claim, the insurer discovers that he failed to disclose GP consultations six months before he took out the policy. At these consultations he reported alcohol-related symptoms, including early morning tremors and a jaundiced appearance. However, there is no evidence that shows the amount of alcohol he was consuming in the period immediately before he took out the policy or that he was advised to stop or reduce his drinking on medical grounds. The insurer assesses the misrepresentation in accordance with the relevant legal requirements and this Code, and concludes that he had been careless. If the insurer had known about these GP consultations, it may have deferred the

underwriting decision until he had taken a liver function test.

Depending on what the outcome of the liver function test would have been (if one had been performed) the underwriting decision might have been any of the following:

- Application accepted at normal rates.
- Application accepted with a higher premium (where the amount of the extra premium would have depended on the actual test result).
- Application declined.

In a case where his medical history while the policy was in-force is consistent with continuing excessive alcohol consumption (for example, death from liver cirrhosis), the insurer may be able to show that the most likely result of the liver function test would have meant that, using the underwriting guidelines applicable at that time, they would not have offered insurance when he applied for the policy. In these circumstances, the insurer would have declined his application and, in accordance with the relevant legal requirements and this Code, the insurer may avoid the policy, decline the claim and, if it did, must return the premiums.

However, if there was evidence of only moderate alcohol consumption after the initial GP consultations, the insurer will need to decide if there is sufficient evidence to allow the insurer to accept the case on rated terms. If it can then in these circumstances, in applying a proportionate remedy the insurer would have to show the terms that are most likely to have been offered and make the appropriate payment.

Case 10 – applying a proportionate remedy to a multi-benefit policy

A man takes out a multi-benefit policy with £100,000 critical illness insurance (CI) and £1,000 a month income protection (IP). The premium he pays is £80 a month. When he took out the policy, he incorrectly answered a specific question about his occupation.

Some time later, he makes an otherwise valid critical illness claim for testicular cancer. After a review of the circumstances of the misrepresentation, the insurer concludes that the misrepresentation was careless and applies a proportionate remedy.

Using the premium rates that would have applied at the time the policy was taken out, the insurer works out that, if he had correctly disclosed his occupation, the premium for the whole policy would have been £100 a month. A premium of £80 a month would have provided £80,000 CI and £800 a month of IP cover. As the CI claim is otherwise valid and a proportionate remedy is appropriate, the insurer reduces proportionately the amount to be paid on the CI claim. Using the formula set out at Schedule 1, paragraph 8 of CIDRA 2012, the insurer pays out £80,000.

Under the terms of the policy, cover for CI ends with the payment of a claim, and the premium for this part of the cover stops. However, as IP is a continuing benefit, the insurer reduces the ongoing IP cover to £800 a month and notifies the customer.

Case 11 – a claim with deliberate or reckless misrepresentation that relates only to a severable benefit

A woman takes out a policy for critical illness insurance (CI) with total permanent disability (TPD) benefit where cover for one of the benefits continues after a successful claim on the other. When she took out the policy she knowingly answered a specific question incorrectly, deliberately concealing an ongoing history of serious back problems. She then makes an otherwise valid CI claim for breast cancer.

The insurer assesses the misrepresentation in accordance with the relevant legal requirement and this Code, and concludes that it was deliberate and reckless.

However, the insurer does not decline the claim because the outcome of the underwriting would only have changed the terms offered for TPD, and not for the main CI benefit being claimed for.

If the back problems had been disclosed, the insurer may have issued the policy at standard premium rates but with an exclusion for back problems for TPD. As this exclusion does not apply to breast cancer, the insurer pays the CI claim in full.

However, as there was deliberate misrepresentation relating to TPD, the insurer may avoid the remaining TPD benefit.

Case 12 – finding out why medical information is misrepresented

A man aged 42 takes out a critical illness (CI) policy for £100,000 for a premium of £40 a month. Some time later he makes a claim for a heart attack.

In assessing the claim, the insurer finds that when he took out the policy he had for several years been taking tablets daily to control hypertension. However, he incorrectly answered a clear question about high blood pressure and a clear question about ongoing treatment. He answered the remaining questions in the application correctly. If he had disclosed his high blood pressure and treatment, the insurer would have charged a premium of £80 a month.

The insurer asks him why he wrongly answered the questions. He explains that he did not consider himself to have had high blood pressure as his pills were effectively controlling it. Further, his doctor had told him that the treatment was “routine” and that his condition was very common for a man of his age and that it was “nothing to worry about”. He did not therefore consider this to be relevant.

The insurer decides that his explanation for the incorrect answer is satisfactory because it fits his medical records and the other circumstances of the case. However, the representation was incorrect and the omission was material.

Taking into account all the circumstances, the insurer gives him the benefit of the doubt. That is, on the balance of probabilities, although he must have known about his condition and treatment, the insurer cannot say that he acted with complete disregard to the truth of his answers. Accordingly, the insurer does not classify the misrepresentation as deliberate or reckless.

Given the questions asked, the insurer may conclude that a reasonable person ought to have known that the representation given was relevant to the insurer. In the circumstances, the customer’s answer to the question about ongoing treatment was not reasonable. Accordingly, the insurer treats his misrepresentation as careless having concluded that it was not innocent.

As the claim is otherwise valid and a proportionate remedy is appropriate, the insurer reduces proportionately the amount to be paid on the claim. Using the formula set out at Schedule 1, paragraph 8 of CIDRA 2012, the insurer pays out £50,000.

Case 13 – where misrepresentation of medical information is deliberate or reckless

A man aged 47 takes out critical illness insurance for £100,000. Two years later he makes a claim for a heart attack.

In assessing the claim, the insurer finds out that when he took out the policy, for a continuous period of three years he had been taking a combination of three types of medication for hypertension. His medical records show that, despite the treatment, his blood pressure had been significantly raised during this period and that he had been to see his doctor at regular intervals to monitor his blood pressure and renew his prescription for treatment. However, he wrongly answered two clear questions in the application about high blood pressure and ongoing treatment. If he had disclosed his high blood pressure and treatment, using the underwriting manual applicable when he took out the policy, the insurer would have applied a risk premium rating of +100%.

The insurer asks him why his answers to the questions were incorrect. He explains that, because he had been taking treatment for many years, he did not consider his condition or the treatment to be important, and that his

blood pressure was controlled by the treatment.

However, contrary to his explanation, the evidence in his medical records shows that his GP had repeatedly warned him about his uncontrolled high blood pressure. Therefore, the insurer may argue that:

- he must have known that his answers were incorrect; and
- he must have known they were relevant to the insurer.

If he had correctly disclosed his condition and treatment, the underwriting outcome would have been a risk premium rating of more than +50%. Accordingly, if the insurer classified the misrepresentation as deliberate or reckless, they could avoid the policy and keep the premiums. However, if the insurer had concluded that the representation was careless, they must apply a proportionate remedy.

Case 14 – where smoking is carelessly misrepresented

A woman takes out a combined (accelerated) life and critical illness insurance policy and declares that she is a non-smoker. Following an otherwise valid claim for cancer, the insurer finds that her medical records show that she was a smoker six months before she took out the policy, and she was also a smoker at the time of the claim.

The insurer asks her why she declared herself to be a non-smoker. She explained that her reason for buying the policy was because she was starting a family. She said she had given up smoking since finding out she was pregnant which was when she took out the policy. The evidence supports this. Her adviser, an employee of the insurer, filled in her application on-line. She recalls that her adviser had only asked her if she was a smoker and not whether she had used tobacco within the preceding 12 months as asked in the application. She accepted that she should have been more careful in checking the copy of the completed application sent to her to review.

In the circumstances, the insurer is likely to accept her explanation as credible given the evidence of the pregnancy as mitigating circumstances and does not avoid the policy. If it does, it will therefore treat the misrepresentation as careless (as opposed to deliberate or reckless) and apply a proportionate remedy.

If she had not been asked to check the application, and as she answered the question asked by the adviser (acting on behalf of the insurer) to the best of her knowledge and belief, there would have been no misrepresentation and the claim should be paid in full.

Case 15 – where smoking is deliberately or recklessly misrepresented

A man applies for critical illness insurance and declares that he is a non-smoker. Following a claim for cancer, the insurer finds that his medical records show that he was a heavy smoker three months before he took out the policy and also after the start of the policy.

The insurer asks why he had declared himself to be a non-smoker but he fails to offer any plausible mitigating explanation. In the circumstances, the insurer may conclude that either:

- he must have known that he was a smoker and, given the question in the application, must have known that this was relevant; or
- he showed no care at all in answering the question about whether he had smoked.

Accordingly, on the balance of probabilities, the insurer may conclude that the misrepresentation was deliberate or reckless. The insurer is therefore able to avoid the policy and keep the premiums