complaint

Mrs L has complained that Liverpool Victoria Friendly Society Limited ("Liverpool Victoria") has rejected her claim for payment of benefit under her Flexible Income Replacement Plan.

background

Mrs L applied for this policy in 2008 and it was issued with effect from October 2008 with an exclusion which stated that no benefit shall be payable in respect of incapacity due to or arising from anxiety state, neurosis, depression or other mental disorder.

Mrs L made a claim under this policy in July 2012 for fibromyalgia, having been absent from work since the middle of June 2012. Her policy had a waiting period of three months before any benefit could be paid.

Initially her GP had completed a GP Claims Report detailing her diagnosis as 'chronic fatigue' and explaining that she had attended a neurologist and that she was originally diagnosed with MS in 2009. Also Mrs L provided a copy of a letter her neurologist had written to her GP in March 2012 which confirmed she had reported a variety of symptoms since May 2009 and he confirmed he did not believe she had MS but that many of her symptoms would fall under the remit of chronic fatigue syndrome.

Liverpool Victoria wrote to Mrs L's GP in July 2012 requesting medical notes and records which related to her first presentation of symptoms which led to her (mistaken) diagnosis of MS and her treatment for this. It also requested the medical notes and records which related to her diagnosis of fibromyalgia.

In response, unfortunately, Mrs L's GP provided Liverpool Victoria with Mrs L's complete medical records rather than the notes relating to the specific conditions Liverpool Victoria had requested.

Liverpool Victoria then read through the entire of these medical notes and records which dated back to 1975. Having done so, it wrote to Mrs L in September 2012 and said that she had not disclosed issues with back pain suffered in 2005 and early 2008, hip pain suffered in 2006 and knee problems also in 2006. It also said she under disclosed the extent of her issues with her mental health as she had overdosed in 1985 and again in 2003. It asked her for an explanation.

Ultimately Liverpool Victoria told Mrs L later in September 2012 that had it been aware of the extent of her issues concerning her back, hip and knee it would not have not offered her any policy when she applied in 2008. It therefore declined to pay her claim, cancelled her policy and returned her payment of premiums to her. Mrs L complained to Liverpool Victoria who maintained its position and she then brought her complaint to us.

The complaint was considered by an adjudicator who upheld it. He did not consider that Liverpool Victoria had any legitimate reason for reading all of any further medical information about Mrs L's medical history as both her GP and her consultant neurologist had confirmed that she had not suffered from fibromyalgia prior to the start of policy cover. By doing so and indeed acting on that information, it had breached a code of practice issued by the Association of British Insurers to ensure that customers were treated fairly.

In addition, the adjudicator considered there had been a breach of guidance issued jointly by the British Medical Institute and the ABI which states, amongst other things, that doctors should only provide relevant information and it was ethically unacceptable to provide extraneous information. It prohibited doctors from sending printouts of full medical records instead of medical reports and in the event they did, ABI members should not accept them. As a result, the adjudicator did not consider that Liverpool Victoria was entitled to rely on the information it had discovered in Mrs L's notes. To resolve the complaint, he asked Liverpool Victoria to reinstate Mrs L's policy and resume its consideration of her claim. He also considered Mrs L was entitled to receive a payment of £200 compensation in respect of distress and inconvenience caused to her.

Liverpool Victoria rejected the adjudicator's findings. It said that the joint BMI/ABI guidance related to the provision of medical information when insurance was applied for rather than when it received a claim. It did not accept that a claim could be assessed simply on the basis that the treating clinicians had placed the relevant medical condition's onset after the commencement of cover. It had noted that both her GP and her consultant neurologist had made reference to Mrs L suffering from chronic fatigue syndrome in their reports and the consultant had also mentioned multiple sclerosis. As a result, it had felt it had a legitimate reason for asking the GP to supply further information about the history of these conditions.

It stated that its intention had not been to check whether there had been any non-disclosure and it was not Liverpool Victoria's fault that it had received her entire medical records from her GP. However, in order to complete its enquiries it had been necessary to examine the information that had been submitted which had brought to light the non-disclosures. It was also significant that these non-disclosures might be directly related to her claim.

It suggested that it might have well come across the information about the undisclosed conditions in any event during its assessment of the claim. For instance, any consultant who was asked to perform an independent medical examination might wish to see Mrs L's entire medical records.

As Liverpool Victoria remained of the view that it had not acted unreasonably in this matter and it asked for the complaint to be reviewed by an ombudsman.

my findings

I have considered all the available evidence and arguments to decide what is fair and reasonable in the circumstances of this complaint.

The issue for me to decide is whether or not it was fair and reasonable for Liverpool Victoria to read through and examine Mrs L's entire medical records that her GP had mistakenly given to it and then base its decision to decline her claim and cancel her policy on the basis of the information it had discovered in those medical records.

Liverpool Victoria had already excluded Mrs L from making any claim in connection with any incapacity due to or arising from anxiety state, neurosis, depression or other mental disorder. Therefore I find that it is immaterial whether or not Mrs L under disclosed the extent of any mental health issues, as she would never have been able to make any claim under the policy for any issue concerning those mental health issues in any event. The relevant guidance produced by the ABI, BMA or both of them jointly provides that both medical practitioners and insurers should only request and/or provide *relevant* information. I find that it therefore follows that insurers should only rely on information that can be considered *relevant*.

Consequently I need to now consider what would be considered relevant in Mrs L's claim. Mrs L's GP stated on the medical certificate he completed in July 2012 that the first time Mrs L was seen by a clinician regarding the condition responsible for her disability was in 2009. Her consultant neurologist stated in his report of March 2012 that Mrs L *"…reports a variety of symptoms since May of 2009…"* Consequently I find that the only relevant information that Liverpool Victoria should only have relied is information from those dates in 2009 and most importantly pertaining to either her mistaken diagnosis of MS; her diagnosis of *'chronic fatigue'*; and/or her diagnosis of fibromyalgia.

However Liverpool Victoria has relied on information pertaining to her back, hip and knee problems from 2005 up to the time of her application in 2008. It has said that had it known of this information it would have excluded any issues with her back, hip and knee. It then says that consequently with the addition of her mental health exclusion, she would have had a total of four exclusions, which would have meant Liverpool Victoria would have declined to agree to insure Mrs L. It has provided evidence from its underwriting manager confirming this.

In its defence of this position, Liverpool Victoria has sought to argue that the ABI Code of Practice and the joint BMA/ABI Guidelines on Medical Information and Insurance does not give guidance concerning the gathering of information at the 'point of claim'. Therefore by implication, without guidance on this point, what it did in reading through all the medical notes furnished by GP was not contrary to the ethos of these industry guidance notes. I disagree.

Both guidance notes are very clear that first, medical practitioners should only provide relevant information and that it is ethically unacceptable for them to provide extraneous information and, secondly that insurers should only have a legitimate reason for requesting information at the point of claim and *'should apply the principles set out in the BMA/ABI guidance'.* In this case I fully accept Liverpool Victoria did not ask Mrs L's GP for the entire number of her medical records. However given that Mrs L's GP did provide all her medical records (presumably by mistake), I do not find that Liverpool Victoria had any right to read through them meticulously and rely on the information contained in them, beyond the 'relevant information' which I have discussed above. I find that this is contrary to the spirit of both guidance notes and therefore I find it was neither fair nor reasonable for Liverpool Victoria to have done this.

Liverpool Victoria also raises the argument that the issues concerning Mrs L's back, knee and hip problems might be linked to her present claim and therefore could well be discovered if any independent medical examiner was instructed to examine Mrs L for the purposes of this claim. I have not explored the reasons why Mrs L did not disclose these problems, as I do not consider it is necessary for the purposes of this complaint. Nevertheless Mrs L should be aware that it is possible that her problems could be legitimately discovered by an independent medical examiner in the further investigation of this claim. This is despite the fact that her symptoms concerning her fibromyalgia and/or chronic fatigue syndrome (and indeed mistaken diagnosis of MS) are clearly documented in her medical records as starting in 2009.

Lastly I find Mrs L has been clearly distressed that her policy has been cancelled and that her claim has not been assessed.

my final decision

For the reasons above, it is my final decision that I uphold this complaint.

I now order Liverpool Victoria Friendly Society limited to do the following:

- reinstate Mrs L's policy and come to a reasonable arrangement with her in order for her to pay the arrears of premium;
- resume its assessment of her claim in accordance with the other terms and conditions of her policy;
- pay Mrs L £200 compensation for the distress and inconvenience she has suffered as a result of its actions.

I make no other order against Liverpool Victoria Friendly Society.

Rona Doyle
ombudsman