DRN-3491866

The complaint

Mr P complains that Standard Life Assurance Limited won't consider a claim under a term assurance policy he held with his late wife.

What happened

Mr and Mrs P met with an independent financial adviser ('*IFA*') in 1999 and agreed to take out the Standard Life policy alongside their capital repayment mortgage. It offered them decreasing term assurance comprising life cover and terminal illness benefit with an initial sum assured of £55,000. The policy started in January 2000.

In June 2005, the policy lapsed after Mr and Mrs P stopped paying for it. Thereafter, Mrs P sadly passed away in 2009.

In 2019, Mr P first complained about the policy. In 2020, Mr P complained again, after having made a subject access request to Standard Life under relevant data protection laws. He did so with the assistance of a representative, Mr M. Mr M said that it had charged Mr and Mrs P an additional underwriting premium and its documentation was misleading as it wasn't clear it was a decreasing term policy. He also questioned whether Mr P may be due a claim payment as he and his late wife could have made a claim in 2005 before the policy ended.

That complaint was later referred to this service, where it was reviewed by one of our ombudsmen. She noted that any concerns about the sale of the policy were a matter for the IFA, not Standard Life. Otherwise, she concluded that matters relating to the documentation and the premium charged were known to Mr and Mrs P in 2000, when they were sent the information from Standard Life. The complaint was therefore been made too late.

The ombudsman did however note that if Mr P had wished to make a claim about Mrs P's illness retrospectively, he'd need to discuss that with Standard Life. So, Mr P liaised with Standard Life between March and August 2021 about a claim.

Standard Life explained that for a claim to be considered it would need evidence showing that Mrs P was diagnosed with a terminal illness and given a life expectancy of less than twelve months before the policy ended in 2005. However, no further evidence was provided.

In September 2021, Mr P raised this current complaint. He explained that he and his late wife were paying for a life illness policy which included cover for all heart conditions. He had suffered from a severe heart condition since 2001, and was sadly diagnosed with a type of cancer in 2015.

Mr M on behalf of Mr P then brought the matter to this service in November 2021, as Mr P had not received a timely reply from Standard Life.

Standard Life apologised for not responding to Mr P's email of September 2021. It said Mr and Mrs P's policy never provided critical illness cover. As the policy ended in 2005 the only claim it could consider - on a concessionary basis - would be a retrospective terminal illness claim. It had already explained how for a claim to succeed it would require evidence to show

that a terminal illness with a life expectancy of 12 months or less was diagnosed before the cover ended in 2005. And Mr P hadn't provided medical evidence of that nature.

An investigator reviewed the complaint but he did not think it should succeed. He said that though there was limited information from the time of the sale, the policy did not appear to have additional critical illness benefit included. So, Standard Life wasn't unfair in being unable to assess a claim. And while Mr P was now suffering with a terminal illness, this did not take place before 2005.

He also noted Mr P had felt Standard Life did not respond promptly to his complaint. Standard Life had agreed and apologised. However, he did not think any compensation was due for the delay, and in the circumstances where Mr P already held information about the policy, an apology was sufficient to account for the delay in replying.

Mr P said he disagreed. He made further written submissions, which I have read in full. In summary, he said:

- this complaint isn't linked to the one he made about Mrs P's illness and should be treated separately;
- the previous ombudsman said Standard Life could take a discretionary view on a claim;
- the subject access request he completed was to obtain medical records for himself;
- in those records, a terminal illness was referred to in 2001;
- he thinks our investigator and service have crossed wires with him – the claim he had made is one of terminal illness, not critical illness;
- our investigator did not put his medical evidence from 2001 to Standard Life;
- this was in direct contrast to the suggestion of the previous ombudsman;
- he thinks the investigator's view was biased in favour of Standard Life;
- under Financial Conduct Authority principles, businesses must treat customers fairly – and our investigator has ignored this;
- instead, Standard Life has made no attempt to resolve his claim and this service has perpetuated that by disregarding it as well.

Mr P also made further written submissions regarding the Financial Ombudsman Service's customer service. I will not repeat those here as they're separate to this complaint matter.

Standard Life had no further comments to make.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having looked at everything carefully, it is my view that this complaint cannot succeed. I know this won't be what Mr P hoped for, but I'll set out the reasons my decision below.

I accept Mr P's point that this complaint is distinct and relates only to his most recent complaint about a claim he could have pursued to Standard Life himself. The basis for references to Mrs P in this decision are where it is necessary to explain the history of the complaint, and the fact that the policy was jointly held by Mr P and his late wife.

The reason our investigator firstly looked at the ability to make a critical illness claim was because in the complaint email to Standard Life of 14 September 2021, Mr M and Mr P set

out that:

> "*I was paying for a life illness policy with extra cover which included cover for heart conditions.*
>
> *I have been unwell with this condition and also have a terminal illness which has only been recently managed due to a misdiagnosis of cancer. I have no strength at times which means I spend a lot of time in hospital.*
>
> *It occurred on: 01/01/2001.*
>
> *This meant that I believe I have been affected with this medical condition which has caused severe heart complications. I feel my cover could have covered this condition.*
>
> *I would like Standard Life to look into this formal registration of the complaint and explain if my policy should have paid out on this*".

An objective interpretation of the complaint statement above reads as if Mr P was referring to critical illness benefit (cover for heart conditions) as that is the main type of personal protection policy taken out for the event of serious illnesses. However, the term assurance policy Mr and Mrs P held with Standard Life did not include critical illness benefit.

Mr P has now clarified that what he meant by his statement was that a terminal illness claim could have been considered, as the term assurance comprised life cover and additional terminal illness benefit.

As the previous ombudsman pointed out, it is possible for a business to consider a retrospective claim under a policy, where it has ended in some circumstances. Standard Life previously told Mr P and Mr M it could agree to this.

I have therefore looked at what the parties' obligations were under the terms and conditions of the policy, up to the time it ended in June 2005. That is the start point. The policy wording under provision 3, entitled '*What we pay on death or terminal illness*' says:

> "***If the policy is in force*** *and terminal illness benefit still applies and*
>
> *(a) we have received satisfactory proof that the life assured has a terminal illness (as defined in (iii) below and subject to policy provisions 8 and 9, and*
> *(b) we have not paid any policy benefits under policy provisions 3(i), 4 or 6(i),*
>
> *we will cancel the policy at the date we accept the claim, and pay the terminal illness benefit shown on the policy schedule.*
>
> *(iii) Terminal illness is defined as:*
>
> *Advanced or rapidly progressing incurable illness where, in the opinion of an attending consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months.*"

I have no reason to question the seriousness of Mr P's condition, and I was sorry to learn of the difficulties he has suffered in obtaining an accurate cancer diagnosis. However, I have not seen any clear evidence to show that before June 2005, Mr P's circumstances met the policy wording above.

This is borne out by the information Mr M set out to Standard Life on his email of 5 March 2001, where he noted that "*in terms of a terminal illness, Mr P also has one now and has been given 1-5 years to live. This diagnosis was over 5 years ago.*"

The intention of a terminal illness payment is an advance payment of a policy's death benefit. For a valid claim under these terms and conditions, it must be found that the policyholder's condition is expected to lead to his or her death within twelve months. Mr P's supplied medical evidence shows his cancer diagnosis came in 2015, and even though I recognise that Mr P has had to take additional legal action in respect of a delayed diagnosis, I do not believe that this extended back before 2005. If it did, there is an absence of medical evidence to show Mr P should have been told before June 2005 that he had less than twelve months to live, based on available medical evidence and treatment options. And to satisfy a claim, Mr P would require that evidence.

I also recognise that Mr P did have a condition of hypertension diagnosed in 2001, for which his GP has written a letter to confirm how Mr P began medication in August of that year. Though Mr M and Mr P have pointed out the seriousness of this diagnosis for Mr P, I have not seen any objective medical information to suggest that this condition was terminal (advanced or rapidly progressing and incurable leading to a reduced life expectancy of less than twelve months as required by the policy) at any time before April 2005.

Though it was originally considering a claim for Mrs P, Standard Life explained clearly to Mr M and Mr P in its email of 4 May 2021 how the term assurance operated. It correctly said "*the purpose of the Terminal Illness Benefit is not to pay out on the diagnosis of a life limiting condition but only once such a condition has progressed, despite treatment efforts, to where the treating consultants can say the person is not expected to survive the next 12 months*".

Standard Life has not been presented with any medical evidence of life expectancy from an attending consultant of Mr P's relating to the period the policy was in force. That is when its obligation to Mr P ended in terms of paying a claim. It therefore hasn't done anything wrong.

I note as an aside that Mr P was concerned that Standard Life did not properly acknowledge this complaint. It was incorrect to do that, and has rightly apologised. I do not, however, believe further compensation is warranted as Mr M has suggested.

Communications began in September 2019 between the parties and these have resulted in a series of complaint matters since then. If a business does not reply within eight weeks of a complaint, a consumer can refer it to our service without any further delay in terms of waiting for a final response. Mr M referred the matter here on Mr P's behalf after the eight weeks had passed.

Though it is frustrating to not receive a timely reply, I find an apology was a fair response to the inconvenience caused to Mr P for an oversight of this nature, in the context of two years of ongoing communications where Standard Life has otherwise been an active participant.

My final decision

I do not uphold this complaint or make any award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P to accept or reject my decision before 5 July 2022.

Jo Storey
Ombudsman