DRN-3642631

The complaint

Mr and Mrs T are unhappy with the way in which The Royal London Mutual Insurance Society Limited trading as Scottish Provident handled their critical illness claim. They say it caused delays and failed to refund premiums paid after the claim should have been settled.

What happened

On 23 August 2021, Mr T made a claim to Scottish Provident for critical illness benefit after he had sadly been diagnosed with a type of cancer. They had held a Pegasus Personal Assurance Plan since March 2003, which was operated by Scottish Provident.

On 25 August 2021, Scottish Provident wrote to Mr and Mrs T and arranged a claim call for 1 September 2021. It also set out that if Mr T had any relevant information about his diagnosis, he should forward it on. It confirmed the policy's sum assured at that date was £36,185.

On 28 September 2021, Scottish Provident wrote to Mr and Mrs T. It said it had written to Mr T's GP and treating consultant on both 1 September and 28 September 2021.

On 8 October 2021, Mr T complained by telephone, and on 21 October 2021 he furthered the complaint by email, noting it had been almost two weeks without acknowledgement. In this email he said he had recently attended hospital and asked if his treating department had heard from Scottish Provident (as it said it had written out for information) but they had not.

Mr T also said that emails had been sent to Scottish Provident on 3 September, 13 September, 1 October and 4 October without reply. Finally he said that though Scottish Provident had noted twice in September 2021 about writing to his GP and consultant, both of them hadn't received the letters and he had to chase the matter himself.

Mr T said he felt obliged to inform others of Scottish Provident's poor service, since he worked in the financial advice sector and understood expected behaviours and standards.

On 4 November 2021, Scottish Provident confirmed it had accepted Mr T's claim under his and Mrs T's policy with effect from 24 August 2021. It confirmed a total payment to Mr and Mrs T of £36,281.86, comprising £36,185 for the claim payment, a premium refund of £67.93 and £28.93 net interest.

On 5 November 2021, Scottish Provident wrote to Mr T noting it had yet to conclude the complaint investigation, but it would write to him within four weeks with an update.

On 3 December 2021, the complaint was rejected by Scottish Provident. It said it was satisfied it had followed a correct process, with appropriate updates. It couldn't explain why Mr T hadn't received emails but they were correctly sent. And Mrs T had received an email during a call of 3 November 2021, so its system had not been failing.

Mr and Mrs T therefore referred their complaint to this service. Mr T supplied a timeline of his actions, and a further explanation of what had happened chronologically. He said that the second claim handler he dealt with had tried to get to the bottom of his and Mrs T's non-

receipt of emails. He also noted how he hadn't blocked emails from Scottish Provident and he would welcome any IT specialist to look at his laptop to check both his private and work emails to prove that this was the case.

He also felt the third claim handler didn't believe that emails and letters were not arriving properly. In his view, Scottish Provident ought to follow up correspondence by telephone, to ensure proper receipt. He finally said that he felt 79 calendar days was an exceptionally long time to settle a critical illness claim and this was only because he chased it the entire way. Scottish Provident did not call him or utilise his two email addresses.

Finally, Mr T questioned the premiums being returned to him. These were collected on 11th of each month and they had paid them in advance, in August, September and October, but Scottish Provident was only proposing to return one premium in its claim payment.

Mr T also made a separate referral to the Financial Conduct Authority ('*FCA*'), to explain that he felt Scottish Provident had systemic failures in relation to its claim handling procedures.

Our investigator did not think the complaint should succeed. He said that Scottish Provident did owe Mr and Mrs T two premium payments after the claim had been settled – one of these was still outstanding. But, it had confirmed that would now be paid. Otherwise, he felt it had fairly processed the claim; though delays took place these were due to Scottish Provident awaiting medical information required to validate the claim, which it had chased.

Mr and Mrs T didn't agree. They made a number of further submissions, noting:

- they do not accept the findings of our investigator;
- though Scottish Provident intends to correct its mistake, it is not being punished in any way for having withheld the premium;
- so the outcome is hardly a deterrent if businesses can withhold money, then merely be required to return it at the final hurdle;
- Scottish Provident gave them a leaflet entitled 'five simple steps to help you make your claim' but then didn't comply with the stated steps;
- for example, it didn't call them or their adviser, despite the leaflet saying so;
- they emailed medical letters to Scottish Provident on 3 September 2021 and 21 September 2021 but had no reply;
- Scottish Provident now accepts that its email to Mr and Mrs T of 21 September 2021 wasn't received;
- but it still didn't chase them to provide an update;
- if there was an issue with the email system it could and should have called them;
- they dispute that there was a need to have a report from Mr T's doctor – Scottish Provident had the clinic letters on file already, so why wasn't this sufficient to tell them if they had a claim?;
- they want the complaint to be referred to an ombudsman.

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.

I was sorry to learn of Mr T's diagnosis, and send my best wishes to Mr and Mrs T.

Though I realise my decision will not be what they've hoped for, I am not able to uphold this complaint aside from recommending that the missing premium be paid – which I believe has

since happened. I'll explain my reasons below.

The Service's role is to investigate disputes and resolve complaints informally, whilst taking into account relevant laws, regulations and best practice. In reaching my decision, I may not comment on every piece of evidence; instead I'll focus on the issues I believe to be central to the complaint. I can see that Mr and Mrs T feel very strongly that the claim process has been unduly and unreasonably prolonged by Scottish Provident. Whilst Mr T is entitled to form his own view on what has gone on, I must also do the same. And from an objective standpoint, I do not consider that this claim has been unfairly handled by Scottish Provident.

It's also important for me to point out that we are not regulators; that role falls to the FCA – and Mr T knows about this, given his professional background. And I understand Mr T has asked Scottish Provident for statistics about claim processes and it has contacted him separately about that. But I don't believe it is appropriate for me to make findings generally on its internal procedures, as they are not specific to this complaint.

After the telephone claim process at the start of September, matters were prolonged because Scottish Provident did not receive a reply from Dr A, Mr T's General Practitioner. I know Mr T has questioned the use of emails, but the two communications Scottish Provident sent at the start and end of September 2021 were sent to the right email address.

I don't see anything wrong with using email as a means of contact, providing it is used with appropriate security measures regarding sensitive data. And Mr T told Scottish Provident of the right address for Dr A, after he received its letter dated 28 September 2021 a few days later. In his email, he restated the same email address for Dr A that had already been used.

I believe the reason for the delay was the fact Dr A had been absent from work. Mr T confirmed as such, noting that on 29 October 2021 he met with Dr A for an in-person appointment, and during that meeting Dr A had explained he had sadly been off work for several months following a heart attack and had only returned to the practice that week.

Similarly, a letter was issued to Mr T's treating hospital – and Mr T told Scottish Provident how he had encountered issued and delays there, and he has since complained separately to the hospital about its service standards.

Mr T also queried why Scottish Provident couldn't use telephone calls. It's not for me to direct a business in how it conducts administration or communications or how to make commercial decisions. But I note that on 28 September 2021, it did call the GP surgery, and a further email was then dispatched again to the confirmed email address.

No two claim processes will be identical. In order to assess the validity of a claim, an insurer will need receipt of medical evidence to confirm the relevant policy definition has been met – as critical illness events in policies such as Mr and Mrs T's are severity-based. Not all claims will meet the defined policy wording, and so appropriate medical evidence from treating professionals will need to be sought and reviewed by an insurer. That is understandably stressful for policyholders alongside dealing with the impact of a particular event or diagnosis. It isn't meant as a discourtesy, but it's a necessary measure to authorise claims.

Mr T feels that Scottish Provident didn't expressly explain whether the information he had sent at the start of the claim was of use, but its correspondence (for example the letter of 28 September) did set out what was happening and the steps it was taking. And, at Mr T's request, Scottish Provident wrote to Dr Y, a different treating consultant at the hospital.

It is unfortunate that when Mr T met with Dr Y's department, it did not have record of the letter. But I believe on balance that the letter was sent – Scottish Provident has provided

evidence of the letter and it is correctly addressed. The vast majority of correspondence is properly received and I wouldn't expect a business to have to track each and every piece of correspondence, given the volumes of outbound letters and emails issued each day.

The first relevant evidence upon which Scottish Provident was able to assess the claim was received on 22 October 2021. It confirmed the acceptance of the claim ten days later on 2 November 2021, and in writing two days after that. I believe that is a fair and reasonable timescale in the circumstances, given the evidence would need to be reviewed by a specialist claims handler and that Scottish Provident will have a limit on specialist staff, as well as other claimants awaiting claim decisions and responses to correspondence.

Most importantly, Scottish Provident has gone further than required by backdating the claim. It could have accepted the claim as at the date it received appropriate evidence. But it didn't do this – it backdated the validity date to the next working day after the claim notification, so from 24 August 2021. Following this, it has paid interest on the claim value and accepted that the two premiums paid after this date of September and October 2021 (not three, as Mr T contended, because the claim was met before the 11 November premium and cover paid up to 10 November) ought to be returned to Mr and Mrs T.

Insurers may continue to take premium payments whilst a claim is being investigated because not all claims will meet the requirements of a policyholder's terms and conditions – so some policies will continue after a declined claim. Ceasing payments could affect the cover being provided; contracts such as these can be lapsed for non-payment of premiums.

I accept that Scottish Provident did not include the October 2021 premium in its claim settlement letter when it should have. And I understand this has since been put right. But I don't accept the view that Scottish Provident should be penalised further for this oversight. As I've explained above, it has chosen to return the premiums over and above what is required; because at 11 September and 11 October 2021, evidence had not been received to validate the claim. I am pleased to note that it chose to backdate the claim and return the premiums, but I do not find further compensation is due for the delay in the October refund.

Putting things right

I believe Scottish Provident has paid Mr and Mrs T the outstanding October premium refund, but if it has not done so, it must make that payment without any further delay.

My final decision

Though Mr and Mrs T undoubtedly feel strongly about this matter, my view is that Scottish Provident has fairly processed the claim payment upon receipt of valid evidence to satisfy the relevant policy definition, and it did not cause unnecessary delays. And so, I do not uphold this complaint aside from the direction to pay the outstanding premium refund – if this has not already been done.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs T and Mr T to accept or reject my decision before 8 November 2022.

Jo Storey
Ombudsman