

The complaint

Ms J complains that The Prudential Assurance Company Limited (“Prudential”) unfairly refused to increase the settlement of her serious illness claim when she provided it with new evidence.

What happened

Ms J had a PruProtect Essentials Plan with Prudential. Her plan included serious illness cover which, in the event of a successful claim and based on a scale of severity, was designed to pay a percentage lump sum.

In 2018 Ms J made a total permanent disability claim through her serious illness cover. She explained she had a number of medical conditions that were rendering her permanently unable to complete four functional activity tests (FATs). They were walking, bending, lifting, and climbing.

Prudential accepted Ms J’s claim but said there was only evidence of her being permanently unable to complete two FATs – walking and bending. As that attracted a severity rating of ‘C’ and a 50% lump sum amount, that’s what it paid in settlement of her claim.

Ms J complained about that rating. Although Prudential maintained its position, it did say it would reconsider matters if further evidence that demonstrated Ms J’s condition had increased in severity was provided. Ms J then referred her complaint to this service and it was considered under separate reference by one of our investigators. But that investigator said Prudential had acted fairly and reasonably and they did not uphold her complaint.

Ms J provided Prudential with further evidence. That included a report produced for another insurer to help it assess a claim Ms J had made with it too. The report had found Ms J unable to walk, bend, lift, and climb, so she asked Prudential to increase her severity rating to reflect that and in turn provide her with a 100% lump sum amount.

Prudential acknowledged Ms J’s abilities were compromised in some areas and noted the report advised she was diagnosed with different conditions. But Prudential reminded Ms J that her PruProtect Essentials Plan specifically excluded any restrictions caused by osteoarthritis and said it had to take that into account. As a result, Prudential explained it considered Ms J’s osteoarthritis to be responsible for the majority of her restrictions, meaning it wouldn’t be changing her severity rating and she wasn’t eligible for any additional payment.

Ms J raised another complaint and when Prudential maintained its position she referred it to this service again. It is this complaint that is the subject of this decision.

Our investigator didn’t think Prudential had sought the opinion of a relevant medical professional when reaching a position on the further evidence provided. And they didn’t think it was fair of it to decline Ms J’s claim for further benefit on that basis. So, they recommended Prudential seek a medical opinion on matters or instruct another assessment to consider the cause of Ms J’s limitations.

Ms J accepted that opinion, but Prudential did not and instead referred the matter to its Chief Medical Officer (CMO) for a full clinical review and opinion. Having done so the CMO set out there was no merit in an additional upgrade of the severity C claim that had already been paid. So as no agreement between the parties was reached the complaint was passed to me to decide.

I issued a provisional decision setting out why I didn't think it was unreasonable of Prudential to find that Ms J didn't qualify for an increased lump sum. That decision now forms part of this final decision, and it read as follows:

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

Having done so and for the reasons I'll now explain I'm not currently intending to uphold this complaint.

Ms J has set out her position in detail and I'd like to thank her for taking the time to do so. Although I have reviewed everything, my findings will focus on those matters I consider relevant and central to the outcome of this complaint. They may not address every single argument made.

In line with the obligations placed on it by the Financial Conduct Authority in the Insurance: Conduct of Business Sourcebook (ICOBS), Prudential has a responsibility to consider claims both promptly and fairly and to not reject them unreasonably.

Ms J has sought to demonstrate an increase in severity by providing Prudential with further evidence including a report produced for the benefit of another insurer. I'll refer to that insurer as "X". From what I understand, when Ms J made a claim with X she received a 100% lump sum payment in settlement, but I don't think it automatically follows that X's claim decision needed to influence Prudential's.

Although Ms J had policies with both X and Prudential, the two were not like for like. X's policy did not contain an exclusion for osteoarthritis while Prudential's did, for example. And X's policy only required three FATs to be failed in order to attract a 100% payment figure while Prudential's required at least four.

When making a claim the onus is on the consumer to show they have a valid claim in line with the policy terms. And, if applicable, it is then for an insurer to show that a relevant exclusion applies. In order to demonstrate eligibility for an upgraded severity rating and a 100% lump sum payment, Ms J would need to show that the severity of her condition(s) had deteriorated and she was permanently unable to complete at least four FATs because of conditions not excluded from her policy.

However, the report Ms J provided did not distinguish which medical conditions may or may not have been affecting her ability to undertake certain FATs. Although I think that's understandable given the report was produced for X and its policy which didn't have any exclusions placed upon it. It did mean that the general failure of FATs was only of relevance within the report as opposed to the causation of such failure too.

Following our investigator's opinion Prudential sought a medical opinion on the further evidence Ms J provided. It did so through its CMO who in summary said:

- *The report wasn't based on any specific objective testing methods. Rather, it had been based on self-assessment and observation.*

- *Ms J's observed failure to lift during the assessment would have been affected by conditions of her hands, elbows, or shoulders – especially as the report noted she'd attempted the lift whilst seated – and that wouldn't satisfy the Prudential policy when her osteoarthritis was disregarded.*
- *Ms J's failure to climb had not been noted in the report. Rather, she'd been noted to have expressed trepidation when asked to climb stairs and observed to be using a ramp sideways – thus indicating the task of climbing was not attempted due to osteoarthritis in her knees more than anything else.*
- *Ms J had been able to climb in and out of a car with support from her husband and:*

“Upon revisiting the files and the reports, there was no significant change in health that was not listed in the 7/2/19 FCE that would make this assessment invalid. As discussed, the tasks of lifting and climbing stairs are not deemed to be affected by her lower back pain, but more so by the pain and OA in her hands and knees.

The other aspect in a TPD assessment is that failing the FATs needs to be permanent as per the contract definition. There was mention of deconditioning in the initial physiotherapist assessment in 2020, as well as weight gain by Ms J. The permanency aspect can be dealt with when additional FATs are failed.”

I do acknowledge the difficulties Ms J says she'll likely experience if she tries to obtain evidence to show an increase in severity excluding osteoarthritis. But at this point, for the reasons given above including the CMO's opinion, I don't currently think it was unreasonable of Prudential to find that Ms J did not qualify for an increased severity rating or higher lump sum payment based on the further evidence she provided.

That Ms J will likely be disappointed by these provisional findings is fully appreciated. I'd like to reassure her that the above is in no way intended to detract from the difficulties she's told us she is experiencing, and I acknowledge that two different policies have both found her eligible for a lump payment as a result of her health.”

Responses to the provisional decision

Both sides have now responded to my provisional decision.

Prudential did not have anything additional to add and confirmed it would wait for Ms J's acceptance.

Ms J said she would not be providing anything else either and instead asked for a final decision which would close this complaint.

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 done so and as neither side provided anything else for me to consider I remain of the same opinion. For the reasons given in my provisional decision I will not be interfering with Prudential's position, because I don't think it was unreasonable of it to find that Ms J didn't qualify for an increased severity rating or higher lump sum payment.

I will again take this opportunity to reiterate that my findings are in no way intended to detract from the difficulties Ms J has told us she faces because of her ill health – I acknowledge two

different policies have paid her a lump sum amount because of her health.

My final decision

My final decision is that I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms J to accept or reject my decision before 20 December 2022.

Jade Alexander
Ombudsman