

## The complaint

Mrs W complained that The Royal London Mutual Insurance Society Limited, trading as Scottish Provident (“RL”) unfairly declined the claim she made on her critical illness policy.

## What happened

Mrs W suffers from medical conditions which have a significant ongoing impact on her daily life, and which limit her independence. She’d bought a policy from RL a number of years before these conditions arose, which provided life and critical illness cover. So, in early 2022, she contacted RL and requested a claim form to make a claim under the critical illness category “*loss of independent existence*”.

There were initial delays in sending Mrs W a claim form, and RL provided incorrect information about their processes. Mrs W complained about this. RL accepted their service had fallen below an acceptable standard and paid Mrs W £150 compensation for this.

Mrs W completed and returned the claim form. RL considered the claim but declined it. They explained that the medical evidence they’d received didn’t show Mrs W met the criteria set out in the policy for loss of independent existence.

Mrs W complained about RL’s decision, and about the amount of time they’d taken to reach it. RL investigated. They didn’t change their claim decision. But they asked their claims assessors to review it under their appeals process. And they said they’d dealt with her emails in line with their service standards.

Mrs W didn’t accept RL’s response and brought the matter to our service. Shortly after this, RL wrote to Mrs W with the outcome of her appeal.

RL confirmed their decision was correct, based on the medical information they’d received. But they noted Mrs W had explained she suffers from a phobia of medical professionals. They suggested they arrange for an assessment by an independent medical professional, who could assess whether Mrs W fulfilled the policy criteria. And they assured Mrs W they’d make them aware of her phobia so the information could be gathered sympathetically.

Mrs W didn’t want to pursue this option. She told us she thought RL should assess, and settle, her claim on the basis of the information they’d been able to gather from various sources – which included her GP and DWP assessments.

Our investigator considered the complaint and concluded RL didn’t need to do any more to resolve it. She noted that Mrs W had provided a good deal of evidence about her medical conditions. But it didn’t evidence the criteria against which RL assess the claim. And, although she noted Mrs W’s difficulties in dealing with medical professionals, she thought it was reasonable for RL to have objective evidence on which to make their assessment.

Mrs W didn’t agree with our investigator’s view. So I’ve been asked to make a decision.

## 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 that, I'm not upholding Mrs W's complaint. I know she'll find this upsetting and I'm sorry about that. I hope it will help her to understand my decision if I explain the reasons why I've made it.

In relation to delay, I can see that Mrs W submitted a claim in late March. RL wrote to her with their decision eight weeks later in mid-June. Before that, RL needed to gather and consider information about her medical condition. Nothing I've seen has shown there was any undue delay in doing this. So, while I appreciate Mrs W wanted a quick response, I don't think RL need to do any more on this aspect of the complaint.

It's clear that the conditions Mrs W suffers from cause her a great deal of pain. I've no doubt from all I've read that makes daily life extremely difficult. And I understand why she wants to make a claim on her RL policy. But I can only say that RL should review the decision they've made if I think how they've assessed her claim is unfair.

The policy document explains what RL will do if they receive a claim. Paragraph 3.2 of the policy provisions says:

*"We will examine each claim for payment of a benefit and will decide whether it can be accepted as an event assured under the policy. In order to make a decision, we will seek confirmation by an appropriate medical specialist that your claim satisfies the appropriate definition.*

*In arriving at our decision, we may request, and will take into account, such evidence and information as we consider to be relevant...."*

I'm satisfied that makes it clear RL will gather evidence before paying a claim. And that it's up to them what type of evidence that is.

Mrs W's claim was made under the loss of independent existence heading. This is defined as:

*"Becoming permanently disabled according to all the requirements of either of the following definitions:*

### *i) Life tasks*

*Becoming permanently disabled:*

- *through ageing, illness or injury;*
- *to the extent of being unable to perform any 3 of the 6 life tasks listed below without the help of another person, but with the use of appropriate assistive aids and appliances; and*
- *the disability is irreversible with no reasonable prospect of there ever being any improvement."*

The six life tasks are washing, dressing, transferring, mobility, continence and feeding. And I think the limit (not being able to undertake three of the six) is clear.

I can see RL based their decision on this definition. I think that's fair. It's clear from their letter declining the claim that they'd assessed evidence from Mrs W's GP, physiotherapist, and a consultant she'd seen in relation to a knee issue to reach their conclusion.

Mrs W challenged that decision. This led to RL offering an appointment with an occupational therapist to assess her ability specifically in relation to those tasks. Mrs W has rejected that suggestion.

I've thought very carefully about this point. I understand Mrs W's concerns that her phobia will be triggered by an assessment. And I've noted her view that the evidence she's supplied is objective – so RL should use it to make their decision.

I've looked at the evidence. Some (such as the GP's notes) is based on information from Mrs W. So I understand why RL don't feel this is objective. Other documents have been created for other purposes and don't answer the specific questions about the life tasks. So I don't think it's unreasonable for RL to decide they don't satisfy their purposes.

Mrs W has said RL should make adjustments because of the problems she has dealing with medical professionals. Businesses do have to make adjustments to their processes to ensure that customers can access their services.

But those adjustments need to be reasonable. In this case, RL have reviewed their claim decision once. And they've given Mrs W options to provide the information they need to do so again. While I appreciate the stress that's likely to cause Mrs W, I don't think it's fair for me to say RL should accept the claim without satisfying themselves it's valid. And so – while I'm sorry it will cause Mrs W further upset – I don't think RL need to do any more to resolve her complaint.

### **My final decision**

For the reasons I've explained, I'm not upholding Mrs W's complaint about The Royal London Mutual Insurance Society Limited, trading as Scottish Provident.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs W to accept or reject my decision before 29 March 2023.

Helen Stacey  
**Ombudsman**