

The complaint

Ms W's complained that The Royal London Mutual Insurance Society Limited ("RLM") declined the claim she made on the terminal illness benefit on her life insurance plan.

What happened

In 2009, Ms W and her husband bought a life insurance plan from a division of RLM. The plan provided £120,000 worth of cover in the event of one of them dying. It also allowed a claim to be made in the event of a terminal diagnosis. The plan is still live and provides cover until December 2025. It was rebranded to RLM in 2015.

In 2017, Ms W was diagnosed with cancer. It had unfortunately already metastasised by this point and Ms W was advised it was terminal. Based on this information, Ms W made a claim on the terminal illness benefit on the plan.

RLM declined the claim at the end of 2017. They said they'd reviewed the evidence – including reports from Ms W's doctors – and had concluded that Ms W didn't meet the definition of terminal illness in the plan.

Immediately after this, Ms W chose to focus on her treatment. But in early 2022 she complained to RLM about their decision. RLM confirmed the plan defined a terminal illness as:

"An advanced or rapidly progressing incurable illness where, in the opinions of an attending consultant and our chief medical officer, the life expectancy of the person covered is no greater than 12 months."

RLM said Ms W's oncologist had told them they thought her life expectancy was between 12 and 18 months. And their chief medical officer had noted she'd responded well to the palliative treatment she'd received, so they couldn't say her life expectancy was less than 12 months at that point.

RLM said that, if Ms W's prognosis had changed, she could contact them to see whether she could make a fresh claim.

Ms W wasn't satisfied with RLM's response and brought her complaint to our service. Our investigator considered it and concluded RLM didn't need to do anything differently to resolve matters. She noted RLM had sent Mr and Ms W a welcome pack in 2009 with the plan documentation – including the plan details document which defined a terminal illness. And she was satisfied RLM had investigated Ms W's situation fully – including consulting their Chief Medical Officer (CMO) before declining the claim.

Ms W didn't agree with our investigator's view. She said she'd never received a copy of the plan details document until the investigator sent it to her. I've now been asked to make a final 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 Ms W's complaint. I know that will upset her and I'm sorry about that. I hope it will help if I explain why I've made that decision.

RLM declined Ms W's claim because they said, at the time she made it, she didn't meet the definition of terminal illness (set out above). They've indicated that, if circumstances change while the plan is still in force, they'd consider a new claim – which is what I would expect them to do. But I'm only concerned with the decision RLM made in 2017.

I'm satisfied RLM considered the 2017 claim reasonably. They requested and considered evidence from Ms W's doctors about her prognosis. That showed that, in April 2017, shortly after her diagnosis, her life expectancy was 12-18 months.

Ms W submitted a claim six months later. By this point, she'd undergone a number of months of treatment, to which her notes say she responded well. RLM asked their CMO to comment. The CMO didn't think at that point her life expectancy met the plan criteria. So I think RLM's decision to decline the claim was made in line with the plan terms.

Ms W has said she wasn't aware of how the plan defines a terminal illness because she never received a copy of the plan details document – only the key facts. And the key facts document doesn't say there's a specific definition of the term.

I've thought carefully about this. As I've said above, I'm satisfied the term was applied fairly in Ms W's case. But I've considered whether RLM should have done more to make her aware of its existence.

RLM have provided a copy of the welcome letter they sent to Mr and Ms W when they bought the plan in 2009. The letter's correctly addressed – so should have reached them. It says it encloses four documents – the plan details, key facts, cover summary and welcome booklet. Ms W says it contained only the key facts.

The front page of the key facts document includes the statement:

"This document does not contain the full terms and conditions of the plan, but does form part of your contract with Royal London on behalf of Bright Grey. The terms and conditions are contained in the plan details booklet and cover summary which we will send you when your plan starts. You may want to refer to the plan details before taking out your plan and you can ask us for a copy of this at any time."

I don't think this statement could make it any clearer that the key facts can't be relied on for full information about the applicable terms and conditions. And it makes clear when the full terms will be sent to Ms W – and that she can request them before this if she wants to.

I'm satisfied from the letter RLM have provided that the letter was posted to Ms W. And I'm satisfied from the key facts document she would have known she should receive the plan details. Nothing I've seen persuades me Ms W told RLM she'd not received them before she made her complaint in 2022. So I can't hold them responsible for her not receiving them. And I don't think they need to do any more to resolve her complaint.

My final decision

For the reasons I've explained, I'm not upholding Ms W's complaint about The Royal London Mutual Insurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms W to accept or reject my decision before 25 May 2023.

Helen Stacey
Ombudsman