DRN-4027147

The complaint

Mr D complains about the amount which Vitality Life Limited (Vitality) has paid in settlement of a claim under his serious illness insurance cover.

Mr D also complains about Vitality's handling of his claim.

What happened

Mr D took out a life and serious illness insurance policy with Vitality in June 2019. The policy was sold by an independent broker.

Unfortunately, in 2021, Mr D experienced a very severe illness and was admitted to hospital.

Mr D made a claim under his policy with Vitality and was paid 50% of the maximum benefit available under his serious illness cover. Vitality said this was because Mr D was entitled to a benefit classed as 'Severity Level C'. Mr D disputed this and complained to Vitality, who sent him final response letters dated 3 March 2022, 9 March 2022 and 25 March 2022. The first of these final response letters addressed Mr D's complaint about Vitality's delays up to that point and Vitality paid Mr D £300 compensation because it said it had taken longer than necessary to assess his claim. The last of these final response letters gave Mr D the opportunity to send Vitality additional medical information if he wanted to appeal its decision about the claim settlement due to him.

Mr D and Vitality continued to correspond with each other. Mr D sent Vitality new medical evidence to consider, and Vitality subsequently requested further information from Mr D's doctor. On 4 August 2022, Vitality sent Mr D a letter explaining why it thought he didn't qualify for anything more than a payment of 50% of the maximum benefit under his policy. On 18 October 2022, Vitality sent Mr D a final response letter maintaining its position about the claim and offering to pay £50 compensation for its failure to respond to one of Mr D's emails. As Mr D remained unhappy, he brought the matter to the attention of our service.

Vitality sent Mr D a further final response letter on 19 December 2022.

One of our investigators looked into what had happened and said she thought the Financial Ombudsman Service could only consider Mr D's complaint as it related to Vitality's decision to pay 50% of the maximum benefit and to Vitality's delays from 25 March 2022 onwards. Our investigator concluded that she didn't think Vitality had acted unfairly or unreasonably by refusing to pay 100% of the maximum benefit available but she said she thought Vitality should pay £150 compensation – in addition to the £50 offered in its final response letter of 18 October 2022 – for the distress and inconvenience which Mr D had suffered as a result of its handling of the claim from 25 March 2022 onwards.

Vitality accepted our investigator's opinion but Mr D didn't, so the complaint has been referred to me as the final stage in our process.

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'm very sorry to hear that Mr D has been through such a traumatic and difficult time. Mr D's illness has undoubtedly been life-changing for him, and I wish him the best for the future.

However, while I'm aware this won't be the outcome Mr D was hoping for, I don't think Vitality has acted unfairly or unreasonably when settling his claim as it did. I'll explain why.

Industry rules set out by the regulator (the Financial Conduct Authority ('FCA')) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. The rules also say insurers must handle claims promptly and provide appropriate information to a policyholder on the progress of a claim. I've taken these rules, as well as relevant industry guidance, into account when making my final decision about Mr D's complaint.

The medical evidence which I've seen clearly states that Mr D will never be able to return to his previous occupation or, indeed, to any occupation which is vaguely similar. And it's not in dispute that Mr D's illness has had a severe and debilitating effect on his life. But not every claim for a serious illness is covered for a 100% maximum benefit payment under Mr D's insurance policy and the limits of Vitality's obligations to Mr D are set out in the terms and conditions of the contract between them.

Mr D's policy provides for the payment of a lump sum on the diagnosis of certain, specified serious illnesses set out in the policy. The lump sum payable depends on the severity level of the illness, as classified by Vitality. One of the serious illnesses listed in Mr D's policy is 'chronic pancreatitis', which is considered a 'Severity Level D' condition and therefore qualifies for a 25% payment of the maximum benefit. I understand Mr D's condition was classified by his treating doctors as being acute and severe, but Vitality has decided the level of severity to attribute to pancreatitis and has clearly set this out within the policy terms. It's not for me to interfere with Vitality's decision about what illnesses it is prepared to cover and/or what level of benefit it is prepared to pay for such illnesses in return for the premium paid for the policy.

However, when Vitality assessed Mr D's claim, it said he would instead be entitled to a 50% payment of the maximum policy benefit because of his intensive care treatment. Vitality therefore paid Mr D the greater of the two benefits which he would have been entitled to under the policy at that time. I think this was fair.

Vitality subsequently assessed Mr D's claim under the total and permanent disability section of his cover. Mr D's policy schedule says:

> *'**Serious Illness Cover***
>
> *Total & Permanent Disability will be based on Permanent Failure of Functional Activity because of your occupational duties (See Plan Provisions for details).'*

This doesn't mean that Mr D's occupational duties are relevant to the assessment of a total and permanent disability claim. Instead, it means that, because of the nature of Mr D's occupation when he took out the policy, any claim for total and permanent disability will be assessed based on the permanent failure of functional activity.

In order for Mr D to be entitled to the 'Severity Level A' payment for total and permanent disability which he is seeking then, under the terms and conditions of his policy, he would

need to be able to demonstrate that he is unable to do at least four work tasks ever again or that he is unable to do at least four tasks designed to assess whether he can look after himself ever again. These are called functional activity tests.

The specific details of the functional activity tests, the individual tasks and their relevant definitions are set out in Mr D's policy. The functional activity tests require the policyholder to need the help or supervision of another person with each task and be unable to perform the task on their own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. The tasks and definitions reflect those set out in industry guidance issued by the Association of British Insurers which is designed, amongst other things, to promote clarity in the market. I don't agree with Mr D's submissions that the policy requirements aren't clear, or that they are vague and/or unfair.

The medical evidence provided by Mr D's doctor says Mr D can perform two of the six work tasks none of the time, three of the six tasks part of the time and one task all the time. In relation to the tasks designed to assess whether Mr D can look after himself, Mr D's doctor has said he needs help to perform four of the six tasks – but Mr D doesn't require full assistance for any of them. I'm satisfied that it's reasonable for Vitality to rely on this evidence from a qualified medical professional. This means Mr D hasn't demonstrated that he meets the policy criteria for a 'Severity Level A' payment for total and permanent disablement.

I understand Mr D says he can only do some of the tasks for limited periods of time, or a limited number of times every day. Neither Vitality, nor I, dispute that Mr D's life and abilities have been severely affected by his illness, but Mr D doesn't meet the criteria outlined in the policy for the claim he is seeking to be paid to him. The fact that Mr D interprets what 'functional' means differently to how it's defined in his policy doesn't mean Vitality has acted unfairly, and this isn't a policy which was designed to protect Mr D's income in the event he was unable to work due to an illness. If Mr D disputes any of the information that his doctor has provided to Vitality, then this is something he'd need to discuss with his doctor directly. And, if Mr D wishes to resubmit a new claim for consideration by Vitality in the future based on new medical evidence if his condition deteriorates then he would be entitled to do so.

Overall, I'm satisfied that Vitality has paid a claim at the highest severity level which Mr D is currently entitled to under his policy, so I won't be directing it to pay anything further in relation to the claim settlement.

Mr D has also commented on the sale of this policy but these aren't issues which Vitality was responsible for. If Mr D wishes to make a complaint about the sale of the policy, then this would need to be directed to the broker who sold him this insurance in the first instance.

It's not in dispute that Mr D brought his complaint about Vitality's delays up until 25 March 2022 to our service outside of the time limits set out by the FCA's Dispute Resolution ('DISP') rules (DISP 2.8.2). But I've considered how Vitality handled Mr D's claim since that date and I don't think it did so in line with industry rules. I think Vitality could have been clearer in explaining to Mr D that his ability to perform his occupation wasn't relevant to his claim, thereby avoiding the inconvenience which Mr D was put to in obtaining a letter from his consultant which didn't change Vitality's decision about his claim. I think there were delays by Vitality in reviewing the medical questionnaire it received in June 2022 and I also think Mr D experienced distress and inconvenience as a result of having to chase Vitality for responses to his emails, at what was already a very difficult time for him. Overall, I think a total payment of £200 (which includes the £50 already offered by Vitality to Mr D in October 2022) is fair and reasonable compensation for the impact of the situation on Mr D.

Putting things right

Vitality Life Limited must put things right by paying Mr D a total of £200 compensation for the distress and inconvenience he experienced since 25 March 2022. This includes the £50 compensation which Vitality already offered to pay Mr V in October 2022.

Vitality Life Limited must pay the compensation within 28 days on which we tell it Mr D accepts my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

My final decision

My final decision is that I'm upholding Mr D's complaint against Vitality Life Limited in part and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 13 June 2023.

Leah Nagle
Ombudsman