

The complaint

Mr K complains that The Prudential Assurance Company Limited (hereafter referred to as 'Vitality') will not consider a claim under his VitalityLife term assurance policy.

What happened

Mr K has held his PruProtect (now VitalityLife) policy since July 2010. It comprises life cover, serious illness (critical illness) benefit including total and permanent disability ('TPD') cover, and income protection benefit. The policy has a 25-year term and annual indexed premium increases. Mr K applied for it through a third party financial adviser in March 2010.

After obtaining a medical report from Mr K's GP, Vitality initially declined to provide any income protection benefit at all, only offering serious illness cover and life cover – the former having a policy exclusion.

After Mr K's financial adviser sent in further medical information, Vitality agreed to insure Mr K at an additional cost due to a rating for cholesterol levels. It also applied an exclusion for serious illness and income protection benefits relating to disease or disorder of the nervous system or any associated complications, as well as a restriction on the type of cover it would offer for TPD benefit – this was granted on a functional activities basis.

Vitality amended the terms it could offer because Mr K disclosed on his application that he had been diagnosed with a history of ulnar nerve compression and associated neurological issues dating back to 1998.

Mr K's adviser queried the exclusion with Vitality, and in return it gave a further explanation as to how the exclusion could apply. Mr K then went ahead with the policy, and it began on 19 July 2010.

In 2018, Mr K complained about the policy exclusion and the loading applied to his policy premiums, and he later lodged a complaint with this service. Mr K contended that the exclusion should be removed. We did not uphold that complaint or agree that the premiums were unfairly loaded from the outset. Accordingly, the policy continued with the exclusion in place.

In 2021, Mr K was diagnosed with a rare type of hereditary peripheral neuropathy. He contacted Vitality to enquire about making a claim for benefits under his policy and sent medical information to Vitality, relating to his diagnosis.

In July 2021, Vitality responded to Mr K. It said firstly that no TPD claim could be considered because it was not able to confirm permanence of failure of activities of daily living nor activities of daily work. Secondly, the illness Mr K has was not a listed condition under his policy, so no serious illness claim existed. And thirdly, it noted that the previously discussed policy exclusion was in place, and this was relevant to Mr K's recent diagnosis.

Mr K appealed to Vitality via email, noting that he believed neurological conditions would at least be assessed.

On 29 July 2021, Vitality explained to Mr K that it took the view that his diagnosis related to the policy exclusion, and it could not consider any claim on that basis. It explained that it would be prepared to consider any other medical evidence to the contrary, should Mr K's consultant or treating medical professionals believe otherwise.

After a series of emails being exchanged with Vitality, Mr K complained.

On 3 September 2021, Vitality rejected the complaint. It said that its chief medical officer ('CMO') had reviewed the complaint and she believed that the disclosure Mr K made in his policy application in 2010 together with the investigations provided on his medical records, indicated that Mr K had severe nerve neuropathy, which had been deteriorating. And his medical records dating back to 1998 had mentioned genetic conditions.

The underwriting decision was therefore to exclude any disease or disorder covered within the nervous system benefit and or any associated complications. The aim of any exclusion is to exclude any future claim based on symptoms that Mr K already had, as this carried a pre-existing risk. Mr K had now been diagnosed with a condition of the nervous system relating to his disclosure in the application, and the exclusion applied meaning no claim for serious illness benefit or income protection could be considered.

Vitality explained that Mr K was not precluded from ever making a claim under the nervous system benefit section of his policy, if a condition arose which was unrelated and therefore not a risk foreseen at the application stage by its underwriters. This had been confirmed to his financial adviser at the time of the application in writing.

In early 2022, Mr K brought his complaint to this service.

Mr K later brought a separate complaint against Vitality about a different condition for which he became severely unwell and was hospitalised. That complaint was dealt with at this service and has since been closed.

The same investigator from this service reviewed this complaint, but he did not think it ought to succeed. He said he hadn't seen any clear evidence that Vitality had acted unfairly in the circumstances, even where it had placed reliance on the policy exclusion. He did not believe Vitality ought to assess a claim for Mr K, since no applicable claims could be pursued.

Mr K explained that while his condition was hereditary, it did not present until later life – and this was the case with many genetic disorders, such as cystic fibrosis. He explained that he intended to pursue matters with his treating consultant.

Mr K then supplied a statement from his financial adviser at the time of the sale of the policy. The adviser said the application was still something he could recall, as he had undergone recent surgery to free his trapped ulnar nerve himself. He therefore felt it was unfair for Vitality to place an overriding exclusion on Mr K's policy, and it was for that reason that he queried it.

The adviser said how a senior staff member at Vitality confirmed that the exclusion noted within the acceptance letter would only apply if it was a further complication of the trapped elbow nerve only; all other neurological conditions would be covered under the policy. At that time, he had verbally relayed confirmation of the same to Mr K along with a follow-up email.

The adviser stressed that the conversation he had with Vitality was undertaken in stronger

terms than the email – and it was expressly stated that the only exclusion which would ever apply was if the trapped elbow nerve deteriorated further.

Mr K also supplied a further statement from his treating consultant neurologist, Dr S, which said that when Mr K had ulnar nerve entrapment surgery prior to 2010 he could not have known he had the condition he went on the diagnosed with in 2021. She also explained that it was “*difficult to say*” if the two were “*directly related*”, because ulnar nerve entrapment was the second most common compressive neuropathy in the UK.

Finally, he said he had also seen an email from Vitality to his GP dated 6 July 2010 which said it had concluded Mr K’s ulnar condition was confined to the upper limbs. This is in complete contrast to his new diagnosis which can affect all of a diagnosed person’s limbs.

Mr K said that he took the view that three independent people had now confirmed that the two conditions were unrelated, and he did not know what else could be provided to determine that his claim ought to be considered.

He also explained that he had made a separate claim to Vitality following a serious illness in late 2022 requiring hospitalisation. However, it remained the case that Vitality refused to assess a claim for his 2021 diagnosis.

Our investigator shared the additional evidence supplied by Mr K with Vitality. However, it said that its CMO had reviewed the information and its view was unchanged. Vitality explained that the medical evidence and statement from the adviser did not make a difference to its initial underwriting assessment, the exclusion or the application of that exclusion now at a potential claim stage.

Our investigator also was not minded to change his view. Though he recognised the explanation Dr S included in her letter, he did not think Vitality had acted unfairly by adding an exclusion to the policy, or by applying it now. It could not be said with any certainty that the symptoms Mr K had before 2010 were not related to his current diagnosis.

He also did not believe that any valid serious illness claim could be pursued as Mr K’s illness wasn’t a listed condition, and he did not meet any of the severity criteria for a TPD claim.

Vitality said it had no further comments to make.

Mr K asked for the complaint to be referred to an ombudsman. He said he did not believe Vitality had truly considered the evidence from his financial adviser. Further, it had failed to comment on the information from the GP at the time. This must indicate Vitality is back-tracking or it lied and mis-sold him his cover in 2010 on a false basis.

He also sent a further email for an ombudsman’s attention, noting that:

- he cannot understand why nobody has contacted his financial adviser regarding what was said in 2010;
- he understands that the investigator and Vitality have commented on his documented history of neurological issues prior to 2010;
- but in his view that is akin to a policyholder being unable to claim for a brain haemorrhage when they had a history of migraine;
- many of the conditions included in his policy have a neurological basis – such as multiple sclerosis and brain tumour;
- so, he questions where the line is drawn the by Vitality and why;

- when he took the policy, as far as he was concerned, the only condition he had (and rightly disclosed) was a trapped elbow nerve;
- Vitality stated that the only exclusion that may ever be applied was to be specifically trapped elbow nerve deterioration – so this is where the line must be drawn;
- Vitality’s understanding of the condition at the time of taking the policy was that it was confined to the upper limbs i.e. trapped elbow nerve;
- so the exclusion was to be for any condition which occurred specifically and exclusively in the upper limbs;
- that is what was relayed to the financial adviser and accordingly to Mr K – and those are the terms he accepted.

The complaint has now been passed to me.

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’d like to thank the parties for their patience whilst this matter has awaited an ombudsman’s decision. I also send my best wishes to Mr K, given his ongoing health issues. I recognise that this process has been frustrating for him, and I do not wish for my decision to cause any further upset. However, for the reasons I will summarise below, I am not able to uphold his complaint against Vitality, because I believe it has acted fairly in the circumstances.

I must be very clear about the parameters of this complaint because Mr K has complained to this service previously about the policy exclusion. Specifically, he complained that he was “*unhappy as should he have needed to make a claim in relation to this exclusion, he wouldn’t have been able to*”.

So, this decision will not be addressing the fairness of the exclusion, or Vitality’s decision to include it the terms of its insurance offer to Mr K. That already forms part of a previous complaint to this service – and I do not have the jurisdiction to revisit that. That means many of the points Mr K has made to our investigator are not matters I can answer here.

For example, the email Mr K refers to that was sent by Vitality’s underwriter to his financial adviser has already been specifically considered in the context of the fairness of the policy exclusion.

In an adjudication of 13 July 2018, our adjudicator concluded that:

“The above shows that it was discussed that any condition that Mr K might later present - that’s unrelated to the exclusion on his policy - would be covered. But there was no mention of the exclusion being removed, so I wouldn’t say that this is something Vitality need to do. In addition to this, Vitality has shown that the application of this exclusion is due to the recurring symptoms of ulnar neuropathy that Mr K has shown from 1998 up until 2010. So I think it’s reasonable that this exclusion remains on the policy.”

The complaint was thereafter closed and not appealed by either party. I cannot revisit it here; our rules permit us to dismiss complaints which have already previously been considered or excluded by the Financial Ombudsman Service.

So, this decision will focus on the refusal of a serious illness (or income protection) claim for Mr K’s recent diagnosis of the specific type of peripheral neuropathy he suffers from, because of the application of the policy exclusion – not the exclusion itself.

If Mr K now believes his policy was mis-sold, that is again a separate matter which he can pursue with his financial adviser in the first instance. The policy was not sold by Vitality.

I do appreciate that Mr K had no idea he would go on to receive his diagnosis in 2021. However, whether Vitality has acted fairly or not cannot be based on my sympathy for a complainant's circumstances. Instead, I must assess the policy wording and how it has been applied, since that forms the basis of Mr K's contract of insurance.

The exclusion says:

"No Serious Illness Cover will be payable under this Plan for any illness or incapacity arising directly or indirectly from:

- Any disease or disorder covered within the nervous system benefit or any associated complications.

*Total & Permanent Disability will be based on Permanent Failure of Functional Activity for health reasons
(See Plan Provisions for details).*

No Income Protection Cover will be payable under this Plan for any illness or incapacity arising directly or indirectly from:

- Any disease or disorder covered within the nervous system benefit or any associated complications."

Mr K's type of peripheral neuropathy is not a listed condition within the PruProtect Plan Provisions. So, whether the exclusion applies or not is immaterial; the condition is not one of the specified conditions covered by Mr K's insurance policy for Serious Illness Cover.

It simply isn't possible for an insurer to provide insurance for every instance of a conceivable critical (serious) illness a person may suffer from, because the cost would be inherently unaffordable for most policyholders taking out the insurance. What critical illness policies provide is insurance against being diagnosed with the most common instances of severe illnesses and the most commonly occurring serious events.

The other two claims appear to be of a hypothetical nature. I have seen no evidence that Mr K is incapacitated such that he cannot work or has permanent failure of functionality.

The type of TPD cover Mr K holds is reflected in the policy wording for neurological diseases and it is based on functional activities – at either severity level A or C. The lower of these two levels requires the permanent failure of two from a list of six functional activity tests ('FATs'). The higher severity level requires four of six FATs. The FATs comprise continence, dressing, feeding, mobility, transferring and washing; each has its own strict definition.

If Mr K feels that he might meet any of these definitions then he can approach Vitality to make a claim. I do not otherwise consider that it has acted unfairly or unreasonably in determining there is no claim to pursue at this stage, as there is no evidence that such a claim is required.

Finally, Mr K's policy provides income protection benefit. This is payable following the deferred period defined in Mr K's policy schedule – which is three months. It also requires the policyholder to provide written notice to Vitality within one month of the end of the deferred period (though this can be extended to 90 days).

The policy then goes on to confirm that the benefit will be paid if Mr K becomes disabled, ill, or injured and he is incapacitated from either performing the material and substantial duties of his own occupation, or incapable of a specific set of activities of daily work or activities of daily living – whichever is the more favourable.

I have not seen any evidence that Mr K has been unable to work because of his diagnosis for longer than this period. However, even if I assume this was the case, I do not believe that Vitality is wrong to refuse a claim in these particular circumstances.

The wording of the exclusion above specifically prohibits Mr K from making an income protection claim if any illness or incapacity arises directly or indirectly from any disease or disorder covered within the nervous system benefit or any associated complications.

I accept that Appendix 1c in the Serious Illness Cover section of Mr K's policy wording "*Stroke and Nervous System category – specified conditions of defined severity*" covers many diseases and illnesses, some of which are unrelated from the symptoms Mr K had before he was insured – and those he suffers from now.

As I've said before, it is unclear whether Mr K has any evidence which would allow him to consider a valid claim for the above serious illness policy definition. But even if this were so, he cannot claim – in principle, for any of the listed conditions in Appendix 1s "*Stroke and Nervous System category – specified conditions of defined severity*" are excluded.

However, the information given by the underwriter at the time to Mr K's IFA explained how it would show a fair and reasonable interpretation of that category (which has more than 30 listed conditions) and only apply the exclusion for conditions arising or connected to the medical disclosure Mr K made. For that reason, the underwriter confirmed:

*"Thanks for your call. I can confirm that if the client were to suffer with a **totally unrelated** [my emphasis] condition, then I would NOT be looking to apply the exclusion wording here. So if for example he were to develop a brain tumour, MS or another unrelated condition, then these would be covered."*

The crux of the matter here is that Vitality says Mr K's diagnosis is related to his previous symptoms, meaning that if he were off work because of it, he cannot make an income protection claim due to the policy exclusion. I find that to be a fair interpretation.

I've seen medical journal evidence which explains how hereditary neuropathy relating to pressure palsies is often overlooked in the first instance, whereby patients may undergo carpal tunnel release or ulnar nerve transposition prior to being correctly diagnosed. The evidence from Dr S does not alter that; it provides a contrasting view on the uncertainty of Mr K's current diagnosis being related to his previous long-standing history of ulnar nerve symptoms. However, it is inconclusive either way.

That Vitality wrote to the GP in July 2010 regarding the ulnar nerve compression hasn't changed my view on it fairly applying the exclusion now either. Vitality said:

"Serious Illness Cover and Income Protection Cover have been accepted on special terms in view of:

Peripheral neuropathies.

Based on the evidence we received, the altered conduction is confined to the upper

arms (ulnar) and has been present for some time, thus we have excluded any neurological conditions from SIC and IPC.”

I do not accept Mr K’s argument that because his condition was restricted to his upper limbs at that time, that Vitality would cover a subsequent peripheral neuropathy diagnosis which also included the lower limbs. That is not what is being said; the explanation is merely to tell the GP what the underwriter’s reasoning was.

The reason for that is clarified in the first part of the letter, which says “*Mr K has asked us to explain the reason for our decision, but due to the confidential nature of the information, we are unable to reply directly to him so have asked him to contact you to discuss this*”.

That Vitality decided to include a policy exclusion was a matter of its commercial judgement. The policy terms were confirmed before Mr K accepted the insurance offer – and I do not believe that application of the exclusion now means it has behaved unfairly or unreasonably.

Through the underwriting process, any pre-existing risk that Vitality did not want to accept was removed, ensuring its policyholders are placed at an equal risk level. This was the reason for exclusions such as Mr K’s. When a claim is later pursued (hypothetically or otherwise) it will assess if the condition being claimed for is related to the pre-existing risk that was present already at underwriting stage. If so, it is excluded accordingly in line with the policy wording for the exclusion.

I know Mr K feels strongly that the exclusion will have a blanket effect – but Vitality has given written confirmation in its final response letter that it won’t do so, if Mr K goes on to suffer with an unrelated neurological or nervous system condition. To remind Mr K, Vitality said:

“This does not mean that you may never be able to claim under the nervous system benefit. If there is a new health event, for example headaches with new sudden leg weakness and a brain scan shows this to be due to a brain tumour, then this was a risk not foreseen at application stage and therefore not intended to be excluded. In other words, the risk of developing a brain tumour would have been equal to any other applicant without any pre-existing neurological complaints. This explains the e-mail by [underwriter] to [financial adviser] that a totally unrelated condition, for example MS or a brain tumour, will be covered. This email was not to remove the exclusion.”

An exclusion relating to peripheral neuropathies was applied and fully reasoned in 2010. Mr K has since gone on to be diagnosed with a hereditary type of peripheral neuropathies, involving palsies. He cannot pursue a claim relating to that diagnosis now, as it is excluded.

My final decision

Though my decision will no doubt be disappointing for Mr K, I cannot uphold his complaint for the reasons set out in full above.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr K to accept or reject my decision before 27 July 2023.

Jo Storey
Ombudsman