DRN-4395963

The complaint

Mr F is unhappy with the way in which Legal and General Assurance Society Limited (L&G) handled a claim on a group critical illness policy, including declining the claim, subsequently introducing a further reason for declining the claim and delays.

What happened

Mr F joined the group critical illness scheme in January 2021 and a claim was made on the policy in or around October 2021 as Mr F had been diagnosed with a rare blood cancer in the spring of 2021. Before then it was believed that he had a chronic autoimmune inflammatory disorder.

L&G requested and considered Mr F's medical records, including a report from his consultant haematologist.

The claim was declined by L&G in December 2021 because under the terms of the policy L&G will not pay:

> benefit for any insured condition occurring within two years of an insured person joining the scheme that has resulted from any related condition which they:
>
> - Have received treatment
> - Had symptoms of
> - Have sought advice on
> - Or were aware of.
>
> For the above, the insured condition may have directly or indirectly resulted from a related condition. The decision as to whether something is a related condition will be based on the opinion of a medical advisor chosen by us.

I'll refer to this as the 'related conditions term'.

L&G concluded that Mr F had symptoms of a rare blood cancer before joining the critical illness scheme. And due to these symptoms having been continually monitored and tested in the two years before being formally diagnosed in the spring of 2021.

Mr F appealed the decision in January 2022. L&G issued its final response letter in April 2022, maintaining its decision to decline the claim and relying on the related conditions term. Subsequently, Mr F's consultant haematologist provided a letter to Mr F, which was forwarded to L&G, dated September 2022. The consultant was asked whether the rare blood cancer results directly or indirectly from the three signs L&G had relied on to conclude that the related conditions term is relevant to the claim. The letter reflects:

> …the condition itself actually caused these signs which were evidence in your medical history. For clarity a medical condition does not result from the signs or

> symptoms, it is in fact the other way round, that the underlying condition causes signs or symptoms…

L&G said it would undertake a review considering this and other medical evidence it was looking to obtain.

This happened around the time Mr F brought a complaint to the Financial Ombudsman raising concerns about the way L&G had handled his claim and the decision taken to decline it.

By way of a letter dated February 2023, L&G confirmed that it was maintaining its decision to decline the claim. As well as relying on the related conditions term, it also said it was declining the claim because he had the rare blood cancer before joining the critical illness scheme. So, it was a pre-existing condition and not covered under the policy.

Mr F is very unhappy that L&G has maintained its decision to rely on the related conditions term to decline the claim. And that L&G has now sought to 'move the goalposts' by including an additional reason to decline the claim which it could've sought to rely on when first declining the claim – but didn't.

Mr F is also very unhappy with the time taken by L&G to carry out various reviews of his claim, including not providing its final response letter within the timeframe of eight weeks it's permitted to have by the regulator.

Our investigator partially upheld Mr F's complaint. He concluded that L&G fairly and reasonably concluded that the claim related to a pre-existing medical condition and not covered under the terms of the policy. However, our investigator didn't think L&G had fairly relied on the related conditions term to decline the claim and its reliance on that term – and subsequent continual reliance on the related conditions term - to decline the claim wasn't fair and reasonable. Our investigator concluded that Mr F had experienced distress and inconvenience as a result and recommended L&G pay him £500 compensation.

L&G didn't dispute our investigator's recommendation. Mr F didn't agree. He raised many points in reply, but these didn't change our investigator's opinion. Mr F requested an Ombudsman's decision. So, his complaint has been passed to me to consider everything afresh to decide.

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.

That includes the points raised by Mr F in his communication dated October 2023 and previous detailed submissions made to the Financial Ombudsman Service dated October 2022 and July 2023. I thank Mr F for clearly setting out his points, which must've taken him significant time to do.

At the outset I acknowledge that I've summarised his complaint in far less detail than Mr F has, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to reach an outcome in line with my statutory remit.

The relevant regulatory obligations

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers. It also says insurers should handle a claim fairly and promptly. And they mustn't unreasonably reject a claim.

Declining the critical illness claim (relying on the related conditions term)

I'm satisfied that L&G didn't fairly and reasonably rely on the related conditions term to decline the claim.

For the insured condition of cancer, the policy says related conditions include but aren't restricted to:

- Polyposis coli
- Chron's disease
- Papilloma of the bladder
- Abnormal smear test
- Any carcinoma in situ or ulcerative colitis

L&G's communications declining (and maintaining its decision to decline) the claim relies on three signs being present before he joined the critical illness scheme as symptoms of the rare blood cancer he was diagnosed with in the spring of 2021. And that's why it's relied on the related conditions term.

Its chief medical officer concluded that Mr F had symptoms of rare blood cancer and had sought advice within two years of joining the critical illness scheme. There may well have been symptoms of rare blood cancer, but I'm satisfied that isn't what needs to be established for the related conditions term to be met.

The related conditions term refers to the insured condition occurring within two years of an insured person joining the scheme **that has resulted from any related condition** which they have received treatment for, had symptoms of, have sought advice on or were aware of (*my emphasis*).

I'm therefore satisfied, for this term to be relevant, it would be fair and reasonable to expect there to be persuasive evidence that the related condition (or conditions) caused the insured condition (in this case rare blood cancer).

The related conditions term also says that the decision as to whether something is a related condition will be based on the opinion of a medical advisor chosen by L&G. But I'm satisfied L&G needs to act reasonably when relying on that opinion. That will involve a number of considerations including the expertise of the medical advisor providing the opinion and the reasons put forward in support of their opinion.

From what I've seen, I'm not persuaded that L&G had sufficient evidence that the rare blood cancer resulted from any related condition or that this was a reasonable conclusion for it to make. Its chief medical officer concluded that Mr F had symptoms of rare blood cancer and I'm satisfied that in itself isn't sufficient to reasonably establish that the requirements of the related conditions term, as set out in the policy terms, have been met.

Further, Mr F's consultant haematologist's letter dated September 2021 - who I'm satisfied is well qualified to provide an opinion given his expertise in this area – says that it is the rare blood cancer which caused the three signs/symptoms evidenced in Mr F's medical history to develop. Given the consultant haematologist's expertise in this area, I'm more persuaded by what they've said.

Declining the critical illness claim (relying on the pre-existing condition exclusion)

I can understand why Mr F is upset that L&G has more recently, in February 2023, put forward an additional reason to decline the claim. However, just because L&G didn't rely on the pre-existing condition to decline the claim at the outset, I don't think it would be fair and reasonable to find that it's not allowed to rely on it at all - or that it's waived its right to rely on that exclusion.

If the Financial Ombudsman Service had determined this complaint before L&G had put forward the additional reason to decline the claim, it's likely in the circumstances of this case, L&G would've been directed to reassess the claim in line with the remaining terms of the policy, disregarding the related conditions term. And I'm satisfied it's most likely L&G would've considered whether the insured condition (Mr F's rare blood cancer) was pre-existing when he joined the critical illness scheme.

That's because L&G's internal notes from shortly before declining the claim in December 2021 - relying on the related conditions term – reflect that it was deciding on what policy term to rely on to decline the claim.

The pre-existing condition term was mentioned. At that stage, it concluded that it would want to obtain further medical information (such as the biopsy and molecular analyses) to confirm whether Mr F had blood cancer before joining the critical illness scheme.

When reviewing Mr F's claim towards the end of 2022, L&G did request further medical records. And says, as a result, it concluded that it was able to rely on the pre-existing condition term to also decline the claim because Mr F had the rare blood cancer before joining the critical illness scheme.

I know Mr F says L&G had all medical evidence available to them in late 2021 to consider the applicability of the pre-existing condition term. And that it's unfair for it to rely on it now. I'll address that point later in my decision.

But it's clear that the pre-existing condition exclusion says L&G:

> Will not pay benefit for any insured condition which the insured person:
>
> - has had, or undergone (sic) before the date they joined the plan
> - has when they join the plan….

So, whilst I accept that Mr F wasn't diagnosed with rare blood cancer until a few months after joining the critical illness scheme, I'm satisfied L&G has fairly concluded that he had it before joining the scheme.

That's because the medical evidence reflects that a biopsy was taken in 2019. And although that biopsy came back demonstrating no evidence of malignancy nor lymphoma, it was this biopsy which was subsequently reconsidered in 2021 and then used to support a diagnosis of rare blood cancer.

As that biopsy was from 2019, and although it was thought he had another condition before being diagnosed with rare blood cancer in spring 2021, I'm satisfied that Mr F had rare blood cancer before joining the critical illness scheme in January 2021.

Mr F has also told the Financial Ombudsman Service that he's not in a position to challenge medical evidence regarding the relevance on the biopsy that took place in 2019 and how it relates to his diagnosis of rare blood cancer in 2021.

So, I'm satisfied that L&G has reasonably relied on the pre-existing condition exclusion to decline the claim.

The service received and the way in which the claim was handled

For reasons set out above, I'm satisfied that the reason relied on by L&G when declining the claim in December 2021 (and subsequently maintaining that it was right to rely on the related condition term as the reason for declining the claim) wasn't fair and reasonable.

Had L&G concluded at the end of 2021, that it wouldn't be reasonable to rely on the related condition term to decline the claim, I don't think it matters whether or not L&G had enough medical evidence then to rely on the pre-existing condition exclusion to decline the claim.

Ultimately, it had an obligation to promptly and fairly handle the claim and I think it's likely that had it requested any further medical information it needed from the GP or Mr F's medical team, and this would've been promptly received. And I think it's likely it would've sought to rely on the pre-existing condition exclusion to decline the claim as it did in February 2023.

So, I'm persuaded that it's likely that the outcome would've been the same. Mr F would've received a decision declining the claim (relying on the pre-existing condition exclusion) around the same time or shortly after the decision was taken to decline the claim for a related condition in December 2021. And I'm satisfied Mr F would have always been very disappointed that his claim was declined.

However, he wouldn't have been put to the unnecessary inconvenience of having to continuingly and tirelessly challenge that his blood cancer was the result of a related condition. That went on for well over a year and even in its letter dated February 2023, L&G maintained that it was right to rely on that clause, despite the consultant's letter dated September 2022 (which Mr F also went to the trouble to obtain).

I accept this would've been upsetting and distressing for Mr F at a time when he was still in the early stages of processing his recent diagnosis and receiving treatment for rare blood cancer. I'm satisfied this would've made an already difficult time needlessly worse for Mr F.

I know Mr F is upset that L&G provided its final response to his complaint about the claim being declined outside of the eight weeks timeframe. L&G not replying within eight weeks meant he would've been able to bring his complaint to the Financial Ombudsman Service after the expiry of that period rather than having to wait for the final response. As it transpires the final response was sent in April 2022 – around 12 weeks after the date of Mr F's complaint. Receiving the response sooner would've enabled Mr F to know that L&G was maintaining the original reason for declining his claim sooner. But I think he would've still been upset by that decision as explained above.

Overall, I'm satisfied £500 fairly reflects the distress, upset and inconvenience Mr F experienced as a result of L&G's failings in this case.

Putting things right

I direct L&G to pay Mr F £500 compensation for distress and inconvenience.

My final decision

I partially uphold this complaint and direct Legal and General Assurance Society Limited to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F to accept or reject my decision before 28 November 2023.

David Curtis-Johnson
Ombudsman