DRN-4484965

The complaint

Mr A complains about the amount of time Zurich Assurance Ltd took to consider his claim on a critical illness policy and the stress this caused him.

What happened

In February 2021 Mr A made a claim on his Zurich critical illness policy and Zurich paid him the sum assured in September 2021. In that time, Zurich had requested further information from Mr A's GP and consultant, which was received on 27 August 2021. The claim was backdated to June 2020, as that was when Mr A began having symptoms, so Zurich refunded the premiums Mr A had paid since July 2020, totalling £572.55. Zurich also paid £133.06 in interest on the sum assured. Mr A was unhappy as he felt Zurich could have done more to move the claim along, and to ensure they reviewed information received from medical professionals in a timely manner. Zurich initially offered Mr A £500 for the delays, and then reduced this to £200, which was paid to Mr A.

Mr A brought the complaint to our service, and Zurich agreed to pay the additional £300 to honour the original offer. Mr A wasn't happy with this and felt £1,000 better reflected the stress and anxiety he was caused at an already difficult time.

An investigator at our service reviewed the complaint and he felt the claim ought to have been paid out in May 2021 and so he awarded 8% interest on the sum assured from May to September 2021. Zurich didn't agree, saying they wouldn't have been able to pay the claim any sooner, as the delay was caused by the lack of responses from the medical professionals involved. As no agreement could be reached the complaint was passed to me for a decision.

I issued a provisional decision setting out my findings as follows:

"The investigator felt if the claim had been escalated to a more senior colleague internally at Zurich sooner, then they would have received the information needed earlier. I don't agree – I can see from the timeline that no matter how many times Zurich chased the two medical professionals for information, they didn't receive a reply. I don't think a different person in Zurich doing that chasing, would have changed this substantially. However, I do think Zurich could have done more to act in Mr A's best interests and I'll explain why.

Following receipt of the initial information from Mr A's GP, Zurich found they needed further information from the GP and the consultant doctor. I'm satisfied that their initial review of the file and decision to request this information was carried out in a fair and reasonable timeframe.
Mr A has argued that the further information Zurich needed was contained in the initial file they'd received from the GP and so they shouldn't have had to ask further questions. Zurich has explained that the initial file showed that Mr A had a history of a chronic illness which hadn't been disclosed when he initially took out the critical illness policy. They said the initial file didn't provide enough information for Zurich to assess whether the illness should or shouldn't have been disclosed.

As part of assessing a claim, it isn't unusual for an insurer to check that they were given correct information when the policy began. I'm satisfied it was reasonable for Zurich to look into the history of the chronic illness, to ensure proper disclosure was made at the time of the sale. This is because it can impact on the terms the policy was offered on – or whether the policy ought to have been offered at all – so the disclosure of information in the application can have an impact on a claim. As I'm persuaded Zurich reasonably requested further information, I've gone on to consider their actions over the months that followed.

I can see that Zurich did chase this information over the months that followed. However, their own timescale for chasing medical evidence is once every seven days and I don't think they kept to that schedule, as they didn't make contact with the GP and consultant that often. I can see that much of this chasing was carried out by phone. From their notes, Zurich tried to call and would be placed into a queue - it appears that when the wait would be more than a few minutes, they would give up and try again a different day.

This happened many times and resulted in periods of time where no contact was actually made with the GP or consultant, due to Zurich not waiting on hold. For instance, between 25 March and 20 May no one at Zurich actually spoke to the GP's office as they didn't stay on hold for long enough. Given the length of time since the claim was received, I'd have expected other methods of chasing to have been attempted, but no written chasing appears to have taken place until 8 July. I don't think this is fair and reasonable, given the minimal number of successful conversations via phone.

I've carefully considered whether, if Zurich had chased using other methods or waited on hold for longer, anything different would have happened. Having done so, although there's a possibility that Mr A might have received the sum assured sooner than he did, I don't think this would have been likely. Mr A told Zurich that when he spoke to the consultant on 30 June 2021, they told him they hadn't gotten round to dealing with the request for information. From the timeline of events, I can see that Zurich had spoken to the consultant's office several times before that to chase for the information.

When Zurich eventually received the replies, not all their questions had been answered. Zurich took a business decision to accept Mr A's verbal recollections of events as sufficient evidence of the information required. As I've set out above, Zurich were reliant on that information in order to properly assess the claim. In agreeing to pay the sum assured without the evidence required, Zurich were acting outside their usual process. I don't think it would be fair to say this is the route Zurich ought to have taken to start with, as it wasn't until after they heard back from the medical professionals that they could have made this decision.

As I don't think the information would have been received any sooner, given the reliance on third parties, I don't think the claim ought to have been paid earlier. I appreciate Mr A was told by his GP that the information had been provided to Zurich earlier than they say they received it. I've seen no evidence of this from the GP, but regardless Zurich was also waiting for information from the consultant. So even if they'd received the GP's evidence sooner, I don't think it would have changed the timeline.

So, I'm not awarding any further payment of interest on the sum assured, other than the £133.06 that Zurich originally paid in interest. However, I do think Zurich ought to have tried to do more to get in touch with the GP and consultant.

I've carefully considered the £500 offered to decide whether I think it is a fair and reasonable amount for the distress caused here. Mr A was clearly going through a very difficult time and as an insurer, I'd expect Zurich to do what they can to speed up the process. However, I must be mindful of only awarding compensation for the stress accountable just to Zurich -

not that which may be accountable to other parties, or that due to the fact Mr A was unfortunately very unwell.

Having considered those factors, I don't think it would be fair to award the £1,000 that Mr A has asked for. I appreciate my decision may come as a disappointment to Mr A, but I hope the above explanation of what Zurich was doing and why, has been helpful. Overall I'm satisfied that the amount of compensation on offer, of £500 total, is fair and reasonable in the circumstances."

Replies to my provisional decision

Zurich agreed with the outcome and said they didn't have anything further to add.

Mr A explained he didn't agree with the outcome – he feels the £500 offer is unfairly minimal, and that the investigator's view was fairer.

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 so, I'm not persuaded to change my decision. I appreciate Mr A will be disappointed by this and I know he feels strongly that Zurich is in the wrong. However, as an independent service, I must consider all of the evidence objectively to reach what I consider to be a fair and reasonable conclusion.

In Mr A's case, I do agree that Zurich hasn't treated him fairly. I've then gone on to consider what would have happened but for their mistakes, a decision that I must make based on the balance of probabilities – what is more likely than not to have happened. I've not received any evidence to suggest that the GP or the consultant would have replied any faster if Zurich had done more to follow up on their requests. So as set out in my provisional decision, Mr A would have been in the same position regardless.

For the same reasons as set out in my provisional decision, I'm satisfied that the amount of compensation Zurich offered is fair for the distress and inconvenience caused here. To clarify, my intention isn't to reflect the whole stress and inconvenience that Mr A suffered - I can only award an amount in this complaint for the stress caused by Zurich alone. As a result, I won't be increasing the compensation here and I find that Zurich should pay Mr A £500 in total, including the £200 which I understand he's already received.

My final decision

Zurich Assurance Ltd has already made an offer to pay £500 to settle the complaint and I think this offer is fair in all the circumstances.

So, my final decision is that Zurich Assurance Ltd should pay a total of £500 to Mr A.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 27 December 2023.

Katie Haywood
Ombudsman