DRN-4642425

The complaint

Mr S has complained that Legal and General Assurance Society Limited (L&G) declined his critical illness claim after he found out he'd had a heart attack.

What happened

In late 2002, Mr S bought a policy from L&G, which would provide him with just over £160,000 worth of cover in the event of his death, or diagnosis with a critical illness. The policy is still live, with the term due to expire at the end of 2026.

Towards the end of 2021, Mr S suffered chest pains. He consulted his GP, who referred him for a cardiac MRI scan. The scan showed evidence Mr S had suffered a heart attack at some point before this.

Mr S made a claim on his critical illness policy. L&G gathered medical information, which they reviewed before declining the claim. They said Mr S's heart attack had not met the policy definition, which is:

"The death of a portion of the heart muscle as a result of inadequate blood supply as evidenced by an episode of typical chest pain, new electrocardiographic changes and by elevation of cardiac enzymes. The evidence must be consistent with the diagnosis of heart attack."

L&G said that, while Mr S had had chest pain, his electrocardiographic (ECG) results were normal and there was no evidence of raised cardiac enzymes.

Mr S complained about L&G's decision, but L&G maintained it was right and was supported by the medical evidence they'd been sent. So Mr S brought his complaint to our service.

Our investigator reviewed all the evidence received and concluded L&G didn't need to do anything differently to resolve the complaint. She was satisfied Mr S hadn't met all the criteria to pay a claim – so it had been fair for L&G to decline it.

Mr S didn't agree with our investigator's view. So I've been asked to make a 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 Mr S's complaint. I hope it will help if I explain the reasons for my decision.

I appreciate the efforts Mr S has made to evidence and support his complaint. I've reviewed everything he - and L&G - have submitted. In my decision I've focused particularly on the points and evidence I consider material to the outcome of the complaint. So, if I don't refer to a specific point or piece of evidence, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

I was sorry to read that Mr S has had a number of health issues over recent years, including in relation to his heart. And I can see L&G accept that, at some point, he's had a heart attack. So I understand why he believes his critical illness claim should be settled.

A critical illness policy has to provide cover for a heart attack. But that doesn't mean insurers must provide that cover in every instance, without limitation. They can decide the type and level of risk they're willing to accept and should set this out in the policy terms.

I've set out the relevant policy definition above. It's clear several elements must be satisfied to meet the definition and that it's not enough simply to say someone has suffered a heart attack.

An insurer should make sure they assess a claim fairly. I'm satisfied L&G did that here. They requested and reviewed Mr S's medical history to reach their conclusion the policy definition wasn't met.

I've been provided with Mr S's medical information. This includes a letter from Mr S's cardiology consultant dated 18 July 2023, which sets out a history of cardiac treatment. The letter says:

"I believe none of his ECGs have shown evidence of myocardial infarction and given that the cardiac MRI has only shown a very small myocardial infarction, it would be reasonable that this is not seen on other imaging. He explained to me that he had some severe chest discomfort in October 2021 and he believes that his heart attack was during this time though there is no evidence for this. His troponin levels I believe have never been elevated on his multiple assessments in the Emergency Department. It is difficult to pinpoint the timing of this very small subendocardial myocardial infarction picked up only on cardiac MRI."

I've not seen any evidence to contradict the consultant's summary. That clearly records Mr S had had a very small heart attack at some point in the past, which wasn't captured on an ECG and didn't elevate his levels of troponin (a cardiac enzyme). So I think it's clear not all the elements of the policy definition have been met.

Mr S has submitted that he's had the policy for many years and the likelihood is that he'd had a heart attack during the term. I accept that's probably true. But I don't think that changes anything, because it's clear not all parts of the definition were met.

Nor do I think it's relevant that another insurer did pay a claim Mr S made on another policy. Each insurer sets the terms of their own policies. They don't have to provide identical cover or settle claims in the same way.

So I've only considered L&G's terms. I think they've applied those fairly and their decision to decline the claim was reasonable. So I don't think they need to do any more to resolve Mr S's complaint.

My final decision

For the reasons I've explained, I'm not upholding Mr S's complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 1 May 2024.

Helen Stacey
Ombudsman