DRN-4679841

The complaint

Miss K has complained about the delay by Legal and General Assurance Society Limited in assessing her income protection claim.

What happened

The background to this complaint is well known to the parties so I won't repeat it in detail here. In summary Miss K made a claim under her income protection policy following a period of ill health. She felt that she had submitted the information required for her claim to be met and complained about the time taken to make a claims decision.

L&G recognised that there had been delays in assessing Miss K's claim and offered £100 in compensation. Our investigator recommended a higher sum of £300 in compensation was paid. L&G agreed. Miss K didn't accept this, because of the delay she said she expected at least £20,000 to settle her debts.

As no agreement has been reached the matter has been passed to me to determine. I should make clear that in this decision I'm considering only the delay in assessing the claim, not the claims decision which was arrived at after this complaint was made.

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 aware I've summarised the background to this complaint, no discourtesy is intended by this. Instead, I've focused on what I find is key issue here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. I've reviewed the complete file and having done so I agree with the conclusion reached by our investigator. I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. So I've considered, amongst other things, the timeline of Miss K's claim to decide whether I think L&G treated her fairly.

L&G received Miss K's claim forms in the third week of January 2023. It contacted her GP and her employer for information and also the rehabilitation team to provide support to Miss K. Details were received from Miss K's employer and the rehabilitation team by the end of February however the GP report was required to assess the claim. Although this was received at the end of March, referral letters were missing. These were eventually received at the beginning of May. Unfortunately, things didn't progress expediently, and Miss K complained at the beginning of July about the time taken to progress her claim. Once the claim was assessed in mid-July, L&G required further information from Miss K's employer before it could complete its assessment.

L&G is not responsible for the initial delay in receiving information from Miss K's GP surgery – although I find it might have been more proactive in chasing this. It is also not responsible

for delays in receiving information from Miss K's employer. But I can see that when medical information was received in May there was a two-week delay in assessing it. Then as there was a need for a medical officer to review the information received, a further delay ensued until mid-July. Miss K needed to chase L&G herself – I find it could have kept her better informed as to the progress of her claim.

Whilst these delays were on going Miss K was unwell and not at work. I accept that she was getting into financial difficulties and needed to borrow money from friends and family. Overall, it has been a stressful period for Miss K. I'm pleased to note that L&G apologised and offered compensation. Whilst I don't consider the sum Miss K suggests should be due is merited, I do find that £300 is fair compensation for the stress and inconvenience Miss K suffered whilst her claim was being assessed.

My final decision

My final decision is that I uphold this complaint. I require Legal and General Assurance Society Limited to pay Miss K £300 in compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss K to accept or reject my decision before 18 April 2024.

Lindsey Woloski
Ombudsman