DRN-5087980

The complaint

Mr and Mrs M are unhappy that The Prudential Assurance Company Limited declined a claim made on their serious illness policy.

What happened

Mr and Mrs M have a policy which offers cover in the event that a policyholder suffers from a serious illness. Mr M claimed on his policy as he said he was diagnosed with COPD and heart failure.

The claim was declined as Prudential didn't think Mr M had met the policy terms and conditions. Mr M appealed the decision, but Prudential maintained their decision was fair. However, they did offer £200 compensation for customer service issues. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what happened and initially upheld Mr M's complaint. However, Vitality provided further information in support of their position, including further comments from their Chief Medical Officer (CMO). This further information persuaded our investigator Prudential had acted fairly when declining the claim. So, ultimately, he didn't uphold the complaint.

Mr M asked an ombudsman to review his complaint. In summary, they said Mr M was awaiting further tests and were awaiting a further report. So, the complaint was referred to me 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.

The relevant rules and industry guidelines say that Prudential has a responsibility to handle claims promptly and fairly. And, they shouldn't reject a claim unreasonably.

The policy terms and conditions say:

The relevant terms in relation to Cardiomyopathy say there is cover for:

- "Cardiomyopathy resulting in a Reduced Ejection fraction

  A disease of the heart muscle causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded."

- "Cardiomyopathy resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy*".

In relation to COPD the policy terms say there is cover for:

> "Chronic Obstructive Pulmonary Disease
>
> A disease of the airways of the lung causing obstruction to the exhalation of air. There must be permanent and irreversible reduction of the maximum volume of air expelled in one second (FEV1) of less than 50% of predicted.
>
> There must be permanent and irreversible obstruction to airflow demonstrated by a FEV1/ FVC ratio of less than 50% and there must be less than 5% variation in three repeated measurements, (which must be performed under the direction of a specialist respiratory physician) whilst on optimal therapy. They must be measured in a respiratory laboratory, which has regular quality control audits available to us".

Did Prudential unfairly decline the claim?

I'm sorry to hear what a difficult time Mr M has had and the impact that not being able to work has had on his finances. However, based on the evidence available to Prudential at the time they considered the claim I think they fairly declined the claim. I say that because:

- Mr M did initially have an ejection fraction of 20-25%. There were some discrepancies in later results with the ejection fraction being recorded as 40-45% and 45-50%. However, the policy terms require there to be a permanent reduction in the ejection fraction.

- Prudential highlighted the overall medical evidence in support of their position which included Mr M being discharged from cardiology and that his heart function had returned to near normal levels. They also highlighted that there was no specific diagnosis of a poor prognosis. Having reviewed the available medical evidence I think that was a reasonable conclusion to reach.

- I appreciate that Mr M is on medication and must have regular blood tests. But, as I've outlined above, the medical evidence indicated that Mr M responded to treatment and his heart was functioning within an acceptable range at the time of the claim. I don't think Prudential intentionally suggested Mr M was not experiencing heart failure. I think they explained that Mr M didn't meet the policy criteria for a payment of benefit, based on the available medical evidence.

- There was no medical evidence provided to Prudential which demonstrated Mr M was diagnosed with COPD. So, I don't think it was unreasonable for them to decline this aspect of the claim.

- I appreciate that Mr M is undergoing further tests and investigations. However, based on the evidence presented during the claim, I don't think Prudential unreasonably declined the claim. If further evidence comes to light because of the ongoing investigations, which Mr M feels supports a valid claim under the policy, he's entitled to send this information to Prudential to review.

Customer service

Prudential have offered a total of £200 compensation as they acknowledge that there were some avoidable delays when assessing the claim.

Clearly this was a worrying and upsetting time for Mr and Mrs M and delays in the claims process meant they received an outcome on their claim later than they should have. I think

that the total of £200 offered fairly reflects the impact of those delays on Mr and Mrs M.

Putting things right

I'm partly upholding this complaint, but I think Prudential's offer of £200 compensation for delays in assessing the claim is fair and reasonable. So, I think Prudential needs to put things right by paying Mr and Mrs M a total of £200 compensation if they haven't done so already.

My final decision

I'm partly upholding Mr and Mrs M's complaint and direct The Prudential Assurance Company Limited to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M and Mrs M to accept or reject my decision before 2 January 2025.

Anna Wilshaw
Ombudsman