DRN-5104372

The complaint

Miss C complains that Legal and General Assurance Society Limited (L&G) has turned down a terminal illness claim she made on a level term life protection plan.

Miss C is represented by Mr E.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

In 2008, Miss C took out a level term life protection plan. The policy was due to end in January 2023. Miss C opted for a sum assured of £100,000. The policy included terminal illness benefit, which would pay the full life sum assured prior to Miss C's death, if she was given a terminal prognosis *and* her life expectancy was less than 12 months. The policy stated that terminal illness benefit claims wouldn't be paid if they were made in the 18 months immediately before the policy expiry date.

Unfortunately, in 2018, Miss C was diagnosed with a serious lung condition. In August 2018, she contacted L&G to look into making a terminal illness benefit claim. She explained that there were two treatments she could try and that her life expectancy was broadly three to five years. On that basis, L&G told Miss C that it wouldn't be able to consider a claim at that point, as she hadn't met the policy terms.

In July 2021, Miss C's consultant, whom I'll refer to as Dr C, provided her with a report which set out details about Miss C's conditions; that her life expectancy was around three years; and that median life expectancy for someone with Miss C's condition was three years from diagnosis. So in August 2021, Miss C says she contacted L&G to 'activate' a terminal illness benefit claim and sent L&G a copy of her consultant's report. L&G has said it didn't receive this, and Miss C didn't chase. But she contacted L&G again in early January 2023.

Subsequently, in January 2023, L&G turned down Miss C's claim. It said the claim had been made within 18 months of the policy expiry date and therefore, terminal illness benefit wasn't payable. It told her that in order for a terminal illness benefit claim to be considered, Miss C would have needed to claim by 21 July 2021. L&G also didn't think there was clear evidence that Miss C's life expectancy was less than six months.

Miss C was unhappy with L&G's decision and so Mr E asked us to look into her complaint. I've summarised what I consider to be the main complaint points Mr E made (which were supported by the opinion of an independent expert in matters of insurance). He said:

- In August 2018, L&G had failed in its regulatory obligations to provide Miss C with clear information and to treat her fairly. Mr E felt that L&G ought to have told Miss C that any terminal illness benefit claim would need to be paid by 21 July 2021. He felt too that at this point, Miss C should have been sent a claim pack and that her claim should have been reviewed by L&G's Chief Medical Officer (CMO). He argued that Miss C's position had been prejudiced as a result;

- Miss C was told that she had to exhaust all other treatment options – but there is no reference to this in the policy;

- Mr E considered that Miss C had effectively notified her claim in August 2018. As the consultant's report was dated 2 July 2021, Mr E felt Miss C had demonstrated she had a valid claim in time;

- The terminal illness benefit was a separate and distinct benefit to the life assurance;

- L&G's call handlers had failed to treat Miss C fairly, given her vulnerabilities.

Our investigator didn't think Miss C's complaint should be upheld. She concluded that L&G had considered the claim fairly, in line with the policy terms.

Miss C and Mr E provided us with a further letter from Dr C which clarified his position. He said that in referring to life expectancy, this was from the date of original diagnosis. L&G were given an opportunity to comment on this letter and told us that it didn't change its stance.

And our investigator still felt L&G had handled the claim fairly. Mr E disagreed and so the complaint was passed to an ombudsman colleague who asked L&G to provide its CMO's comments on the further letter from Miss C's consultant.

The CMO wrote that, in his opinion, there was insufficient evidence to conclude that life expectancy was less than 12 months prior to 21 July 2021. L&G clarified that it didn't propose to rely on arguments regarding the timing of the claim and accepted Dr C intended his life expectancy estimate to run from the date of diagnosis rather than the date of his report. However it maintained that the claim didn't meet the policy conditions.

Mr E, on behalf of Miss C, also presented a detailed submission. This set out what he considered to be the serious defects in L&G's approach and failure to meet FCA expectations.

As no agreement was reached the case was passed to me to decide. I issued a provisional decision saying as follows:

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, whilst I'm very sorry to disappoint Miss C, I don't think it was unfair for L&G to decline her claim. I'll explain why.

First, I'd like to reassure Miss C that while I've summarised the background to her complaint and the detailed submissions she and Mr E have sent to us, I've carefully considered all that's been said and sent to us. I'm sorry to hear about Miss C's illness and about the impact this has had on her. I appreciate this has been a difficult and distressing time for her. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I consider to be the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly and provide reasonable guidance to help a policyholder make a claim. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the contract terms;

regulatory rules and guidance; good industry practice; and the available evidence, to decide whether I think L&G handled Miss C's claim fairly.

I've firstly considered the policy terms and conditions, as these form the basis of Miss C's contract with L&G. It's common ground that Miss C took out a life assurance policy in January 2008. Miss C's specific policy schedule sets out the policy benefit as follows:

On the death of the Life Assured before the Expiry Date, or upon diagnosis of a Terminal Illness at least 18 months before the Expiry Date there shall become payable the Sum Assured of £100,000.00 .

Following the payment of a death or Terminal Illness claim, no further benefits will be payable from this policy, and premiums will cease to be payable.

The 'policy conditions' include the following term:

If the Life Assured has a Terminal Illness, namely an advanced or rapidly progressing incurable illness, where in the opinion of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months, Legal & General will make an advance payment of the Sum Assured. This benefit will not be available during the 18 months immediately before the Expiry Date. Once the payment has been made the policy will terminate and no further benefit will be payable.

In my view, L&G has clearly explained in the policy the circumstances in which terminal illness benefit will be paid and that the benefit won't be available in the 18 months immediately before the policy expires.

I appreciate Mr E believes that the terminal illness benefit is a separate and distinct benefit to the life assurance payment. He's pointed to Miss C's policy quotation which does set out these benefits separately. But I don't agree that these are, or were ever intended to be, separate benefits. I find the schedule makes it clear that the £100,000 sum assured will be paid either on the death of the policyholder or in advance, as terminal illness benefit if the terms are met. The terms explicitly say that if terminal illness benefit is paid, then the policy will terminate and no further benefit will be available. As such, I find it's clear that terminal illness benefit is paid, in certain circumstances, as an effective advance of the overall sum assured.

Mr E has referred to a recent publication by the industry regulator which specifically deals with terminal illness benefit claims. I've considered the October 2023 FCA Review. The review post-dates the actions of L&G in this case. But even assuming that the Review represented earlier good industry practice, and contrary to the representation made by Mr E, I don't find overall that L&G has failed to meet the expectations of the regulatory system (including the general regulatory requirement to treat customers fairly) or of good industry practice. I've addressed the individual complaint points in more detail below.

The 2018 claim

Mr E's submissions on behalf of Miss C included a very helpful transcript of her 2018 call with L&G. During the call, Miss C explained that she was looking into making a terminal illness claim. She explained, in summary, that treatment options were being explored and that life expectancy for her condition was generally between three and five years. Based on the information Miss C gave during the call, I don't think it was unfair for L&G's call handler to decide, promptly, that a terminal illness benefit claim wouldn't be paid. It was clear that Miss C's claim didn't meet the policy terms for benefit to be payable. I don't think it was unreasonable for L&G to make a claims decision based on the information Miss C had given

to the call handler, without referring the claim on to its CMO. In my view, the call handler managed Miss C's expectations well and gave her clear and not misleading information about why she didn't have a valid claim.

Nor do I think L&G had an obligation to tell Miss C that she'd need to make a terminal illness benefit claim by 21 July 2021. And given her claim at that point would not have been payable, I don't think L&G made any error by not sending Miss C a claims pack at that point, (although I note it said it would send a copy of the policy). I find that would have put Miss C to unnecessary time and inconvenience in obtaining information for a claim L&G already knew wouldn't be met.

I recognise that the L&G adviser told Miss C she couldn't make a claim until she had exhausted all treatment options. But I don't find that L&G's actions prejudiced Miss C. I accept that this isn't explicitly stated in the policy, but it stands to reason that if treatment is available and advised, it may impact on life expectancy. Here treatment options were potentially available to Miss C at that time and would have impacted her life expectancy.

L&G has now considered Miss C's claim and hasn't relied on 'late notification' – which I consider was fair. Miss C obtained medical evidence which she has submitted in support of her claim.

The 2021 claim

As I've set out above, on 2 July 2021, Miss C's consultant, Dr C, set out her prognosis in a detailed report. I've included what I think are his key conclusions below:

'As a result of lung fibrosis (Miss C) has sustained a reduction in lung function…of more than 75%. On that basis her life expectancy is reduced to about three years…

In general, with idiopathic pulmonary fibrosis (IPF) the estimated survival from diagnosis is 3-5 years…

The mean life expectancy of patients with IPF is 3 years from diagnosis with a five-year survival of 30-35%.'

Miss C sent a letter to L&G on 29 August 2021. Within her letter, Miss C said she wanted to 'activate' a claim under the terminal illness benefit, as her life expectancy had now dropped below 12 months. And the letter indicates that she'd attached a copy of Dr C's report.

L&G says that it didn't receive that letter and it didn't actively look into Miss C's 2021 claim until she emailed in January 2023. Having completed its assessment L&G concluded that the evidence didn't show that Miss C had been given a life expectancy of less than 12 months prior to 21 July 2021. That's because while the consultant clearly set out the median life expectancy of someone with IPF from diagnosis; he referred to Miss C's life expectancy being reduced to about three years. So I don't think it unfairly concluded that the evidence didn't indicate that the terms had been met.

Again, while I appreciate Miss C has concerns about the way L&G's call handler treated her during a call in January 2023, I think the transcript indicates that Miss C was treated fairly. The call handler gave Miss C clear information; gave her the chance to discuss her position and offered her the option to take a break if she needed to. And I find that overall, the call handler's conclusions about the claim were in line with the policy terms.

Following our investigator's view, Mr E provided us with a further letter from Dr C, dated 18 October 2023. I accept that he is a respiratory expert with many years' experience in his field. The letter includes a statement of truth and says:

In my previous reports and correspondence when I have referred to Life Expectancy (LE) I followed convention in accepting that for interstitial pulmonary fibrosis, calculation of LE is from the date of diagnosis rather than present age at review.

L&G's CMO assessed the evidence and further letter from Dr C dated 18 October 2023 and provided an opinion. It has been shared with the parties so I won't repeat the details in full here. In summary he didn't conclude that Miss C's life expectancy was less than 12 months prior to 21 July 2021. He also noted that Miss C's diagnosis was hypersensitivity pneumonitis and not idiopathic pulmonary fibrosis (IPF). He said that hypersensitivity pneumonitis and IPF, although both types of diffuse parenchymal lung disease, are distinct conditions following different pathologies and have different life expectancy ranges.

The CMO suggests, by reference to objective evidence, that the median survival for this condition, hypersensitivity pneumonitis, is seven to nine years from diagnosis. Of course, each case is to be looked at on its individual facts, but no evidence has been submitted to dispute this. Dr C writes that the estimated mean survival for IPF from diagnosis is three to five years and that in general five-year survival post lung transplant is close to 50%. But he hasn't detailed survival rates for hypersensitivity pneumonitis.

I don't accept the submission that information regarding the CMO's biography and medical qualifications mean that little or no weight should be given to his report. There is nothing to show his opinion wasn't honestly reached based on all relevant considerations. There is medical evidence that Miss C's condition was diagnosed as hypersensitivity pneumonitis, which would give a different prognosis. This is also consistent with what Miss C herself has said in correspondence, both to L&G and to this Service. I don't find the CMO's opinion was unreasonable.

*Importantly, for the terminal illness benefit to be paid the policy requires both an 'attending Consultant **and** our Chief Medical Officer' (my emphasis) to be of the opinion that the life expectancy is no greater than 12 months. This isn't an unusual policy term and is not satisfied in the circumstances here.*

Miss C has undergone major surgery to treat her condition. I accept that survival beyond the expiry date of the policy is not a ground for rejecting a terminal illness claim. But I don't see that treatment options, such as transplant, were taken into consideration when a diagnosis was first given in 2018. Treatment options will impact on life expectancy. Although I would add that Dr C clearly considered lung transplant in his July 2021 report. Thankfully it would seem that this treatment option has significantly prolonged Miss C's life, although I fully accept that she is not a well woman.

Even if I'm wrong on this point though, and consideration was given to all treatment options in 2018 or later, I don't find I could fairly or reasonably conclude that Dr C's recent evidence is enough to show that the relevant policy term has been met. This is because Dr C's opinion alone isn't enough to satisfy the policy term.

Accordingly, and whilst I know how disappointing my decision will be for Miss C, I'm not currently persuaded that L&G has treated Miss C unfairly, unreasonably or contrary to her policy terms by concluding that Miss C hadn't shown she met the terminal illness definition and declining her claim. And I'm not persuaded that it treated her unfairly in telephone conversations or in the assessment of her claim.

Finally I should add that the Financial Ombudsman Service is free for consumers to use. I do understand why Miss C has chosen to be represented, but given my provisional findings, I'm not minded to make any award for the costs she may have incurred.

I said I'd look at any more comments and evidence that I received, but unless that information changed my mind, my final decision was likely to be along the following lines of my provisional decision.

Both parties responded. Miss C didn't accept my provisional findings and made further representations as did her representative.

Importantly Miss C submitted new medical evidence from her treating Consultant, whom I will refer to as Dr B. The evidence has been seen by both parties.

L&G's CMO made further comments which Miss C and her representative have also seen.

I advised Miss C that I wasn't minded to change my provisional conclusion based on the new evidence. I didn't find Dr B's opinion was sufficiently firm about life expectancy to meet the policy requirements. But also the policy requires both the attending Consultant and the insurer's CMO to be in agreement, and this is not the case here.

Miss C's representative informed us that they had received a response from the hospital Trust, having sent them the CMO's comments. The response read *'The Trust and Dr B do not have any further comments at this stage. Dr B's diagnosis remains as seen in all clinical notes and letter from her to (Miss C) as Hypersensitivity Pneumonitis'.*

Miss C's representative also reiterated the point previously made that the L&G didn't give appropriate advice in 2018. It was argued that the conversation in September 2018 breached principles 6 and 7 of ICOBS and has a result the claim wasn't processed as it would have been had L&G complied with its regulatory obligations.

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 grateful to the parties for the detailed responses. I have read them with care. If I haven't specifically responded to any point, it is not because I have disregarded it; rather I have focused on the key points which I deem to be material to forming my opinion as to what is fair and reasonable in all the circumstances of the case. For the avoidance of doubt my considerations have also included the regulator's rules and guidance, the law, regulations, and good industry practice.

As indicated in my provisional decision unless the new information changed my mind my final decision was likely to be along the lines of my provisional decision. I'm very sorry to disappoint Miss C but the new information and submissions doesn't persuade me to depart from the conclusion I reached.

As the policy term is the crux of this complaint, I will set it out again for completeness:

4. If the Life Assured has a Terminal Illness, namely an advanced or rapidly progressing incurable illness, where in the opinion of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months, Legal & General will make an advanced payment of the Sum Assured. This benefit will not be available during the 18 months immediately before the Expiry Date.

New evidence has been submitted in response to my provisional decision – that of Dr B, Miss C's treating Consultant. Dr B was asked whether, in their opinion 'had on or before July 2021 Miss C's life expectancy fallen to below 12 months?' The email evidence in response is dated October 2024. Dr B said:

There was an initial improvement in lung function following steroid treatment in Feb 2019. The trajectory of lung function was then one of progressive decline despite therapy. I had no direct contact with (Miss C) in July 2021. At her physiology appointment on 02.08.2021, her lung function was now classed as severe with FVC 40% and TLCO 21%. She had already been referred for lung transplantation due to the trajectory of her condition – but was not accepted onto the active wait list until November 2021. Whilst it is difficult to give opinion of exact prognosis in July 2021– I would not have been surprised if (Miss C) had died within 12 months of this date due to the severity of her disease.

Dr B confirmed that the diagnosis was Hypersensitivity Pneumonitis, not idiopathic pulmonary fibrosis. I mention this as Dr C previously diagnosed the latter, and Miss C herself has said that she was diagnosed with a sub-variant of Hypersensitivity Pneumonitis, known as Chronic Hypersensitivity Pneumonitis (CHP). She differentiates CHP from Hypersensitivity Pneumonitis. Miss C has provided detail about this and her own history, which I have taken into account. But to accord with the policy definition it is the opinion of the attending Consultant and CMO that I must consider.

Dr B added, in response to a question:

Steps to arrange assessment and lung transplant referral would not automatically equate to mean that I considered (Miss C's) life expectancy exceeded 12 months.

It's not in dispute that Miss C suffered and continues to suffer with a very severe condition. I recognise that the process of complaining is stressful and I'm sorry that my decision doesn't bring her welcome news. But what is material is the opinions of her treating Consultant and the CMO regarding her prognosis in July 2021. The fact that Miss C has survived beyond the expiry date of the policy is irrelevant here. Dr B accepts that there was a possibility that Miss C's life expectancy would not exceed in 12 months in 2021, but they haven't said that life expectancy was no greater than 12 months.

It doesn't follow that had Miss C been advised by L&G that she should obtain a prognosis as to life expectancy on or before July 2021, then Dr B would have advised that Miss C's life expectancy was within the policy limit. Even if I found there was an error or regulatory failure on L&G's part with regard to advice, I'm not persuaded that the medical evidence of Dr B would differ or that enquiries at that time by L&G would have resulted in a different outcome.

So having considered the evidence of Miss C's attending Consultant, I don't find that Miss C met the policy requirement. Nor was I able to conclude the contemporaneous evidence of Dr C, referred to in my provisional decision, made such a finding with regard to Miss C's Hypersensitivity Pneumonitis.

For completeness I have considered the opinion of L&G's CMO. He didn't find that the policy definition had been met. I don't accept that in order to resist Miss C's claim L&G should appoint a respiratory consultant. I recognise that the CMO is not a respiratory Consultant, but it is not a policy requirement that the CMO must specialise the condition being claimed for. I also reject the submissions that the CMO's evidence should be discredited for this or any of the other reasons advanced. These include that the communication from L&G to the Ombudsman did not meet the expectations of the Financial Conduct Authority, the British

Medical Association or the General Medical Council, that the CMO hadn't spoken to Miss C's treating physicians or examined or interviewed her.

As I don't find by the evidence (original or new) or representations now submitted that the policy term has been met, I'm not persuaded to change my provisional findings, which I adopt here. This being so it wouldn't be fair and reasonable for me to require L&G to pay Miss C the terminal illness benefit.

It is suggested, that if that is my conclusion, L&G should be invited to agree to the test case procedure set out in our rules – DISP 3.4.2. I don't consider it would be more suitable for this case to be dealt with as a test case. Whilst I recognise the importance of the matter to Miss C, the complaint doesn't raise an important or novel point of law. I acknowledge that the common law requires consistency. But each case brought to this Service must be considered on its unique facts. My decision has been reached in this way.

My final decision

For the reasons given above I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss C to accept or reject my decision before 14 February 2025.

Lindsey Woloski
Ombudsman