DRN-5311522

The complaint

Mr V complains that Legal and General Assurance Society Limited weren't transparent about the terms and conditions of his employer's group critical illness policy.

What happened

Mr V is a beneficiary of his employer's group scheme. He joined the scheme in April 2022. Prior to this date he'd been diagnosed with a benign tumour. In March 2023 Mr V was advised the tumour was malignant.

He claimed on the policy, but the claim was declined as Legal and General concluded the condition was excluded because it was pre-existing. Mr V complained to Legal and General because he didn't think information about the exclusions was made clear when he joined the scheme. Legal and General explained that Mr V's employer was the policyholder and information about the benefits were available via their benefits platform.

Mr V complained to the Financial Ombudsman Service. He said no medical questions were asked and the terms and conditions weren't provided. He felt Legal and General was passing the buck to employer. He also highlighted that he wasn't aware the tumour was malignant at the time he took out the policy.

Our investigator looked into what happened. She didn't think Legal and General had acted unreasonably in declining the claim bearing in mind the policy terms. She also explained that Mr V's employer determined the level of cover available under the policy and Legal and General didn't have to ask medical questions. Furthermore, she explained that the policy information was provided by the employer. So, she didn't uphold the complaint.

Mr V didn't agree and asked an ombudsman to review the complaint. He provided some additional medical evidence which he said supported that he wasn't experiencing symptoms when he joined the scheme. 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 decline of Mr V's claim

The relevant rules and industry guidelines say that Legal and General have a responsibility to handle the claim promptly and fairly. And they shouldn't reject a claim unreasonably.

The relevant policy terms and conditions say:

> "We will not pay benefit for any insured condition which the insured person:
>
> - has suffered, or undergone before the date they joined the scheme;
> - is suffering from when they join the scheme, for which a duration period is

included within its definition (for example six months for multiple sclerosis); or

- has previously received benefit under the scheme for.

As long as a later diagnosis confirms this, we'll consider an insured person to have:

- had an insured condition;
- undergone an insured condition; or
- been in a duration period included in an insured condition definition;"

The Related Condition clause is;

"We will not pay benefit for any insured condition occurring within two years of an insured person joining the scheme or any increases in benefit that has resulted from any related condition for which they:

- have received treatment;
- suffered symptoms of;
- have sought advice on; or
- were aware of".

I don't think it was unreasonable for Legal and General to decline the claim. I think that they reasonably concluded the more recent diagnosis was related to Mr V's original diagnosis in 2019 which is excluded from cover. So, I think they've fairly applied the exclusions in the circumstances of this case.

I've considered the further information Mr V has provided but I'm not persuaded this means Legal and General have unfairly declined the claim. The report focuses on the surgery that took place in 2019 and what actions were taken during surgery. I don't think it persuasively demonstrates that Legal and General have unreasonably declined Mr V's claim.

I've also taken into account that Mr V says he didn't have symptoms at the time he joined the scheme. However, the medical evidence presented to Legal and General indicated that the tumour was mis-diagnosed in 2019. So, I still think the overall available evidence indicates that the exclusions above most likely apply.

The information Mr V was given when he joined the scheme

Mr V's policy isn't individually medically underwritten. It's a group scheme and it's Mr V's employer who decides the level of cover they want to offer to their employees. In this case they've selected a policy which excludes pre-existing conditions. There's no requirement for Legal and General to complete medical screening in such circumstances. And, in any event, the fact that no medical questions were asked doesn't necessarily mean that the policy won't contain exclusions.

As Mr V's employer is the policy holder it's for them to ensure that information about the policy is made available to their employees. Mr V's employer has confirmed to Legal and General that this information is available via their benefits platform. It was for Mr V to check to see if the level of cover was right for him. And it was open to Mr V to obtain more information from his employer. In reaching that conclusion I bear in mind that Mr V had

undergone surgery for a serious medical condition a few years before joining the scheme. On balance, I'm persuaded it's most likely he had a fair opportunity to access and review information about the cover offered.

My final decision

I'm not upholding this complaint.

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

Anna Wilshaw
Ombudsman