DRN-5328364

The complaint

Mr G complained that Legal and General Assurance Society Limited (L&G) declined a claim on his life and critical illness policy.

What happened

Mr G took out a life and critical illness policy with L&G in 2013. I was sorry to hear that in July 2023 Mr G was admitted to hospital and was in a very serious condition.

In September 2024, Mr G felt well enough to raise a claim. L&G reviewed Mr G's claim but didn't feel he met the condition definitions for any conditions listed in the terms and conditions. Mr G was unhappy and raised a complaint. He didn't feel L&G understood the complexity of his condition. He also felt they'd ignored the information provided by his consultant.

L&G didn't uphold Mr G's complaint. They endorsed their claim outcome for the same reasons. As Mr G was still unhappy, he brought his complaint to this service.

Our investigator didn't uphold Mr G's complaint. They didn't think L&G had unfairly declined the claim. Mr G appealed. He said his consultant's comments had supported that he'd met the policy terms. As no agreement could be reached, the complaint has been passed to me to make a final 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.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether L&G acted in line with these requirements when it declined to settle Mr G's claim.

At the outset I acknowledge that I've summarised his complaint in far less detail than Mr G has, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to reach an outcome in line with my statutory remit.

I'd like to start by acknowledging the seriousness of Mr G's condition. Mr G has suffered from a complex medical condition and needed expert treatment to save his life. I wish Mr G all the best with his continued treatment.

Critical illness policies don't cover every potential critical condition. They provide cover for a

specific list of conditions which have a defined definition. For a claim to be successful, the life assured needs to have met the definition on the policy. In this case, L&G have considered Mr G's claim against four different conditions covered on his policy. These are as follows:

"***Coma*** *– resulting in* ***permanent*** *symptoms*

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- *Requires the use of life support systems; and*
- *Results in* ***permanent neurological deficit with persisting clinical symptoms.***

For the above definition the following is not covered:

- *Coma secondary to alcohol or drug abuse.*

Kidney failure *– requiring dialysis*

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

Systemic lupus erythematosus (SLE) *– with severe complications*

A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

- ***Permanent neurological deficit with persisting clinical symptoms****; or*
- *The* ***permanent*** *impairment of kidney function tests as follows:*
  - *Glomerular Filtration Rate (GFR) below 30ml/min.*

Total and permanent disability *– of specified severity*

- *Unable to do your own occupation ever again.*"

I'll cover off each of the above definitions separately below.

Coma

It's not in dispute that Mr G was in a coma. What has been disputed is whether the coma has resulted in permanent symptoms, and in particular, permanent neurological deficit (PND) with persisting clinical symptoms.

Mr G has said that he has suffered from PND and provided instances of self-reported symptoms. However, in the medical report from his consultant, L&G asked about neurological symptoms. Mr G's consultant was asked the following questions:

"Is there currently any signs and symptoms of neurological deficit?

If there is neurological deficit, do you expect the current level to be permanent?"

Mr G's consultant answered the first question '*He did not have active neurological symptoms at his last review*'. He answered the second question '*N/A*'. As such, Mr G's consultant has

recorded Mr G as not having any PND. So, I don't think it's unreasonable for L&G to have not accepted the claim under this condition.

Kidney failure

Under this definition, Mr G is required to need end stage kidney failure in both kidneys and require regular dialysis. Whilst I accept that Mr G has required dialysis, at this current time he doesn't. As such, I don't think Aviva has been unreasonable in not accepting a claim under this condition. If Mr G's kidney function was to deteriorate and he again needed dialysis, I would expect L&G to review his claim further.

SLE

As a starting point, Mr G hasn't had a definite diagnosis of SLE. However, Mr G has provided a lot of information around his symptoms, his official diagnosis and SLE. In the report completed by L&G, his consultant was asked the following question:

"*If the patient has been diagnosed with [condition] is it feasible they may have SLE causing the [condition]?"*

Mr G's consultant answered the above question '*Yes, absolutely. He certainly has [condition], It has been termed [condition], but SLE is an entirely reasonable potential causative entity. If one consulted the SLICC criteria for SLE, he would meet them also*".

My understanding is that the only way to confirm if Mr G was suffering from SLE would be to complete a kidney biopsy. Mr G's medical team have ruled out having a biopsy due to his positive response to his treatment and the negative impact completing the biopsy could have on Mr G's health. I don't think it would be reasonable for Mr G to have to undergo a procedure with potential negative impacts on Mr G's health based on the evidence that has been provided to date.

However, even if I accepted that Mr G has SLE, he would still need to meet the rest of the definition for a successful claim. As already discussed above, I don't think there is sufficient evidence to say Mr G has PND. So, Mr G would need to evidence permanent impairment of kidney function with a GFR of below 30 ml/min. At the point of the claim being reviewed, Mr G's GRF was above 30 ml/min. So, I don't think it was unreasonable for L&G not to accept a claim under this definition.

Mr G has provided information around the GFR and its accuracy. Mr G believes that urine albumin-creatine ratio should be considered instead. I accept that Mr G does have some kidney damage, which is likely permanent. I've considered all the information Mr G has provided carefully, but I still don't think it's unreasonable for the claim to have not been accepted. The policy terms are clear on how the conditions are defined. Whilst Mr G doesn't agree with them now, he accepted them when he took out the policy. My understanding is that GFR links to the stages of chronic kidney disease. So, whilst I am very sorry to hear about Mr G's ongoing kidney treatment, he hasn't met the policy terms for a claim to be successful under the SLE definition.

Total and permanent disability

It has been reported that Mr G has returned to work. I appreciate that his employer has made some amendments to help Mr G return to work. However, for the definition to be met, Mr G needs to be unable to do his own occupation ever again. Based on the evidence provided I don't think L&G has been unreasonable in not accepting a claim under this

condition. If Mr G's employment status was to change, I would expect L&G to review a claim further.

I'm very sorry that my decision doesn't bring Mr G more welcome news at what I can see is a very difficult time for him. But in all the circumstances I don't find that L&G has treated Mr G unfairly, unreasonably, or contrary to the policy terms and conditions in declining the claim.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint. I don't require Legal and General Assurance Society Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 10 April 2025.

Anthony Mullins
Ombudsman