DRN-5340912

The complaint

Mr R is unhappy with the delays he experienced whilst Legal and General Assurance Society Limited handled his terminal illness claim.

Mr R brought his complaint through a third-party representative, however, for simplicity, I'll refer to all submissions as being made by him personally.

What happened

Mr R was sadly diagnosed with stage four oesophageal and liver cancer and claimed on his terminal illness policy in June 2024. Mr R said that L&G caused unnecessary delays whilst handling his claim and failed to communicate clearly, or in his preferred medium. Mr R said L&G's actions caused him distress at the most vulnerable time of his life. He refused to accept the compensation offered as he believes the offer is derisory.

L&G accepted it could have communicated better with Mr R. In summary, it said that it should have given him more detailed updates, however, the delays were necessary given it needed to validate his claim. It offered £200 compensation as an apology.

Our investigator said the offer was fair. She found L&G hadn't been clear about the reasons behind some of the delays, in particular, where it was investigating a potential mis-representation by Mr R. She also said L&G didn't listen to Mr R's concerns around using the portal for updates about his claim. Our investigator said that L&G didn't delay Mr R's claim unnecessarily though, as it needed to validate the claim. She explained where there were delays, this was driven by the medical professionals involved with Mr R's care and so there wasn't anything more L&G could have reasonably done in that situation.

Mr R disagreed. In summary, he explained that his GP sent L&G his medical records earlier than L&G reported. He also said that he told L&G he was having difficulty accessing L&G's claims portal in August and that this was ignored as it continued to send updates using the portal. Mr R said L&G should increase its offer of compensation given the impact this has had on him overall.

And so, it's now for 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.

Having done so, I've decided to uphold it, however, I won't be asking L&G to increase the compensation offered. I know Mr R hasn't accepted L&G's offer, but I think it's fair in the circumstances.

Before I go on to explain why, I should say I'm aware Mr R's claim has now been paid. I'm aware he's unhappy with the settlement he received and has raised a separate complaint about that. I must make it clear that I won't be considering anything related to that complaint

here. That's to say my final decision will focus solely on the events he originally complained about – the delays and poor communication – up until 9 September 2024, when L&G issued its final response.

I've drafted a brief chronology below to help highlight the key events in Mr R's claim.

- 9 July 2024 – Mr R returned the completed claim form and his medical evidence confirming his diagnosis.

- 22 July – L&G reviewed the documentation and wrote to Mr R's GP and consultant oncologist requesting further information.

- 5 August – information from the consultant oncologist was received by L&G.

- 22 August – information from the GP received, however, this information was incomplete and so L&G had to ask it to provide the full file. This was provided the following day.

- 1 September – L&G reviewed the information and was unable to validate Mr R's claim. It decided to reach out to the GP again and ask more questions.

I should say that L&G must follow the rules set out under the insurance code of business sourcebook (ICOBS). The relevant rule says L&G must handle claims promptly and fairly, and must not avoid a claim. I've kept this in mind whilst considering its actions here.

L&G's policy terms also say;

"Terminal illness is defined as a definite diagnosis by your hospital consultant of an illness that satisfies both of the following:

- *The illness either has no known cure or has progressed to the point where it cannot be cured; and*
- *In the opinion of your hospital consultant and our Medical Officer (a qualified doctor employed by Legal & General), the illness is expected to lead to death within 12 months".*

I'm satisfied the above chronology supports that L&G weren't the main cause of the delays Mr R experienced. I say that because the evidence I've seen shows the delays are mainly caused by Mr R's GP practice not sending his medical records in good time. I appreciate this isn't a view shared by Mr R, however, I think the chronology clearly highlights where the delays were in respect of his claim.

Mr R subsequently explained his GP surgery sent the requested information earlier than 22 August, however, I've not seen evidence of that. The GP surgery emailed Mr R explaining it'd sent the requested information on 13 August, however, it didn't provide any persuasive evidence to support its position on that point. I've reviewed L&G's claims file and there's no trace of that information being received prior to 22 August and so I find that more persuasive in the circumstances.

On 1 September, L&G's medical officer reviewed all the medical evidence and decided Mr R had satisfied the terminal illness clause under the policy. However, it was still unable to pay his claim at that point because the GP's medical records highlighted a potential discrepancy with what Mr R had declared prior to taking out the policy. L&G needed to gather further evidence in order to validate the claim, and so it asked more questions of the GP. I should

say that's relatively normal, given L&G had discovered something it wasn't aware of previously.

So, I'm satisfied the evidence I've seen shows the delays weren't primarily caused by L&G.

But I still think the £200 compensation is fair because L&G didn't communicate with Mr R effectively and I think that caused him distress. I should say that I understand the arguments made by Mr R about the impact this has had on him and that I'm not saying this hasn't had caused him distress or worry. It's that I'm not persuaded this has had such an impact that I should increase the compensation beyond £200. I say that because I'm aware that Mr R appointed his representative to continue to handle his claim from end of July – almost a month after he first brought the claim.

And so, whilst I'm persuaded Mr R was still impacted by poorly detailed communication from L&G, this was ultimately managed by the representative and therefore had less of an impact than it otherwise would have had the third party not been appointed to handle things from that point.

I think L&G's lack of detail in updates was unfortunate in the circumstances. I agree it could have explained its concerns more clearly by being more specific. One of the issues it needed to better understand was whether Mr R had failed to disclose his diabetes from the outset and what impact that would potentially have on any benefit payable under the policy. I note L&G went back to the GP for clarification on that point, however, it didn't explain this clearly to Mr R.

In addition, L&G seemingly ignore Mr R's request not to use the portal to communicate updates about his claim. L&G were made aware of the issues Mr R experienced with the portal by 7 August, yet it continued to use it to provide updates. Consumer Duty directs firms to offer different forms of communication and so writing to Mr R should have been considered given he explained he was having difficulty using the portal. I agree Mr R was also caused distress and inconvenience by being sent a link to access the claim form when it should have been clear from the case notes Mr R was having difficulty accessing the portal.

My final decision

I'm upholding Mr R's complaint and direct Legal and General Assurance Society Limited to pay him £200 compensation for the distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R to accept or reject my decision before 11 April 2025.

Scott Slade
Ombudsman