DRN-5347496

The complaint

Mr A and Ms F are unhappy that Legal and General Assurance Society Limited ('L&G') didn't pay the full benefit on a group critical illness policy ('the policy') they're both beneficiaries of after Mr A was diagnosed with a critical illness.

What happened

Mr A joined the policy in 2018 and the critical illness benefit selected for him was £10,000. This benefit increased to £50,000 in August 2022.

A claim was made on the policy in early 2024 after Mr A was diagnosed with cancer.

L&G agreed to pay the £10,000 benefit but it declined to pay the remaining benefit of £40,000 because it concluded that the following policy exclusion applied:

> We will not pay benefit for an insured condition occurring within the two years of an insured person joining the plan that has resulted from any related condition for which they:
>
> - Have received treatment
> - Had symptoms of
> - Have sought advice on, or
> - Were aware of
>
> For the above, the insured condition may have directly or indirectly resulted from a related condition.

I'll refer to this as 'the exclusion'.

Unhappy, Mr A complained to L&G and when it maintained its decision, he brought a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. Mr A disagreed so this complaint has been passed to me to consider everything afresh to decide.

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.

That includes the detailed submissions provided by Mr A. I won't respond to each point made. I hope Mr A understands that 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 we're 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 point to be able to fulfil my statutory remit.

L&G has an obligation to handle insurance claims fairly and promptly.

I know Mr A and Ms F feel very strongly that L&G has acted unfairly by only agreeing to pay the £10,000 benefit and I have a lot of empathy for Mr A and the circumstances which led to the claim. However, I don't uphold this complaint. I'll explain why.

- The policy terms reflect that the exclusion will also apply to each increase in an insured person's benefit. And for this purpose, whenever the exclusion refers to the day of joining the plan, it should be read as the day of the increase.
- Mr A was diagnosed with cancer within two years of the benefit increasing in August 2022.
- Having considered the medical evidence I'm satisfied that L&G has fairly and reasonably applied the exclusion as I'm persuaded that Mr A was aware of a related condition before the benefit increased.
- Mr A was diagnosed with renal carcinoma and this was the reason a claim was made under the policy.
- There's an entry in Mr A's GP notes dated 12 May 2022 – so a few months before the benefit increased - reflecting that a telephone consultation took place and that the doctor "explained will need further imaging to further investigate the renal lesion".
- I'm satisfied that L&G has fairly concluded that the telephone consultation was with Mr A. The entry refers to "pt also asked" and I'm satisfied that the reference to "pt" is patient – so in this case Mr A.
- Further, when responding to our investigator's view, not upholding this complaint, Mr A said: "through the course of the conversation, [the doctor] relayed 1) moderately fatty liver 2) a kidney cyst 3) more detailed scans would be required". I don't think that's wholly inconsistent with what the GP entry reflects.
- I've taken on board all Mr A's comments including what he says about the kidney cyst / lesion not being promptly investigated through no fault of his own. And that this led to an unnecessary delay in his cancer diagnosis.
- I accept that Mr A wouldn't have been aware that the kidney lesion / cyst discovered (it seems incidentally as a result of an ultrasound on his abdomen) was cancerous before the benefit increased in August 2022. However, at the time the benefit increased, I'm persuaded that Mr A was aware of the existence of the kidney cyst / lesion and further investigation was required. The medical evidence supports that CT imaging on this lesion / cyst was undertaken in late 2023. This informed the decision to remove the cyst and the histology report confirmed the cancer diagnosis.
- I'm satisfied L&G correctly paid the £10,000 benefit as this was the benefit in place when Mr A was originally added to the policy and, in the circumstances, the exclusion isn't relevant to this element of the benefit.

My final decision

I don't uphold this complaint.

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

David Curtis-Johnson
Ombudsman