DRN-5501019

## The complaint

Ms W's complained that Legal and General Assurance Society Limited ("L&G") unfairly delayed settlement of her critical illness claim.

## What happened

In autumn 2022, Ms W bought a life and critical illness policy from L&G. The policy provided increasing cover over a term of 18 years. But Ms W subsequently rejected the indexation, so cover remained at its initial level of £36,000.

In May 2024, Ms W was diagnosed with cancer. So she submitted a claim to L&G. L&G gathered medical evidence to help them assess her claim. Towards the end of September, L&G paid Ms W a total of £36,354.59, made up of the sum assured, plus interest. And they separately refunded her the premiums paid while the claim was considered.

Ms W complained about the length of time it had taken to settle her claim. She said this had added hugely to the stress of dealing with her diagnosis which had left her unable to work. And so she was unable to secure living accommodation when she was forced to move.

In response, L&G explained how they'd assessed Ms W's claim. They said they'd had to request medical evidence on several occasions to clarify the position. And they'd contacted Ms W to explore the answers she'd given to the health questionnaire she'd completed when she applied for the policy. But they acknowledged there were occasions they could have progressed matters more quickly. They offered Ms W £300 compensation for this, which they later increased to £400.

Ms W didn't accept L&G's offer and brought her complaint to the Financial Ombudsman Service. She told us she thought £5,000 would be a reasonable amount to compensate her for what had happened.

Our investigator reviewed the information provided and concluded the £400 L&G had offered was a reasonable amount to compensate Ms W for the delays in her claim. He said it was reasonable for L&G to request the information they had from Ms W's doctors – and he couldn't hold them responsible for any delays in the doctors replying to those requests. But he was satisfied there were short delays on L&G's part. And he said they could have communicated with Ms W more clearly about what they were doing to progress the claim.

Ms W didn't agree with our investigator's view. L&G made no comment, except to confirm they've now paid Ms W the £400 compensation they offered. I've now been asked 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 that, I'm not upholding Ms W's complaint. I'll explain why.

It's clear from everything I've read that Ms W has had an extremely difficult time. That would be the case for anyone receiving a cancer diagnosis. But, for Ms W, this coincided with other difficulties in her life. She's referred throughout her complaint to being in a "critical" situation. And she looked to her critical illness policy to alleviate some of those difficulties.

I understand why she made that connection. But the policy provides covers for someone who's diagnosed with a condition that's defined as a "critical illness". So, before they pay a claim, L&G is entitled to satisfy itself that the medical condition meets that definition by reference to medical evidence. And they're entitled to check the medical information provided at the time the policy was purchased was accurate. My role is to decide whether L&G have been fair and reasonable in how they've done this.

It took from late May until late September – just over four months – for L&G to process and pay Ms W's claim. I appreciate Ms W felt that time very keenly. But, as I've said above, it's not unreasonable for L&G to have verified she had a valid claim before paying it.

As our investigator explained, I can only say L&G should pay compensation if I'm satisfied not only that something went wrong, but that was L&G's responsibility. As in all cases of this type, L&G had to rely on third parties to provide them with the information they needed to verify the claim. That inevitably added to the time it took for the claim to be processed. But that doesn't mean L&G delayed. I'm satisfied they reviewed Ms W's claim as they would any other.

Ms W expressed some concern that L&G made several separate requests for information to satisfy themselves she'd provided accurate information in her application. I accept this might look inefficient. But guidance provided by the Association of British Insurers (ABI) says insurers should limit requests for medical information to what they need to assess the claim, or to check that a customer gave an accurate medical history.

I can see in this case that information provided by Ms W's GP prompted L&G to make these history checks. They needed to make several requests to do this as well as contacting Ms W. I'm pleased to see those enquiries led to payment of the claim. But, as L&G followed the ABI guidance in how they approached this, I can't say it amounted to an unreasonable delay.

I agree there were short periods when L&G could have processed information more quickly. But, like our investigator, I think the £400 compensation L&G have already paid is sufficient to recognise this. So I'm not asking them to do any more to resolve Ms W's complaint.

**My final decision**

For the reasons I've explained, I'm not upholding the complaint Ms W's made about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms W to accept or reject my decision before 23 May 2025.

Helen Stacey
**Ombudsman**