DRN-5503553

## The complaint

Mr O's complained about the amount of time The Royal London Mutual Insurance Society Limited, trading as Scottish Provident ("RL") has taken to consider his claim.

## What happened

Mr O bought a policy from RL in 2000. The policy provided him with cover if he was diagnosed with one of the covered critical illnesses, a terminal illness or was totally and permanently disabled so that he couldn't do his job.

Mr O had been diagnosed with a form of glaucoma in 2002. By spring 2023, this had caused his sight to deteriorate to the point where it was very difficult to do his job. So in early 2024, he made enquiries about whether he could make a claim on the policy. His condition didn't meet the policy criteria for blindness, so wasn't considered as a critical illness claim. But RL considered under the total permanent disability section of the policy. The claim remains ongoing.

Mr O has complained about the steps RL has taken to verify the claim and says this has caused unreasonable delay. RL responded to his concerns on 19 September 2024. Mr O didn't accept RL's response and brought his complaint to our service.

An investigator reviewed what had happened up to 19 September 2024 and concluded that, up to that date, RL had dealt with Mr O's claim fairly and reasonably. While she acknowledged Mr O's complaints about what has happened since then, she explained we couldn't investigate those unless they were first raised with RL.

Mr O didn't agree with our investigator's view. So the complaint's been passed 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.

Having done that, I'm not upholding Mr O's complaint. I know he'll find my decision frustrating and I'm sorry about that. I hope it will help if I explain the reasons why I've made it.

Before I do that, I want to clarify that the Financial Ombudsman Service can only investigate where a business has had the opportunity to consider, and respond to, their customer's complaint. I know Mr O has ongoing concerns about how RL are dealing with his claim. But I can't look at any concerns that have arisen since RL sent their final response letter in September 2024 because Mr O hasn't raised them with RL. If he wants our service to investigate anything that happened after the date of the final response letter (19 September 2024), Mr O will need to make a new complaint to RL first.

My role is to decide whether RL have assessed Mr O's claim fairly and reasonably. I can only say they should do something differently if I think they didn't do that – and that had a

negative impact on Mr O. And I can't step into RL's shoes and decide whether the claim should be paid.

We expect businesses to deal with claims promptly and fairly, in line with the terms of the policy. But we think it's fair for businesses to gather and review information to help them decide whether a claim meets the policy terms. And they can check that the information they received when they sold the policy was accurate.

In this case, the policy document confirms that, to consider a claim, RL will need to a completed claim form and confirmation from a medical specialist that the condition claimed for meets the policy definition.

Although Mr O's sight has sadly deteriorated, the deterioration hasn't met the policy definition of blindness. So RL have been considering whether it means it has totally and permanently disabled him, such that he can no longer do his job. I think it was reasonable for them to do this.

The policy definition says total permanent disability is:

*"Becoming permanently disabled through illness or injury:*

- *before age 65,*
- *while having a full time (16 hours or more a week) remunerative occupation immediately before the start of the disability, and*
- *to the extent of being medically or physically unfit to perform that occupation.*

*The disability must be irreversible with no reasonable prospect of there ever being any improvement."*

When they received his claim form, RL contacted Mr O's employer for information. I know Mr O wasn't happy about that. But I think it was reasonable for them to do that, because the policy terms say that Mr O should have a full time role, which he can no longer perform. So it was fair for RL to assess whether that term was met.

I can see from the documents provided that Mr O's employer didn't respond to RL for nearly three months. While I accept that was frustrating for Mr O, it wasn't RL's fault. So I can't say they should compensate him for this. Nor do I think it was unreasonable for RL to ask further questions when they did get the information, because it gave different details about when Mr O's condition prevented him from doing his job.

RL were also entitled to satisfy themselves that Mr O's condition meant he would be permanently disabled. It was reasonable for them to request medical information to help them do this.

RL didn't request this information until late June. While they could have requested this sooner, I don't think it caused any avoidable delay, because the doctors sent documentation while RL were still clarifying information from Mr O's employer. So I don't think the claim would have progressed any faster if medical information was received sooner. I'm satisfied that RL regularly chased both the employer and the doctors to get what they needed. So, overall, I don't think they were responsible for delaying the claim between when it was made and when their final response letter was sent.

I understand Mr O is also unhappy that RL investigated whether he'd provided accurate information about his medical condition when he'd bought the policy.

Insurers rely on the information provided by customers to decide whether to offer cover, on what terms and at what cost. So we think it's reasonable for an insurer to check this if, when

they're assessing a claim, they receive something which makes them question the accuracy of the application information.

The report received from Mr O's doctors in July 2024 said that Mr O was first diagnosed with his condition in 2000. That was the year he applied for the policy. He didn't declare in his application that he had any issues with his eyes. In those circumstances, I think it was reasonable for RL to make further enquiries to satisfy themselves the sale of the policy had been based on accurate information.

It's now just over a year since Mr O submitted his claim. So I understand why he's frustrated RL still haven't decided whether to pay it. I hope they can do that soon. But, for the reasons I've explained, I don't think they dealt with the claim unreasonably up to 19 September 2024. So I don't think RL need to do anything more to resolve this complaint.

**My final decision**

For the reasons I've explained, I'm not upholding Mr O's complaint about The Royal London Mutual Insurance Society Limited, trading as Scottish Provident.

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

Helen Stacey
**Ombudsman**