DRN-5543029

The complaint

Mr and Mrs R complain that Unum Ltd has unreasonably declined to consider a critical illness claim. They are represented by a claims management company ('*CMC*').

What happened

Mr R holds employee benefits through his employer's group protection scheme – including critical illness and life cover - and these had a provision to add cover for a partner or spouse. Mr R's elected benefits are revisited annually in June, with benefits to begin on 1 July.

In January 2014, Mrs R was diagnosed with a type of cancer, which required many months and years of treatment up to 2017, including a double mastectomy. Sadly, Mrs R's cancer recurred in 2022. At that time, Mr R made a claim under his employer's group scheme – which was underwritten by a different insurer.

The claim was declined on the basis that Mrs R had previously suffered with cancer. So, Mr R approached Unum to establish if a retrospective claim could be made, as it was the insurer for his employer's group critical illness scheme from November 2009 onwards.

In October 2023, the broker for the employee benefits scheme told Mr and Mrs R that Unum couldn't consider their claim. Unum said it had tried to assess it, but it did not have sufficient eligibility information to establish whether Mrs R was part of the employer's group scheme at the relevant date of her diagnosis – because the scheme had closed meaning it couldn't keep records beyond data protection limitation periods, which had since passed.

So, Mr R complained via the broker. It was argued that the condition relied upon by Unum was unfair, because Mrs R had ongoing deficit from her diagnosis and treatment for several years, and she couldn't make a claim at the time.

In November 2023, Unum rejected the complaint. It said the late notification had impaired its ability to assess the claim, specifically regarding Mrs R's eligibility to the scheme – for which there was no clear evidence that she was a member at the time of her diagnosis. So, it couldn't change its decision to decline to process the claim.

The CMC lodged Mr and Mrs R's complaint with this service, where it was considered by one of our investigators. She felt that the clause relating to a time limit for notification of a critical illness event was not the crux of the issue – as Unum had suggested. However, she did otherwise agree that Unum had been reasonable to decline the claim, because on the information she had seen from Mr R, it wasn't clear that Mrs R was a member of the Unum group scheme in January 2014.

The CMC provided further evidence in the form of some HMRC benefit statements (P11Ds) Mr R had retained from 2014/15, 2015/16, 2016/17, 2017/18, 2018/19 and 2019/20. It said that it was only in later years that Mrs R's cover became separated from Mr R's on his P11D, but looking at the P11Ds together, it should be taken that Mrs R had cover. For example, in 2017, she was itemised as having cover and she couldn't have secured this upon Mr R's renewal if she had applied at that time, because she had already been diagnosed with

cancer three years prior.

However, our investigator said the additional evidence didn't change her view on the complaint. And Unum also remained of the view that it hadn't seen sufficient evidence to be sure Mrs R had critical illness cover in 2014.

The CMC said Mr and Mrs R wanted the complaint to be referred to an ombudsman. It said:

- The broker for the employee benefits scheme operated by the employer provided a spreadsheet showing the cover in place for Mrs R with figures over relevant benefit years. And the values on the spreadsheet accorded with the P11Ds that Mr R has been able to source, such as in 2014/15.
- It is therefore highly unlikely that this spreadsheet is inaccurate.
- Further, the P11Ds show cover was in place – though not the amount.
- It feels that these two forms of evidence are sufficient for Unum to confirm Mrs R was insured at the relevant date, and so it ought to reverse its decision not to consider a retrospective claim.

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.

I'm aware I've set out the background to this complaint in less detail than the parties and I've done so using my own words. However, in reaching my conclusion I've focused on what I consider are the key issues. Our rules allow me to take this approach; it simply reflects the informal nature of our service as a free alternative to the courts. If there's something I haven't mentioned, it isn't because I've ignored it. It's since I don't need to comment on every individual argument to be able to reach what I believe is the right outcome.

Having reviewed this complaint carefully, I agree with the outcome reached by our investigator. I appreciate my decision will be a disappointment for Mr and Mrs R, especially given the CMC has said how challenging their circumstances have been over the last 11 years. I don't underestimate that, but I must be fair to both parties when deciding a complaint.

I also note the CMC has referred to Unum's requirements under the FCA's Principles including those set out at Principle 12, the Consumer Duty. I've carefully considered the detail of those obligations but for the reasons I'll go on to explain, I don't think that Unum has behaved unfairly in the circumstances. So, I can't ask it to do anything further to resolve the complaint.

Like our investigator, I don't believe the crux of the complaint is the 'late notification' condition in Unum's policy wording. That condition says:

> "*If Unum's claim form documentation is not returned fully completed to Unum within 90 days of the critical illness event, Unum shall have no liability to pay benefit in respect of the member, the member's child or the member's spouse, as appropriate. However, if Unum's claim form documentation is returned fully completed to Unum after the 90 days, Unum shall, under its sole discretion, determine whether to consider the claim received.*"

The insurance industry regulator, the Financial Conduct Authority ('*FCA*'), has set out rules and guidance contained in the 'Insurance: Conduct of Business Sourcebook' ('*ICOBS*').

The relevant section, ICOBS 8.1.1, provides that insurers must not unreasonably reject a claim. ICOBS 8.1.2B provides that rejection of a claim for breach of a condition or warranty … is unreasonable unless the circumstances of the claim are connected to the breach.

In my view, that means it would be unfair to decline a claim where the insured event (Mrs R's diagnosis of a type of cancer) would have happened regardless of whether the policy condition was complied with or not. It follows that I don't find it fair or reasonable for an insurer to rely on a late notification clause unless it had been unfairly prejudiced by that late notification. I note Unum has discretion to look at retrospective claims in principle, and I can see that it has tried to do so in Mrs R's case.

That being said, Unum is only able to consider a claim for the insured event of a critical illness if Mrs R was insured under the group scheme at the time of her diagnosis.

I recognise that the former broker has supplied a spreadsheet breaking down the start and end dates for Mr and Mrs R's critical illness cover and premiums from 1 July 2014 to 30 June 2019. And that the CMC has pointed out how the premium values (when multiplied to account for the totals on the relevant P11D's over the same period) match some of the entries for individual premiums on the spreadsheet. However, Unum has explained how its current broker cannot validate that spreadsheet, and it has no supporting documents from the time of each of Mr R's annual benefit selections across the reference period.

Turning to the P11Ds, they vary from year to year as to the itemisation of the various benefits included with Mr R's employment. The CMC says that the P11Ds do not break down the critical illness benefit between Mr and Mrs R. That isn't the case entirely though - as the 2017/18 P11D shows specific cover was itemised as "*Critical Illness Insurance (Employee and Partner)*".

The CMC says the relevant P11D for the period of Mrs R's diagnosis was the 2014/2015 P11D, because to cover that tax year, Mr R must have selected that benefit in June 2013 – because the employee benefit year covers part of the following tax year. I accept that, as the P11D for 2014/15 covers two periods within that tax year (April to June, and July to March for monthly benefit).

But the 2014/15 P11D does not set out if Mrs R is included or not. It says, "*Critical Illness Insurance April 14 to June 14*" and "*Critical Illness Insurance July 14 to March 15*". It then goes on to set out life cover as "*Spouse/Partner Life Assurance*". That is the same as the later 2017/18 P11D.

I appreciate that the shorter period April to June on the 2014/15 P11D has the same figure as the shorter period on the 2017/18 P11D three years later (where critical illness partner cover was specifically itemised). However, the larger period differs, as do some of the figures for the P11Ds in the intervening years. Furthermore, I don't agree these figures tally with the spreadsheet premium breakdown, as suggested; for example, the spreadsheet has different premiums for 2014/15 and 2017/18 for both Mr and Mrs R, so it would not explain the same figures on the P11Ds.

Where the evidence is incomplete, inconclusive or contradictory, I'll make conclusions on the balance of probabilities – that is, what I think is more likely than not to have happened based on the available evidence before me and the wider surrounding circumstances.

Unum says that this information and the spreadsheet taken together aren't sufficient persuasive evidence that Mrs R had critical illness cover in place in January 2014, and I believe that is a fair conclusion to reach in all the circumstances.

That isn't to say that Mrs R wasn't possibly a member of the group critical illness scheme at the time of her diagnosis in January 2014, but rather, there is a lack of clear, objective evidence for Unum to verify her membership. The P11D from that time does not, of itself, evidence that Mrs R was a member of the scheme. And though the former broker has provided a spreadsheet of premiums, this isn't dated and is a restricted list of limited data, including annual start dates and the monthly premiums. Without verifiable evidence of Mrs R being underwritten by the scheme in January 2011, I don't think it's unreasonable for Unum to decline a claim.

It's also important for me to point out that we do not act in the capacity of a regulator. That remit falls to the Financial Conduct Authority ('*FCA*'), where it may look at wider issues governing how businesses conduct their operations or exercise what may be commercial judgement on the provision of a particular service. My role isn't to substitute my view for that of a business but instead, to determine if a business has acted fairly in all the circumstances of a complaint. And in this case, I am not persuaded that Unum has been unfair or unreasonable by declining the claim, where it cannot ascertain with any certainty that Mrs R was a member of the group critical illness scheme at the date of her diagnosis.

I recognise that because of the significant amount of time that has passed, it may not be possible for Mr and Mrs R or their CMC to unearth any further evidence as to Mrs R's insurance status through Mr R's employment back in 2011. However, they remain free to present any new evidence should they locate it to Unum and similarly, they are not precluded from making future complaints.

My final decision

Despite my sympathy for Mr and Mrs R, I do not uphold their complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs R to accept or reject my decision before 18 July 2025.

Jo Storey
Ombudsman