DRN-5682834

## The complaint

Mr C complains about how Liverpool Victoria Services Limited (LV) handled a claim on his life and critical illness policy.

Throughout the claim and complaint process, Mr C has had a representative helping him. In this decision, any reference to Mr C includes the actions and comments of his representative.

## What happened

Mr C took out a life and critical illness policy with LV in 2016. Due to a decline in health, Mr C contacted LV to log a claim in May 2023. The claim was eventually settled in October 2024. Mr C was unhappy with how long the claim took, how much he's been paid and how LV handled the claim. He raised several complaints with LV. LV didn't uphold Mr C's complaints. They didn't think they'd done anything wrong. Mr C was still unhappy so brought the complaint to this service.

Our investigator didn't uphold Mr C's complaint. She agreed that LV hadn't done anything wrong. She said that whilst there were delays, these weren't LV's fault. Mr C appealed. He raised the following points:

- Delays weren't solely due to the medical professionals
- His employment was irrelevant to his diagnosis
- Inappropriate use of the term "mild dementia"
- Compensation should be paid for distress caused and procedural failures

As no agreement could be reached, the complaint has been passed to 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.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly. So, I've thought about whether LV acted in line with these requirements with how they handled Mr C's claim.

At the outset I acknowledge that I've summarised his complaint in far less detail than Mr C has, and in my own words. I'm not going to respond to every single point made. 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 it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I'm satisfied I don't need to comment on every individual point to be able

to reach an outcome in line with my statutory remit.

I'm sorry to hear about Mr C's health. I wish him and his family all the best for the future.

I've covered off what I see as the main complaint points separately below.

**Claim delays**

I've reviewed the claim history in full. Whilst I appreciate the claim was ongoing for a long time, based on what I've seen, I agree with the investigator that this wasn't as a result of LV. When LV needed medical information, I can see that this was requested promptly and chased on a regular basis. I appreciate Mr C doesn't believe all the information was needed, but I've covered that off below. I also think LV assessed the information within a reasonable period of time when received.

Mr C believes a joined up approach should have been used to contact all medical professionals at the same time. LV needed specific information which was provided by specific medical professionals. So, I don't think contacting everyone all the time would have necessarily helped with the claim being resolved quicker. Mr C has also raised about not including himself and his rep in all of these emails. I think LV were proactive in updating Mr C after every request so I don't think there would have been a difference with him being included in the email itself. I've addressed his rep not being in the emails below.

LV did forget to chase up Mr C's historic medical information from his GP. However, this was requested again quickly with a response from his GP received quickly. The response was assessed by their medical officer at the same time as the rest of the medical information, so I don't think this ultimately caused a delay.

**Payment amount**

LV accepted the claim as of 1 August 2024. Based on this as a settlement date, the sum assured paid to Mr C appears correct based on the terms and conditions. However, Mr C feels the claim should have been paid earlier. He's made the following comments:

- His consultant was world leading in her field and he queries LV's consultant's qualifications

- His employment is irrelevant to his diagnosis

- There was an inappropriate use of the word "mild" in his condition severity.

As a starting point, I'm not medically trained and so it's not appropriate for me to comment on whether I think Mr C met the policy definition at an earlier date. My role is to review the evidence to decide based on the information available, did LV act fairly and reasonably in how they came to their claim outcome.

LV's claim handlers have also confirmed to Mr C that they're not medically trained. As such, they requested opinion from a medical officer (MO) on the information provided and the policy definition. Each time LV received new information, I can see LV requested further opinion. LV has confirmed their MO was a specialist in the field in question. Whilst Mr C has requested confirmation of their specific qualifications, I don't think that's appropriate here.

Based on the information LV had received, and the guidance they were provided, I don't think LV were unfair or unreasonable in accepting the claim when they did.

Mr C has asked if LV initially correctly declined the claim based on the use of the term mild and whether they sought the correct expertise. Whilst LV could have sought further expertise on the initial report, I don't think it was required. The report sets out Mr C's test results and shows only one area of impairment. LV were able to use this to decline the claim. I don't think this was unfair or unreasonable.

I agree with Mr C that his employment is irrelevant to his diagnosis, however, the policy definition requires diagnosis of a specific severity. Based on what I've seen, LV didn't use Mr C's employment as the sole reason for declining the claim initially. This was mainly based on a consultant's report from March 2023.

**Customer service**

Mr C has said that he felt there were repeated breakdowns in communication. I don't agree there were. I think LV regularly provided Mr C with updates on the complaint and its status.

Mr C has also said he asked LV to include his partner in emails. He's said this was asked both at the start of the claim process and during it. I've asked LV for copies of call recordings when the claim was first set up. Unfortunately, due to changing their phone systems, LV no longer have copies of these calls. However, I've been through the contact notes in detail. The first time Mr C's partner is named in a contact record is July 2024, it's noted that consent was taken to speak to her. I've listened to this call. Mr C asked for his partner to be included in calls, but didn't ask for her to be included in emails. Had Mr C asked for his partner to be included at the start of the claim, I think Mr C would likely have raised about this not happening sooner. Based on what I've seen, I think it's most likely that Mr C didn't ask for his partner to be included in emails until much later in the process. However, I can see that when Mr C's partner emailed LV, they did respond to her and included Mr C too. It's also noted that Mr C's partner wrote to LV from Mr C's email account, suggesting she had access to the emails sent by LV.

After July 2024, LV did have calls with Mr C alone, but this happened when Mr C contacted LV. When LV called Mr C, this was through his partner. I don't think it would have been helpful for LV to not speak to Mr C when he called to talk to them.

Having reviewed the service provided by LV, I don't think they've done anything wrong. So, I won't be asking them to do anything on this point.

I'm very sorry that my decision doesn't bring Mr C more welcome news at what I can see is a very difficult time for him. But in all the circumstances I don't find that LV has treated Mr C unfairly, unreasonably, or contrary to the policy terms and conditions in how they've handled Mr C's claim.

**My final decision**

For the reasons I've given above, my final decision is that I don't uphold this complaint. I don't require Liverpool Victoria Services Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 17 October 2025.

Anthony Mullins
**Ombudsman**