DRN-5703836

The complaint

Mrs H has complained that Legal and General Assurance Society Limited ("L&G") unfairly declined the critical illness claim she made following heart surgery.

What happened

In 2009, Mrs H bought a life and critical illness policy with a 25 year term. In early 2024, Mrs H underwent surgery on her heart. So she made a claim on the critical illness part of her policy. L&G declined the claim because they said the condition she was claiming for wasn't covered by the policy terms.

Mrs H complained, but L&G didn't change their decision. So Mrs H brought her complaint to the Financial Ombudsman Service.

Our investigator reviewed the information provided by the parties and concluded L&G didn't need to do anything different to resolve the complaint. He was satisfied that the surgery Mrs H had didn't meet the definitions in the policy. So he thought it was reasonably for L&G to have declined the claim.

Mrs H 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 Mrs H's complaint. I know this isn't the outcome she was hoping for. I hope it will help if I explain the reasons for my decision.

I was very sorry to read about Mrs H's health issues over the last few months. I'm pleased to see she is recovering. But there's no doubt in my mind that she suffered a serious medical issue. So, I understand why she feels she should be able to claim on her policy.

But, despite its name, the success of a claim on a critical illness policy doesn't depend on how ill someone was – it depends on whether the condition they have is covered by the policy terms. Critical illness policies have to provide cover for heart attacks, strokes and cancer – none of which Mrs H had. Beyond that, they can specify what conditions they will cover, and the conditions which must be met for cover to be provided.

Mrs H's surgery involved a median sternotomy (incision through the breast bone) to repair a hole in her heart. The drainage from a vein was also corrected.

Mrs H's policy provides cover where a median sternotomy is performed to repair or replace a heart valve, or to correct narrowing or blocking of a coronary artery with by-pass grafts. The relevant sections say:

"Heart Valve Replacement or Repair – with surgery to divide the breastbone

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

Coronary Artery By-Pass Grafts – with surgery to divide the breastbone

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts."

I've reviewed the medical evidence provided by Mrs H's doctors to L&G. While it's supportive of Mrs H's claim, it doesn't show that she had by-pass grafts, or that any of her heart valves were repaired or replaced.

So I think it was reasonable for L&G to decline her claim, on the basis the policy conditions hadn't been met. Mrs H has submitted the policy term is met because the function of one of her heart valves has improved as a result of the surgery. But I can't agree with that, because the term is clear that cover is provided when it is the valve which is repaired – which wasn't the case here.

Mrs H has also said it's unfair for L&G to decline the claim because more recent versions of their policy would have covered her condition. And L&G never provided her with the opportunity to update her cover.

I understand why Mrs H says this. But the cover Mrs H has – and the premium she paid - is based on the information she provided at the time she bought the policy. I can't reasonably say L&G should apply more recent terms to her claim.

I can see Mrs H says she'd have expanded her cover if L&G had told her that was an option. I've thought about this but it's not something I can say L&G should have done. They didn't sell Mrs H the policy – she bought it via a broker. It would be for the broker to advise her about reviewing her cover. And, while I note what she's said, I can't be satisfied Mrs H would have updated her cover, because any new policy would have had to be underwritten and costed. It's very unlikely that additional cover would have been offered without Mrs H having to pay a higher premium.

Mrs H has outlined the issues she's faced as a result of her ill health. While I do sympathise, I can only say L&G should do something different if I don't think they've applied their policy terms fairly and reasonably. I don't think that's the case. And so, I don't think they need to do anything more to resolve Mrs H's complaint.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H to accept or reject my decision before 9 September 2025.

Helen Stacey
Ombudsman