DRN-5766299

The complaint

Mr S complains about Legal and General Assurance Society Limited's actions relating to a claim he made on his critical illness insurance cover.

What happened

The history of this complaint is well known to both parties, so I won't repeat all the details here. In brief, Mr S took out critical illness cover in 2002. The policy was bought via a broker and is now underwritten by L&G.

In July 2024, Mr S contacted L&G about making a claim for cardiomyopathy. Following initial assessment, he was told it wasn't possible to proceed with his claim as his policy didn't provide cover for his condition.

Mr S said this was unfair and created a two-tier system, as newer policies did provide such cover and he'd been a loyal, paying customer for years. He complained, but L&G maintained its position.

Mr S was unhappy about this, so came to the Financial Ombudsman Service. Our investigator didn't uphold the complaint, saying she couldn't fairly ask L&G to pay a claim for a condition that wasn't covered under the policy.

Mr S disagreed so the complaint has come to me for 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 so, I'm not upholding this complaint. I know this news will be disappointing to Mr S and I'm sorry about that. I'll explain my reasoning below, focusing on what I consider to be the central issues. So if I don't refer to something specifically, it's not because I haven't thought about it. Rather, I don't think it changes the outcome. I'd particularly like to assure Mr S that I've considered all of the cases and regulatory references and requirements he cited. Each complaint is considered on its own merits, taking into account the relevant law and regulation. I've not identified anything in the evidence Mr S cited that would lead me to alter my decision.

Critical illness benefit provides cover for serious illnesses and conditions. Aside from an industry best practice requirement to provide cover for three core conditions – cancer, heart attack and stroke – insurers are free to decide which conditions they will and won't cover. No policy provides cover for all serious illnesses and conditions in all circumstances.

Mr S took out his policy in 2002. So the terms he agreed to in 2002 are the terms against which any claim is assessed. I've reviewed Mr S's policy terms and unfortunately, in 2002, cardiomyopathy wasn't one of the conditions covered under Mr S's policy.

I can understand Mr S's frustration about this and the fact that policies issued after 2004 do provide such cover. Mr S feels L&G have acted unfairly in not telling him about the inclusion of cardiomyopathy on its newer policies.

Insurers are expected to keep customers informed about any changes to their existing policies – such as L&G has done in relation to the reviewable premiums on Mr S's existing policy. But there's no requirement for an insurer to tell customers about new products or about changes that are made to the conditions covered under newer policies. Such changes do not apply retrospectively to existing customers. Each policy is priced according to the policy holder's individual circumstances and accepted on the specific terms offered.

I appreciate Mr S feels he should've been told. But I've not identified any failing here by L&G and it was open to Mr S to review his policy or seek advice at any point, should he have felt his cover needed updating.

Mr S has also said that L&G told him his cardiomyopathy was a covered condition, without any qualification. And this created a legitimate expectation that was subsequently not met. But I don't think that's the case here.

I've listened to the call Mr S made to L&G, first enquiring about making a claim. Early on in the call, the agent asked Mr S what he was looking to claim for and what his diagnosis was. Mr S said he'd seen that cardiomyopathy was on L&G's current list of things you can claim for, but he took the policy out years ago, so didn't know whether it was covered. After checking, the agent tells Mr S that cardiomyopathy was only added to the covered conditions in 2004 and his policy was taken out in 2002. She explained that she wasn't saying Mr S couldn't claim. Rather, she was just noting the condition wasn't on his policy. She suggested Mr S could start a claim and let an assessor look at it.

Mr S commented that this didn't sound very good and the agent reiterated that she wasn't sure if that meant Mr S was covered as she wasn't an expert to say that he couldn't claim. She again suggested he start a claim and if the assessor didn't think Mr S was covered they would let him know.

Having listened to this conversation, I'm satisfied no expectation was raised regarding the likely progress of a claim. Indeed, I think it was quite clear that Mr S had questions about the extent of his cover and the agent gave no false hope about any prospect of success.

So overall, I don't think L&G has acted unreasonably in relying on the terms of Mr S's policy to say his claim could not progress as cardiomyopathy wasn't a covered condition. Neither do I think L&G treated Mr S unfairly whilst his claim was being raised and investigated. It follows I'm not going to ask L&G to do anything more in respect of this complaint. Once again, I'm sorry to send unwelcome news to Mr S.

My final decision

For the reasons given above I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 25 September 2025.

Jo Chilvers
Ombudsman