DRN-5862982

The complaint

Mrs B complains about the settlement value of a claim she made on her life and serious illness policy, provided by Vitality Life Limited. Mrs B is also unhappy about the way in which Vitality communicated its decision.

What happened

The history to this complaint is well known to the parties, so I won't repeat all the details here. In brief summary, in 2018, Mrs B took out life and serious illness cover. Most unfortunately, in June 2024, Mrs B suffered a cardiac arrest whilst at home, necessitating emergency life-saving treatment and the subsequent surgical insertion of an implantable cardioverter defibrillator (ICD).

Mrs B later contacted Vitality to make a serious illness claim. After receiving information from Mrs B's treating consultants, Vitality accepted the claim, making a payment to Mrs B of £14,202 in January 2025. The payment was made under the policy definition for *permanent defibrillator insertion due to cardiac arrest* – an event which is paid at severity level D (25% of the benefit) under the terms of Mrs B's policy.

Mrs B complained but Vitality maintained its position. So Mrs B came to the Financial Ombudsman Service. Our investigator didn't uphold her complaint, so Mrs B asked for an ombudsman to review everything and issue a final decision.

By way of clarification, I'd like to cover off one point about the scope of Mrs B's complaint. I've noted that Vitality made an offer of £100 compensation to Mrs B in connection with issues relating to the provision of information following a Data Subject Access Request. Mrs B rejected the compensation and has subsequently confirmed to our investigator that she is not complaining about the £100. I'm aware our investigator did refer to this in his opinion, but given Mrs B's clearly stated wishes, my decision will deal only with her complaints about the settlement of her 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.

Having done so, I'm not upholding this complaint. I know this will be disappointing news for Mrs B and I'm sorry about that – particularly as I can see Mrs B has experienced some very challenging times following her cardiac arrest. I'll explain my decision, focusing on the points and evidence I consider material to the outcome. So, if I don't refer to a specific point or piece of evidence, it's not because I haven't read and thought about it. Rather, I don't think it changes things. My reasoning is summarised below.

Serious illness insurance provides cover for defined events, illnesses and conditions. But it doesn't provide cover for serious ill-health in all circumstances. In line with best practice guidance from the Association of British Insurers, aside from providing cover for three core

conditions - cancer, heart attack and stroke - insurers are free to decide which conditions they will and won't cover.

Mrs B took out cover in 2018. So any claim against the policy is assessed on the terms and conditions in place when the policy was accepted – not any different terms that may be applicable to other or newer policies.

Mrs B's policy terms set out the conditions covered and the severity levels relevant to each condition. Mrs B's policy schedule shows that she chose primary cover, meaning that the amount of benefit paid will range from 15-100% of the full amount, depending on the defined severity of the condition.

I've reviewed the medical evidence available. The hospital discharge summary confirms that Mrs B suffered a cardiac arrest, secondary to dilated cardiomyopathy. She was referred for an ICD which was fitted two weeks later. Mrs B was discharged with follow-up care from the cardiology clinic.

I can see Mrs B's claim was assessed under appendix 1 section 1.b of her policy - *Heart and Artery category – specified conditions of defined severity*, contained on pages 74-77 of the full policy terms. Mrs B's claim was settled under the category *permanent defibrillator insertion due to cardiac arrest*. This category is paid at 25% of the full benefit. I've considered the conditions covered in section 1.b alongside the medical evidence.

Having done so, I'm satisfied Mrs B's claim didn't meet any definition for a higher payout. For example, any of the categories dependent upon a reduction in the ejection fraction require that reduction to be permanent. Mrs B's consultant was unable to confirm this when providing information for the purposes of the claim. So I don't think Vitality acted unfairly in settling Mrs B's claim as it did.

Mrs B was also unhappy about how Vitality communicated with her. She's said she received her payout without any explanation about what she was being paid out for and how the amount of benefit had been calculated.

I can understand Mrs B would've found this frustrating and that she lacked important information at a difficult time. Vitality indicated that its business process is to provide headline information only, as the full explanation can be found in the policy documentation, sent out when the policy commenced. But I can see that Mrs B did receive confirmation of the claim category and severity level approximately two weeks after her claim was paid, when she raised a complaint. The email stated:

> *Your claim was reviewed under the definition: Defibrillator Insertion due to Cardiac Arrest, and this procedure is payable under severity level D, which is 25% of your serious illness.*

Mrs B also received further and fuller explanations in letters sent in April and May 2025. I acknowledge Mrs B was left with some unanswered questions, but I think Vitality provided enough information relatively early on for Mrs B to know the basis of her settlement.

I appreciate Mrs B feels strongly about this situation and likely will not be happy with my decision. But overall, I don't think Vitality acted unfairly, so I'm not going to ask it to do anything further in respect of this complaint. Once again, I'm sorry to send unwelcome news.

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 Mrs B to accept or reject my decision before 3 November 2025.

Jo Chilvers
Ombudsman