

The complaint

Miss H complains that Phoenix Life CA Limited (PL) declined a claim on her life and critical illness policy.

What happened

Miss H took out a life and critical illness policy in 2000. Due to a deterioration in health, Miss H contacted PL to raise a claim with claim forms sent to Miss H in November 2024. PL declined the claim in early-March 2025. Miss H was unhappy and raised a complaint. PL didn't uphold Miss H's complaint as they didn't think they'd unfairly declined the claim. PL invited Miss H to provide additional information for the claim to be considered further. As Miss H was still unhappy, she brought the complaint to this service.

Whilst the complaint was with this service, Miss H provided PL with further information. PL declined the claim again based on the new information. Whilst no new complaint was raised with PL on the further decline, PL has consented to us considering it within this complaint.

Our investigator didn't uphold the complaint. They didn't think PL had unfairly declined the claim based on the evidence available and the terms and conditions. Miss H appealed. She said PL had previously accepted she couldn't stand and a month later have said she can. 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.

I'm very sorry to hear about Miss H's health and how it impacts her day to day life. I wish her all the best for the future.

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, and not unreasonably decline it. So, I've thought about whether PL acted in line with these requirements when it declined Miss H's claim.

Having done so, and whilst I appreciate it'll come as a disappointment to Miss H, I've reached the same outcome as our investigator.

At the outset I acknowledge that I've summarised her complaint in far less detail than Miss H 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.

As a starting point, it's important to understand what the policy requires for a successful claim. The policy sets out the following:

“Permanent Disability Benefit and Permanent Disability Prepayment

Failure of activities of daily working

If the Life Assured has not reached 60 years of age at the date of admission of the claim the Life Insured shall be considered to be disabled for the purposes of this section if as a direct result of illness or accident sustained during the term of the policy the Life Insured is permanently and totally unable to perform three out of six of the following activities of daily working without the physical assistance of another person, even with the use of appropriate assistive aids and appliances:

Walking

Walking, on a level surface with a walking stick or other aid, more than 200 metres on the flat without having to stop or suffering severe discomfort.

Standing

Standing, with the aid of a walking stick if necessary.

Use of pen, pencil or keyboard

Using a pen, pencil or computer keyboard with either hand.

Hearing

Hearing, with the use of a hearing aid if necessary, well enough to understand someone speaking a common language in a normal voice in a quiet room.

Speech

Being understood in a common language in a quiet room by people with normal hearing.

Vision

Seeing, using spectacles, contact lenses or other aids if necessary, well enough to read a large print book (16 point) placed in front of the life insured.

In addition, the life insured must be under the care and attention of a specialist appropriate to their condition.

For the purposes of this definition ‘physical assistance’ means the actual physical participation of another person in the activity or activities and not merely their supervision or encouragement.”

There has been no dispute that Miss H doesn't meet the hearing, speech and vision criteria within the policy definition. Initially PL declined the claim on the basis there was no evidence that she met the use of pen, pencil or keyboard criteria. However, following the claim decline Miss H's GP provided the following information:

“I can confirm that the above-named person is unable to walk on a level surface with a

walking stick more than 200 metres without having to stop or suffering severe discomfort. She requires the aid of a walking stick to stand. Due to pain in the joints of her hand she tells me that she is now unable to use a pen/pencil or keyboard without assistance and has to get family members to help with this."

PL accepted that Miss H met the pen, pencil or keyboard criteria after receiving the above information. However, the GP's letter above confirmed that Miss H was able to stand with use of a walking stick. This was new information that they hadn't been told previously. PL then declined the claim on the basis that only two of the six (walking and pen/pencil/keyboard) criteria had been met. Having reviewed the evidence provided, I don't think PL has unfairly declined the claim based on the information provided by her GP and the policy terms and conditions.

Miss H has said in response to our investigators view that PL had accepted she'd met the standing criteria previously. In their claim decline letter in early-March 2025, PL stated the following:

"It is likely that standing and walking may be satisfied with your condition."

PL hadn't confirmed that Miss P had definitely met the standing criteria, however, the claim was declined as these were the only two criteria potentially met. Then following the above information from her GP, it was confirmed that Miss H didn't meet the standing criteria.

I'm very sorry that my decision doesn't bring Miss H more welcome news at what I can see is a very difficult time for her. But in all the circumstances I don't find that PL has treated Miss H unfairly, unreasonably, or contrary to the policy terms and conditions in declining the claim.

Should Miss H's condition deteriorate further, or should she have any additional evidence, she'll be able to provide this to PL for them to consider further.

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 Phoenix Life CA Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss H to accept or reject my decision before 4 December 2025.

Anthony Mullins
Ombudsman