

The complaint

Mrs R complained that Legal and General Assurance Society Limited declined a claim on her group critical illness policy.

What happened

Mrs R was a member of a group critical illness policy. I'm sorry to hear about Mrs R's health. She's had two major diagnoses in a short period of time, and she's been through a difficult time as a result. I wish her all the best with her future treatment and recovery. In October 2024, Mrs R submitted a claim to L&G as a result of a heart condition. L&G declined the claim in December 2024 as they didn't think Mrs R met the policy definition. Whilst she was unhappy, due to her treatment Mrs R didn't raise a complaint until April 2025. L&G didn't uphold Mrs R's complaint. They still didn't think she met the policy definition. Still unhappy, Mrs R brought the complaint to this service.

Our investigator didn't uphold the complaint. They didn't think L&G had unfairly declined the policy. Mrs R appealed. She thought she met the definition at the point of raising the claim and it was unfair for L&G to request medical evidence at a later date. She also thought our investigator was looking at the definition and her diagnosis too narrowly. 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, and not unreasonably decline it. So, I've thought about whether L&G acted in line with these requirements when they declined Mrs R's claim.

At the outset I acknowledge that I've summarised her complaint in far less detail than Mrs R 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 terms and conditions say. For the condition Mrs R is claiming for, the policy sets out the following definition:

“[Condition] – of specified severity

A definite diagnosis of [condition] by a consultant cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical

activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity.*

For the above definition, the following are not covered:

- i. [condition] secondary to alcohol or drug abuse.*
- ii. All other forms of heart disease, heart enlargement and myocarditis.*

**NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain."*

A large part of the dispute has been whether Mrs R has received a definite diagnosis. This is because her consultant has reported her diagnosis as "likely" and "working diagnosis". Mrs R has said this is because a consultant wouldn't make a definitive diagnosis for her condition due to its nature.

Whilst I appreciate the information provided by Mrs R, I don't find that L&G have unfairly declined the claim even without considering whether Mrs R has received a definite diagnosis. This is because in a consultation in March 2025, Mrs R was classified as Class 2+ on the NYHA scale. As the definition requires both a diagnosis and specified severity, you need both to have a successful claim. Whilst I'm sorry to hear about the impact Mrs R's condition has had on her, she doesn't currently have a permanent loss of ability to perform physical activities to at least class 3 of the NYHA scale. So, I can't say it was unreasonable for L&G to decline the claim on this basis.

Mrs R has said she doesn't think it's fair for L&G to request further medical information and not just assess it on the information from the time. She thinks she met the criteria at that time. I don't agree. Whilst she was classified as Class 3 on the NYHA scale at the point of claim, the definition requires permanency. There was no evidence of permanency at the time and her classification has since been downgraded to Class 2+ showing an improvement. I don't think it was unreasonable for L&G to request up to date medical information to validate the claim.

Mrs R has raised concerns about some of the comments made by L&G's medical officer (MO) regarding her claim. As I'm not medically trained, I'm not able to comment on whether the MO's comments are correct or not. However, I don't think the comments in question change the outcome of the claim and the claim has still been fairly declined for the reasons above.

I'm very sorry that my decision doesn't bring Mrs R 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 L&G has treated Mrs R unfairly, unreasonably, or contrary to the policy terms and conditions in declining the 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 Legal and General Assurance Society Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs R to accept or reject my decision before 14 November 2025.

Anthony Mullins
Ombudsman