

The complaint

Mrs S complains about the settlement figure from Zurich Assurance Ltd on a joint life assurance policy she held with her late husband (Mr S).

What happened

Mrs S took out a life assurance policy with her late husband in 1994. I was very sorry to hear that Mrs S's husband died in December 2024. I send my condolences to Mrs S and her family. Mrs S had initially raised a claim in August 2024 under the terminal illness definition. The claim was accepted and paid. However, Mrs S was unhappy with the amount paid as the sum assured had reduced in September. Unhappy, Mrs S raised a complaint. Zurich didn't uphold the complaint as they didn't think they'd done anything wrong. Still unhappy, Mrs S brought the complaint to this service.

Our investigator didn't uphold the complaint. They thought the claim had been paid fairly. Mrs S appealed. She maintained that her late husband had been given a terminal diagnosis in July 2024. 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. So, I've thought about whether Zurich acted in line with these requirements with how they settled Mrs S's claim.

Having done so, and whilst I appreciate it'll come as a disappointment to Mrs S, 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 Mrs S 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 set out the remit of this complaint. Mrs S has also raised with us about the customer service provided by Zurich and has said she thinks the policy was mis-sold. These issues aren't mentioned in Zurich's final response letter and I've not seen any evidence they've been raised with Zurich by Mrs S. So, I've not considered them in this complaint. Should Mrs S remain unhappy with these issues, she'll need to either raise them with Zurich, or, provide us with evidence they've been raised as complaints and eight weeks have passed. We'd then be able to look into them as new complaints.

The policy terms and conditions set out what is needed for a successful claim. Terminal illness in the policy is defined as follows:

“means worsening, incurable disease which, in the opinion of an appropriate consultant physician of a major UK hospital, and in the reasonable opinion of the Company, has reduced the life expectancy of the relevant Life Assured to less than twelve months.”

Zurich wrote to both Mr S’s consultant and GP to assess the claim. Mr S’s consultant’s report in late September stated the following:

“I would estimate his life expectancy to be statistically about one year or over. However, his co-morbidities might reduce this (life expectancy from now with treatment).”

In early October, Mr S’s GP wrote the following:

“I have advised the patient that his condition means he is unlikely to live more than another 12 months”

For a successful claim, the policy requires confirmation of less than 12 months to live. The consultant has given more than 12 months and the GP has said unlikely to live more than 12 months. Neither of these give a definite life expectancy of less than 12 months. The policy also requires the prognosis to be by a consultant and not a GP. As already stated, the consultant’s prognosis was more than 12 months. Zurich requested the opinion of their medical officer and he was in agreement with the consultants prognosis.

The policy sum assured reduced at the start of September and both the above comments were after this date. So, I don’t think it was unfair or unreasonable for Zurich to have settled the claim as they have.

Mrs S has said her husband was given a terminal diagnosis in July. Whilst I don’t dispute this, the policy definition requires a prognosis of less than 12 months to live as well as the terminal diagnosis.

I’m very sorry that my decision doesn’t bring Mrs S 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 Zurich has treated Mrs S unfairly, unreasonably, or contrary to the policy terms and conditions in how they’ve settled 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 Zurich Assurance Ltd to do anything further.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs S to accept or reject my decision before 24 February 2026.

Anthony Mullins
Ombudsman