DRN-5935009

The complaint

Mr and Mrs S complain that The Prudential Assurance Company Limited (that I'll refer to as 'Vitality') turned down Mr S's Serious Illness Cover insurance claim.

As the complaint concerns Mr S's claim, I've mainly referred to him throughout the decision.

What happened

In 2014, Mr and Mrs S took out Serious Illness Cover with Vitality, and this was arranged by a financial adviser. The policy is designed to pay a percentage of the sum assured based on the severity level of a covered medical condition.

Mr S made a claim after being diagnosed with medical conditions that he thought would be covered under the policy. Vitality turned down his claim, as it said the conditions weren't covered. Mr S complained to Vitality about this.

Vitality issued its final response on the complaint. It still said the conditions Mr S was claiming for were not covered. However, it noted that it had not provided Mr S with updates on two occasions and it had failed to send him an acknowledgement to his complaint. It apologised for this and offered him £50 compensation. Unhappy with Vitality's response, Mr and Mrs S brought a complaint to this service.

Our investigator looked into things and recommended the complaint be partly upheld. She thought it had been fair for Vitality to turn down the claim, but she recommended that it increase its compensation payment to £150 to recognise the poor service provided.

Vitality accepted our investigator's findings and recommendations, but Mr and Mrs S did not. The matter has therefore been passed to me for a 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must not unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr and Mrs S's complaint.

I've read the policy schedule and the policy terms and conditions. These form the basis of the contract between Mr and Mrs S and Vitality.

The policy schedule says:

*'We'll make a payment to you if you are diagnosed with a specified illness which meets the definition contained in the **PRIMARY** option that you have selected as part of your Serious Illness Cover. Benefit payment will be proportional to the severity of the illness.'*

The policy terms say:

'The lump sum we pay you will be a percentage of your Serious Illness Cover between 5% and 100%. That percentage will depend on how severe your illness is – based on a scale from levels A to G.
…
Your plan schedule shows whether you have Primary or Comprehensive Serious Illness Cover.

With Primary cover you are covered for severity levels A, B, C and D. With Comprehensive cover you are covered for all the severity levels – from A to G.'

The policy also explains that a claim will only be paid if the insured is diagnosed with a condition that Vitality covers (specified in Appendix 1), and the condition must meet the definition set out in Appendix 1. The amount payable will depend on the severity of the condition, the type of cover held (Primary or Comprehensive), and the amount of cover held.

Appendix 1 in the policy then sets out the definitions of various medical conditions that are grouped by body system categories. Each covered condition is then listed within a severity level of A to G.

Mr S has been diagnosed with severe sepsis and a pneumonia infection, as well as an abscess. The 2014 policy terms don't include cover for sepsis or a pneumonia infection. They also don't include cover for Mr S's particular type of abscess. So, I'm satisfied it was reasonable for Vitality to turn down the claim as none of the conditions were covered.

Mr S has made some arguments as to why he considers the sepsis and abscess ought to be covered. I'll address each in turn.

Sepsis

Mr S points out that newer policies include cover for severe sepsis. I've checked Vitality's website, and I see that severe sepsis is indeed now covered. Though the website confirms the information is based on the latest version of Vitality's Serious Illness Cover. And it says if someone already has a plan, they should refer to their own plan documents. It also says that if someone wants to upgrade their Serious Illness Cover to the latest version, additional underwriting and costs may be incurred.

Vitality has a document titled 'Serious Illness Cover Historic enhancements and changes'. I've read the latest version of this from 2024, and this document explains the various changes that Vitality has made to its Serious Illness Cover over the years, and whether any amendments apply retrospectively. In 2019 Vitality added severe sepsis as a covered condition, but the document made it clear this change didn't apply retrospectively. In other words, it only applied to new policies from 2019.

Mr S has specifically referred to Vitality's obligation to comply with the principles set out in the Consumer Duty that was introduced by the Financial Conduct Authority (FCA). This sets a higher standard for firms in respect of how they interact with their customers and applies to events from 31 July 2023. He has referred to the cross-cutting rule that says firms should avoid causing foreseeable harm. I've taken this into account when deciding if Vitality has acted fairly and reasonably.

However, I'm satisfied Vitality didn't need to apply conditions covered under a newer plan to Mr S's claim. Vitality has explained that premium rates on newer plans will take into account risks associated with that cover. The premium Mr and Mrs S have been paying for their cover is based on the risks Vitality agreed to cover under that particular policy. I think that's fair and reasonable.

Though, even if Vitality had decided to include cover for severe sepsis retrospectively (which it hasn't), it's still the case that a claim wouldn't be payable. That's because Vitality will pay 15% of the sum assured for severe sepsis, and Mr and Mrs S's policy documents confirm this equates to severity level E. They hold Primary cover which only covers severity level A to D. So, it wouldn't be covered anyway. Whilst Mr S thinks his diagnosis meets the spirit and intent of the Serious Illness Cover under severity levels A to D, ultimately, it's up to Vitality to decide what severity level it gives to the medical conditions it covers.

I therefore don't require Vitality to make any payment towards Mr S's claim for sepsis.

Abscess

Mr and Mrs S's policy covers permanent rectal fistula (though it does exclude fistula in ano). Mr S has an ongoing abscess with persistent drainage. He says this is recognised as part of a fistula/abscess disease spectrum.

The NHS says that with Mr S's type of abscess, a fistula can develop, but I haven't seen any medical evidence that this is what Mr S has.

Though even if the medical evidence *did* support that Mr S's condition would be considered a permanent rectal fistula (and wouldn't be specifically excluded as a fistula in ano), this falls under severity level F in the policy. As I've said, Mr and Mrs S hold Primary cover which only covers severity level A to D. So, it wouldn't be covered in any event.

Mr S argues that it's a purely technical exclusion for Vitality not to pay the claim because his schedule says he has cover for severity levels A to D. I disagree. If Mr S had wanted cover for all the conditions, he would have needed to take out Comprehensive cover which would have been priced accordingly.

Whilst I'm very sorry to hear about the impact Mr S's conditions have had upon him and his family, I also don't require Vitality to make any payment towards Mr S's claim for abscess, for the above reasons.

Other issues

Mr S has raised concerns about the sales process. As the policy was sold to him and his wife by a financial adviser, any concerns about the sale should be raised with the adviser. Vitality wasn't responsible for the information Mr and Mrs S were given by their financial adviser about the product, and the difference between Primary and Comprehensive cover.

Mr S says he's been diagnosed with another condition and wants me to tell Vitality to pay the claim. Though Vitality hadn't made a claims decision about this when Mr S brought his complaint here. If Mr S is unhappy with Vitality's claims decision in respect of this condition and it can't resolve his concerns, he can bring a new complaint to this service.

Vitality has already accepted it failed to update Mr S on occasions and didn't send an acknowledgment to his complaint. And as our investigator has pointed out, Vitality did start enquiries into other conditions Mr S had that he wasn't claiming for, rather than just focus on those subject to the claim. Vitality has agreed to pay total compensation of £150 for these issues, and I agree this is reasonable and recognises to impact to Mr S.

My final decision

My final decision is that I partly uphold this complaint. I require The Prudential Assurance Company Limited to pay Mr and Mrs S £150 compensation*.

* The Prudential Assurance Company Limited must pay the compensation within 28 days of the date on which we tell it Mr and Mrs S accept my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs S to accept or reject my decision before 29 December 2025.

Chantelle Hurn-Ryan
Ombudsman