

The complaint

Mrs M is unhappy with the way Vitality Health Limited has handled a claim made on her critical illness policy ('the policy').

Although Mrs M is being represented in this complaint, for ease, I've referred to her throughout.

What happened

The policy was taken out in the 1990s.

Mrs M was sadly diagnosed with Parkinson's disease in 2022. She subsequently made a successful claim on the policy for cash benefit 1 which is when the policyholder is diagnosed as having one of the listed critical illnesses under the policy.

The policy terms and conditions also reflect that an additional benefit can be paid ('cash benefit 2' or 'cash benefit 3') if certain criteria are met.

After Mrs M was medically retired from work, Vitality requested further information and said it will pay cash benefit 2.

Based on her circumstances, Mrs M felt that she qualified for cash benefit 3 rather than cash benefit 2. Cash benefit 3 is significantly more than cash benefit 2.

Mrs M underwent a functional capacity evaluation in October 2024.

In light of the conclusions in the report, and the available medical evidence at the time, Vitality concluded that the criteria for cash benefit 3 to be paid hadn't been met.

Unhappy, Mrs M complained to Vitality. After it maintained its position, she referred her concerns to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold Mrs M's complaint.

Mrs M disagreed and raised a number of points in reply. These, ultimately, didn't change our investigator's opinion. So, this complaint has been passed to me to consider everything afresh to decide.

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.

That includes all points made on behalf of Mrs M (along with all the other evidence). However, I won't respond to each of these. I hope she understands that 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 we are an informal

dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every point to fulfil my statutory remit.

Issues I don't have the power to consider

Just so everyone is clear, I've focused on the issues addressed in Vitality's final response dated December 2024, in so far as they relate to the concerns raised about the information Vitality has taken into account when assessing whether Mrs M is entitled to the cash benefit 3 under the terms of the policy and its decision to not pay that benefit.

Mrs M did raise earlier concerns with Vitality that were addressed in Vitality's final response dated June 2024. Except in limited circumstances - which I've explained below - the rules that govern the Financial Ombudsman requirement stipulate that a complaint must be referred within six months of the date of the final response. Mrs M didn't bring a complaint to the us until much later, in June 2025. I accept that Vitality did respond to Mrs M's follow up points to the final response dated June 2024, in September 2024. But Vitality was clear that if Mrs M was unhappy, it had already provided referral rights to the Financial Ombudsman Service.

We can still consider complaints raised outside of the six-month period if the financial business (in this case, Vitality) consents to us investigating a complaint out of time, or if there are exceptional circumstances meaning that the complaint couldn't have been referred to us within time.

Vitality confirmed in its final response dated June 2024, that it wouldn't consent to us looking at the complaint out of time. And from what I've seen, I'm satisfied that there aren't any exceptional circumstances for Mrs M not referring a complaint to us about the concerns addressed by Vitality in its final response dated June 2024 (and, further, in its letter dated September 2024) to the Financial Ombudsman Service within the stipulated timeframe. So, I don't have the power to consider them.

The relevant policy terms

The terms and conditions of the policy relevant to this complaint are:

Cash benefit 2

If, as a direct result of the critical illness which we have paid a claim for under cash benefit 1:

- You are unable to return to work for a continuous period of 12 months from the date of receiving the initial diagnosis of that critical illness; and
- You are still unable to do so at the end of those 12 months;

We will pay you the amount of benefit in the Benefit Table under cash benefit 2 of your plan at the end of that period.

To qualify for the Critical illness Cash Benefit 2, you must give us:

- written confirmation from your specialist that you have been unfit to return to work as a direct result of your Critical illness since the date of receiving the initial diagnosis; and
- written confirmation from your employer (or from your accountant if you are self-employed), that you have not been back at work during the whole of the 12-month period; and

- proof of your earnings during the 12 months immediately before the date of receiving the initial diagnosis of your Critical illness.

Cash Benefit 3

If, as a direct result of the Critical illness which we have paid a claim for under cash benefit 1:

- you are unable to return to work for a continuous period of 12 months from the date of receiving the initial diagnosis of that Critical illness, and
- you are still unable to do so at the end of those 12 months, and
- you are so totally disabled as to be beyond reasonable hope of improvement;

we will pay you the amount of benefit in the Benefit Table under Cash Benefit 3 for your Plan at the end of that period.

- a) To qualify for the Critical illness Cash Benefit 3, if you were in work before the date of receiving the initial diagnosis of your Critical illness, you must give us:
- written confirmation from your specialist that you have been unfit to return to work as a direct result of your Critical illness since the date of receiving the initial diagnosis; and
 - written confirmation from your employer (or if you are self-employed from your accountant) that you have not been back at work during the whole of the 12-month period; and
 - proof of your earnings during the 12 months immediately before the date of receiving the initial diagnosis of your Critical illness.

We will also assess your ability to perform the activities of daily living at the end of the 12-month period. You must be unable to perform 4 or more of the activities of daily living and to be unlikely ever to improve.

These activities of daily living are set out in Section 1.

- b) To qualify for the Critical illness Cash Benefit 3, if you were not in work before the date of receiving the initial diagnosis of your Critical illness, we will assess you 3 months after the date of receiving the initial diagnosis. You must be unable to perform 4 or more of the activities of daily living. You must remain unable to perform 4 or more of the activities of daily living 12 months after receiving the initial diagnosis and to be unlikely ever to improve.

You can claim for either Cash Benefits 1 and 2 OR Cash Benefits 1 and 3.

Activities of daily living are defined by the policy terms as:

Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means.

Dressing: The ability to take on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.

Feeding: The ability to feed oneself once food has been prepared and made available.

Toileting: The ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate.

Mobility: The ability to move indoors from room to room on surface levels.

Transferring: The ability to move from a bed to an upright chair or wheelchair.

Vitality's decision not to pay cash benefit 3

In considering what is fair and reasonable in all the circumstances of the case, I've taken into account all relevant law and regulations, regulator's rules, guidance and standards, codes of practice and good industry practice at the relevant time. That includes Vitality's regulatory obligation to handle insurance claims fairly and promptly – and to not unreasonably decline a claim.

It isn't disputed that Mrs M was diagnosed with Parkinson's disease and that this was a critical illness under the policy terms. That's why cash benefit 1 was paid to her. Vitality also accepts that cash benefit 2 is payable. Under the policy, either cash benefit 1 and cash benefit 2 can be claimed or cash benefit 1 and cash benefit 3.

I have a lot of empathy for Mrs M's situation. I appreciate Vitality's decision to not pay cash benefit 3 will have greatly impacted her financially.

The crux of the issue I'm satisfied I need to consider is whether Vitality has fairly concluded that it hadn't been established that Mrs M couldn't do four out of the six daily living activities, which is one of the requirements for cash benefit 3 to be paid. I know she'll be very disappointed that for reasons set out below, I'm satisfied that Vitality has acted fairly and reasonably by concluding it shouldn't be paid:

- Mrs M was medically retired from her job with effect of the end of 2022. However, I'm not persuaded that this means Mrs M wasn't able to carry out at least four of the daily activities set out in the policy terms.
- From what I've seen, I'm satisfied Vitality reasonably requested Mrs M's medical history from her GP but there's no evidence that this was received.
- However, I've considered the medical evidence provided.
- The occupational health report dated August 2022 (shortly after Mrs M's diagnosis) reflects that Mrs M reported having considerable difficulty with normal day-to-day activities. She was able to dress herself slowly, but she couldn't get in and out of a bath unaided. Nor could she cook.
- The letters from Mrs M's consultant neurologist don't specifically comment on the daily living activities set out in the policy terms. However, in their letter dated January 2023, they comment that Mrs M's "coordination and walking had improved. Her shaking has also gotten a bit better...she has no bladder or bowel upset...on examination, she did appear to be moving more freely than when I first met her".
- Later that year, in September 2023, the consultant neurologist says they'd seen Mrs M in clinic and "she was doing very well...she can struggle a bit with some activities in the late afternoon but during the rest of the day, especially if she has had a good nights sleep, is very functional". And, on examination, although it was observed that Mrs M had a slight tremor, the consultant neurologist says she has "a good range of spontaneous movements and had normal arm swing when walking".

- The FCE report dated October 2024 reflects that based on Mrs M's self-reporting and indirect testing Mrs M wasn't able to carry out five of the six daily activities set out in the policy terms. Further, based on direct testing, she could only mobilise whilst aided. However, the medical professional who conducted the FCE concluded that "a review of the FCE test results indicate that the physical abilities demonstrated by her during the assessment cannot represent her true functional capabilities, and I can only therefore conclude that her actual abilities are greater than she was willing to perform during testing". The FCE report goes on to explain why.
- Given the overall conclusions of the report, carried out by someone independent of the parties, I'm satisfied that it was reasonable for Vitality to conclude that it hadn't been established that Mrs M couldn't carry out at least four of the six daily activities.
- When making this finding, I've taken into account all points made by Mrs M including what's been said about the qualifications of the medical professional and there being nothing to suggest they're an expert in complex neurological conditions such as Parkinson's disease. However, the report confirms that they are a qualified functional capacity evaluator with almost 30 years' experience. Given the nature of the FCE and the observations made, I don't think the conclusions of the report are unreliable because the FCE wasn't carried out by someone with a specialism in Parkinson's disease. Further, I don't agree that the FCE was unsuitable, not fit for purpose and inconclusive. I'm satisfied that it was fair for Vitality to rely on the conclusions in the FCE report.
- I'm not persuaded in the circumstances of this complaint that Vitality reasonably ought to have contacted Mrs M's treating clinicians for updated reports. I think it was reasonable to rely on the conclusions in the FCE report and the inconsistencies noted.
- I've also considered the occupational therapist's reports Mrs M has provided, dated September 2024 – so around a month before the FCE. The reports reflect that Mrs M was unable to perform three activities of daily living as per the policy terms: washing, dressing and toileting. However, that's less than the minimum of four required under the criteria for cash benefit 3. Further, in relation to toileting, the occupational health report reflects that the limitation relates to managing clothing independently after toileting rather than the ability to use the lavatory or manage bowel and bladder function.
- I'm satisfied that the terms and conditions relevant to this complaint are the ones provided from when the policy started and that they clearly and reasonably set out what's required for the cash benefit 3 to be paid. I'm not persuaded that the later guidance issued by the Association of British Insurers – 'ABI' - (relating to how certain terms and critical illnesses are defined) is relevant to this case as the guidance (and various updates to it) was introduced after the policy started.
- Alternatively, and for completeness, I've seen the policy terms from 2024 and the terms relevant to this complaint – as set out above – are the same. I therefore think it's likely on the balance of probabilities that the relevant terms relating to cash benefit 3 have remained the same since the policy was taken out and I'm not persuaded that they aren't in line with the relevant ABI guide to minimum standards for critical illness cover. Although that guide refers to differently defined daily tasks (and only three needing to be established), that's in the context of the critical illness definition of 'total permanent disability'. Whereas the tasks in the policy document relate to cash benefit 3 which can be paid after cash benefit 1 has been paid (for any

condition defined as a critical illness under the policy terms).

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 6 March 2026.

David Curtis-Johnson
Ombudsman