DRN-6012133

The complaint

Ms T complained that The Royal London Mutual Insurance Society Limited (RL) declined a claim on her critical illness policy. Ms T also complained about the customer service provided.

What happened

Ms T took out a critical illness policy with RL in 2003. I was sorry to hear Ms T was diagnosed with cancer in July 2024. She raised a claim with RL but it was declined under an exclusion. Ms T was unhappy and raised a complaint. RL didn't respond to her complaint so she brought the complaint to this service.

Our investigator didn't uphold Ms T's complaint. He didn't think the claim had been unfairly declined. He also didn't think the service provided by RL was unreasonable. Ms T appealed. She didn't think our investigator had looked into the complaint fairly and he'd overlooked facts. As no agreement could be reached, the complaint was passed to me to make a final decision.

Because I disagreed with our investigator's view, I issued a provisional decision in this case. This allowed both RL and Ms T a chance to provide further information or evidence and/or to comment on my thinking before I made my final decision.

What I provisionally decided – and why

I previously issued a provisional decision on this complaint as my findings were different from that of our investigator. In my provisional decision, I said:

"*I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.*

Based on what I've seen so far, I intend to uphold Ms T's 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 RL acted in line with these requirements when they declined Ms T's claim.

At the outset I acknowledge that I've summarised her complaint in far less detail than Ms T 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.

I've separated the complaint points raised by Ms T for clarity below.

Claim decline

As a starting point, it's important to understand what the policy terms and conditions say. RL has provided us with a copy of the critical illness definitions guide which is dated from May 2003 and has the following definition:

"Cancer

Any malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term cancer includes leukaemia and Hodgkin's disease but the following are excluded:

- *All tumours which are histologically described as pre-malignant, as non-invasive or as cancer in-situ.*

- *Any skin cancer other than invasive malignant melanoma."*

Ms T has disputed the definition used by RL to decline the claim. She doesn't believe the critical illness definitions guide is relevant due to a handwritten date on it. She also states the definition is different to what is recorded on the website. Looking at the website, it states the definition from May 2003 is as follows:

"Any malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term cancer includes leukaemia and Hodgkin's disease but the following are excluded:

- *All tumours which are histologically described as pre-malignant, as non-invasive cancer in-situ.*

- *Any skin cancer other than invasive malignant melanoma."*

The definitions are exactly the same other than "or as" is missing between non-invasive and cancer in the first bullet point. Ms T believes that under the website definition, she would have a successful claim as her cancer wasn't described as pre-malignant, non-invasive cancer in-situ.

I've asked RL about the definition on the website and they apologised as they believe there is an error in the recorded definition and it should reflect what's in the definitions guide.

The Association of British Insurers (ABI) published a Statement of Best Practice for Critical Illness Cover in April 1999. This was replaced with an updated version in May 2002. The guidance provides recommended definitions for certain conditions including cancer. The suggested ABI definition from May 2002, which was relevant at the point that Ms T took out her policy was as follows:

"Any malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term cancer includes leukaemia and Hodgkin's disease but the following are excluded:

- *All tumours which are histologically described as pre-malignant, as non-invasive or as cancer in-situ.*

- *All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least TNM classification T2N0M0.*

- *Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus.*

- *Any skin cancer other than invasive malignant melanoma."*

So, the ABI definition is in line with the definition guide in response or including the "or as" between non-invasive and cancer. In all definitions there is a comma between "pre-malignant" and "as non-invasive" which suggests a list.

Based on what I've seen, I do think the definition in the definition guide is correct and there is an error in the definition on the website. So, I'll be basing this decision on the definition in the definition guide. However, I do think the error on the website has caused Ms T distress and inconvenience, so I intend to award compensation for this. Whilst Ms T would have been sent the definitions guide, this was over 20 years ago. I don't think it's unreasonable for her to have relied on the information on the website in responding to the claim outcome and expecting it to be correct. RL has said Ms T has only recently come across the definition on the website and so think an apology is sufficient. I don't agree. Ms T raised the incorrect definition with RL in response to the claim decline outcome in November 2024.

In relation to the claim outcome, RL requested a report from Ms T's consultant. In the report, her consultant provided the following details:

- *Biopsy result 40mm intermediate grade DCIS. No microinvasion*

- *Confined to [body part] in situ disease.*

This means that Ms T's cancer was non-invasive and in-situ and was excluded under the policy. Whilst I'm very sorry to hear about Ms T's diagnosis and the surgery she required, I don't think RL have acted unreasonably in declining the claim. I wish Ms T all the best for the future.

Customer service

Policy terms

RL have informed Ms T that they haven't retained her policy documents. Whilst this is true in part, as set out above, RL do have some of the policy documentation. The documentation RL haven't retained is the policy schedule. However, based on the information RL have provided, I don't think there's anything that would have been on the policy schedule that would impact the outcome of this claim. Ms T would have been sent the policy documentation when she took out the policy but also no longer has a copy. However, I would still have expected RL to have retained a copy of the policy schedule and by not having it, I do think it's caused Ms T distress and/or inconvenience. I've considered this as part of my compensation award below.

Didn't have a single point of contact

Whilst I appreciate Ms T had responses from more than one member of staff at RL, she did have an assigned case handler. However, when they weren't available, emails would be allocated to other staff members to respond to queries. This is to provide faster responses to customers. I don't think this is unreasonable, so I don't think RL has done anything wrong regarding this point.

Asked to chase medical documents

As our investigator has stated, the onus is on a consumer to show they have a valid claim.

I think RL were proactive in chasing Ms T's medical information. So, I don't think it was unreasonable to try to speed up getting the medical information by asking Ms T to help chase her consultant too.

Not kept up to date with claim

Having reviewed the claim history, I think RL kept Ms T up to date throughout the claim. So, I don't think they've done anything wrong regarding this point.

Complaint incorrectly logged

Under the Financial Conduct Authority's rules, firms are required to treat dissatisfaction raised as a complaint. Based on Ms T's email, I don't think it was unreasonable for RL to pass the details onto their complaints team. So, I don't think RL has done anything wrong on this point.

Complaint not responded to

Whilst complaint handling isn't a regulated activity, we can look into complaint handling when it's ancillary to the complaint being raised. Based on the customer service points raised, I agree this is ancillary, so, I will be looking into it. RL didn't look into the complaint or issue a final response letter to Ms T, so I do think they could have done more. I'm upholding this point and have considered compensation for this below.

Letter

I'm not aware that RL have broken any GDPR rules. The letter was sent to the correct person and correct address. Whilst I do think it would have been helpful for RL to have used Ms T's full name, I can't say they've done anything wrong in how they've addressed the letter.

I appreciate that it must have been frustrating for Ms T to not receive a response to her complaint, for RL to not have retained her policy schedule and for the information on the website to be incorrect. Although this is a distilled version of events, I've considered everything in the round and I think Ms T has been caused an unreasonable amount of distress and inconvenience which has required a reasonable amount of effort to sort out. In line with our website guidelines, I'm intending to award Ms T £200 compensation."

I set out what I intended to direct RL to do to put things right. And gave both parties the opportunity to send me any further information or comments they wanted me to consider before I issued my final decision.

Responses to my provisional decision

RL didn't respond to the provisional decision by the deadline.

Ms T confirmed she didn't agree with my provisional decision as she still thought the claim should be paid. In summary, she made the following points:

- She meets the policy definition
- Retaining the policy documents is a legal requirement
- Website omission isn't an error
- RL doesn't always follow the ABI guidelines

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've thought carefully about the responses to my provisional decision. Most of Ms T's response isn't new information and has already been considered in my provisional decision. Having done so, while I appreciate it will come as a disappointment to Ms T, my conclusions remain the same.

Based on the information provided, I'm not persuaded that the definition on the website doesn't provide an error. I'm more persuaded that the same error has occurred on multiple definitions. Whilst I agree with Ms T that policy documents should be retained by RL, in this case, it's only the policy schedule they don't have. As I've already set out, I don't think this detriments Ms T's claim, but I included it in my compensation award. I'm satisfied that the documents provided by RL are relevant to Ms T's policy and so are the most reliable source of the definition. Ms T would also have been provided with her policy terms and conditions when she took out the policy. She's not been able to provide copies of these documents to dispute the documents provided aren't accurate or the correct versions.

I accept that RL's critical illness document definition for cancer isn't exactly the same as the ABI's. However, this is because it doesn't have as many of the exclusions which the ABI's does. So, it's less restrictive. However, as I set out in my provisional decision, the exclusion being used in this case is exactly the same.

Whilst I'm sorry that my outcome doesn't bring Ms T more welcome news, I'm still not persuaded that RL have treated her unfairly in declining the claim.

Putting things right

To put things right, RL should pay Ms T £200 compensation for the distress and inconvenience caused.

My final decision

For the reasons I've explained above, I uphold this complaint and direct The Royal London Mutual Insurance Society Limited to put things right by doing as I've said above, if they haven't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms T to accept or reject my decision before 7 January 2026.

Anthony Mullins
Ombudsman