

The complaint

Mr and Mrs M complain that Legal and General Assurance Society Limited (L&G) has turned down a claim for terminal illness benefit which Mr M made on a term assurance policy.

Mr and Mrs M's representative brought this complaint on their behalf, but for ease of reading, I'll simply refer to Mr and Mrs M.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

In December 2007, Mr and Mrs M took out a term assurance policy, which had a term of 18 years. The policy included terminal illness benefit. This stated that if a policyholder was diagnosed with a terminal illness and, in the opinion of their treating consultant *and* L&G's medical officer, their life expectancy was no greater than 12 months, L&G would pay the life sum assured in advance. Terminal illness benefit wasn't available during the last 18 months of the policy term. As Mr and Mrs M's policy was due to expire in December 2025, terminal illness benefit cover was due to end in June 2024.

Unfortunately, in May 2024, Mr M was diagnosed with terminal cancer. And in March 2025, he and Mrs M made a terminal illness benefit claim.

Initially, L&G turned down the claim because it said it had been made within the last 18 months of the policy term and was therefore excluded from cover. However, following Mr and Mrs M's appeal, it later concluded that there wasn't enough evidence to show that in May 2024, Mr M's life expectancy would have been no greater than 12 months. So it didn't think terminal illness benefit was payable.

Unhappy with L&G's decision, Mr and Mrs M asked us to look into their complaint.

Our investigator didn't think it had been unfair for L&G to turn down Mr M's claim. He didn't think the evidence from Mr M's treating doctor showed that Mr M's life expectancy had been no greater than 12 months. And he also provided Mr and Mrs M with an opinion from L&G's oncologist which stated that if they'd reviewed Mr M's claim in June 2024, they'd likely have concluded his life expectancy was around 18 months. On that basis, the investigator didn't think L&G had acted unreasonably.

Mr and Mrs M disagreed and so the complaint's been passed to me 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.

Having done so, whilst I'm sorry to disappoint Mr and Mrs M, I don't think it was unfair or unreasonable for L&G to turn down their claim and I'll explain why.

First, I'd like to say how sorry I was to hear about Mr M's diagnosis and the impact of his illness on him and on his family. It's clear this has been a very upsetting time for Mr and Mrs M. I'd also like to reassure them that while I've summarised the background to their complaint and their representative's detailed submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been made and our rules don't require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think L&G handled Mr M's claim fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr and Mrs M and L&G. In summary, Mr and Mrs M held a term assurance policy which was designed to pay out a defined 'sum assured' in the event of either of their deaths during the 18 year term of the policy. However, the policy also provided for terminal illness benefit to be paid in specific circumstances – effectively as an advance payment of the life sum assured. I've set out the relevant section of the policy below:

*'If either Life Assured has a Terminal Illness, namely an advanced or rapidly progressing incurable illness where, **in the opinion of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months**, Legal & General will make an advance payment of the Sum Assured. This benefit will not be available during the 18 months immediately before the Expiry Date.'* (My emphasis added.)

In my view, the policy terms explain, in a clear, fair and not misleading way, that in order for terminal illness benefit to be paid, both the policyholder's attending consultant *and* L&G's Chief Medical Officer must conclude that the policyholder's terminal illness has led to their life expectancy being no more than 12 months.

As I've explained, L&G initially declined this claim because Mr and Mrs M made it within the last 18 months of the policy term. Given Mr M was diagnosed with terminal cancer in May 2024, I'm satisfied he was given a terminal prognosis while the opportunity to make a claim for an advance payment of the sum assured remained in place. But as L&G now appears to accept this point, I don't think I need to make any further finding on it.

Instead, I think the central issue for me to decide is whether it was reasonable for L&G to conclude that Mr M's life expectancy was greater than 12 months in May 2024. So I've looked very carefully at the available evidence to decide whether I'm persuaded this was a fair conclusion for L&G to draw.

In late May 2024, Mr M's treating consultant recorded that Mr M had been given a terminal diagnosis of cancer. They stated that any '*systemic therapy would be aimed at trying to control the disease for as a long as possible.*' They also explained Mr M's likely prognosis was follows:

'I have informed him that without treatment prognosis is likely to be measured at less than 12 months. With combination immunotherapy the median overall survival is 18 months but I have cautioned (Mr M) that these are average figures and unfortunately we can never be certain.'

The consultant said that Mr M was keen to consider systemic therapy. And an SR1 form was also completed. This form is a medical report completed by healthcare professionals in some parts of the UK to confirm a patient has a progressive disease and isn't expected to live for

more than 12 months.

It's clear from the consultant's evidence that without treatment, Mr M's life expectancy would likely have been less than 12 months from the time of diagnosis. However, given the treatment it seems Mr M wanted to pursue, the treating consultant stated that median overall survival with his condition was 18 months. So it isn't clear to me that the treating consultant was of the view, at the time of diagnosis, that Mr M's life expectancy was no greater than 12 months.

And, as I've already explained, in order for terminal illness benefit to be payable, the policy also requires L&G's Chief Medical Officer to be of the opinion that a policyholder's life expectancy is no greater than 12 months. L&G's consultant oncologist – also an expert in cancer - has recently reviewed the treating consultant's May 2024 letter and concluded:

'The median survival in the relevant trial is 18 months (PMID 35124183) and I note the patient was well at the start of treatment with PS=0. With the info available, I would have suggested a likely outcome of 18 months, if we had been asked in June 2024.'

On that basis then, I'm satisfied that following an assessment of the available medical evidence, L&G's Medical Officer didn't find that Mr M's life expectancy would've been no greater than 12 months after his diagnosis. I also think it was reasonable for L&G to take into account the disease-control therapy the consultant proposed for Mr M's condition when assessing what his life expectancy was likely to be.

I appreciate Mr and Mrs M feel that the initial rejection of the claim in March 2025 without a medical review having taken place prejudiced their position and prevented L&G asking for more evidence. But it seems to me that even if the Chief Medical Officer *had* reviewed Mr M's claim at that point, they'd have been entitled to rely on the existing evidence to reach a decision as to Mr M's likely prognosis. As I've said, I don't think the treating consultant's May 2024 letter indicates they'd concluded that Mr M had a life expectancy of no greater than 12 months at that time. So I don't agree that any delay in the medical review of the claim has led to an unfair outcome in the circumstances of this particular case.

Mr and Mrs M have indicated that their treating consultant may be able to provide further evidence about Mr M's condition, given it's around nine months since they first made the claim. It's open to Mr and Mrs M to obtain further evidence, at their cost, should they choose to do so and to send it directly to L&G for its review. I'd expect L&G to consider any such new evidence in line with its regulatory obligations and the policy terms. If Mr and Mrs M are unhappy with the outcome of any review, they may be able to make a new complaint about that issue alone.

Overall, I do sympathise with Mr and Mrs M's position, especially as the policy itself has now ended. But I find L&G acted fairly and reasonably when it concluded that Mr and Mrs M hadn't provided enough evidence to show Mr M had a valid terminal illness benefit claim on the policy. And that means that I don't think it was unfair or unreasonable for L&G to turn down Mr M's claim.

My final decision

For the reasons given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M and Mrs M to accept or reject my decision before 10 March 2026.

Lisa Barham
Ombudsman