DRN-6021524

The complaint

Mr B complains Zurich Assurance Ltd ("Zurich") was wrong to decline to consider a critical illness claim he made on a policy whose cover Zurich lapsed after a premium went unpaid.

Mr B's complaint includes that he didn't receive notification of the missed premium and that Zurich couldn't evidence that it sent him notification and Zurich lapsed his cover after 30 days whereas for newer customers this period is two months.

Mr B is represented in the complaint by Mr P and brings the complaint on behalf of the B Trust which holds the policy in trust. For simplicity I've referred below to Mr B when referring to things said or done by Mr B or by those representing Mr B or the Trust.

What happened

Our investigator wrote to the parties setting out relevant circumstances. In brief summary:

- The last premium Zurich received for the policy was on 1 November 2024. Mr B says the policy direct debit was cancelled accidentally when a joint bank account was dissolved.

- Zurich was notified by Mr B's bank on 26 November 2024 that the direct debit had been cancelled. As a result, Zurich says it sent letters by post to Mr B at the address it held for him on its files, as follows:

  - A first letter, dated 27 November 2024, giving notice that Mr B's direct debit had been cancelled and requesting a new direct debit so premiums could continue being paid.

  - A second letter, dated 13 December 2024, giving notice that Zurich hadn't been able to collect the premium due that month. This gave notice that the cover would stop under the policy terms if the premium remained unpaid at the month end – and if it wasn't paid by then, policy reinstatement would depend on Mr B's health.

- Zurich initially told us it hadn't retained copies of the first two letters – and didn't tell Mr B the dates of the letters. Mr B said this indicated inadequacies in Zurich's systems. But Zurich has since provided copies of these letters which also show the dates.

- Mr B suffered a health episode on 8 January 2025 and asked his IFA to initiate a policy claim for him on 13 January 2025. He says he first found out about the missed premium from his IFA. The IFA informed Zurich of Mr B's new address. Mr B has said his previous residence was sold in October 2024. He says he continued to receive post from that address but didn't receive the first two letters or any other correspondence from Zurich.

- Zurich sent a 14 January 2025 letter to Mr B's new address. This said: *"We are no longer able to provide protection while the contributions remain unpaid."* It asked him to pay two months' premiums, as two months' premiums had been missed by then, but it said: *"Reinstatement of your Policy may depend on your health"*. Mr B says this is the only letter he did receive, and it was too late to reinstate the policy by then. He says the letter acknowledged he might not have received the previous two letters from Zurich. It said: *"We have recently been advised of your new address and you may not have received our previous correspondence."* Mr B says by this admission Zurich accepts and confirms his assertion that the postal service is a flawed information delivery system.

- Zurich says it accepts Mr B's claim is made in good faith and that the policy direct debit was cancelled accidentally. But it says at the time of his claim the policy cover was no longer in force due to the missed premium. The policy terms say:

    - *"If you don't make a payment when it is due, the plan will continue providing cover for 30 days. At the end of the 30-day period the plan will end and you won't get any of your payments back. If we accept a claim during this 30-day period under the terms of your plan, we'll deduct any due payment from the amount we pay.*

      Although your plan will have formally ended and you will therefore have no rights under the plan, you can ask us to reinstate your cover up to 60 days after your plan ended. To help us consider your request, we'll ask you for details about your health and activities. If we agree to reinstate your plan, you will need to send us a cheque for the payments you have missed. We do not have to reinstate your plan."

Mr B spoke to Zurich on 24 January 2025, finding that Zurich wouldn't be considering his claim. He appealed to Zurich that day to reconsider. Zurich told Mr B: *"…at the time of your [health episode], the plan was two months underpaid, and whilst it was still active, it was not on risk or providing life cover."* It said a senior claims assessor would revisit the file. Its final response letter of 18 February 2025 confirmed it had decided not to change its decision to decline to consider Mr B's claim. It said Mr B's plan had lapsed.

Mr B has said that having paid for the policy for the past ten years, finding he is unable to claim on it as soon as he needs to claim on it, is a serious injustice and Zurich seems to be trying to evade the claim. He says Zurich has deprived him of a significant sum of money that would've helped ease financial burdens he's struggling with. He seeks redress for extreme stress he has endured as a result, and payment of the sum.

Mr B says policies with Zurich taken out after 2018 had a grace period of two months and if this had been so for his policy he would've still been within that period when he first learned of the missed premiums – and so would've been able to reinstate the cover. So he says he has been materially disadvantaged by having a historic policy he as paid in good faith for over 10 years, as opposed to being a more recent customer.

Our investigator thought the policy terms were clear the policy would only continue providing cover for 30 days after a payment is missed – and Zurich had followed a fair process and given Mr B a fair opportunity to act to stop the policy from lapsing, bearing in mind the letters and notifications it had sent.

So our investigator didn't see grounds to uphold the complaint or to recommend that Zurich reinstate the policy, consider a claim or take any other steps.

Mr B asked for an ombudsman's review, emphasising firstly that Zurich hadn't rationalised pre-2018 policyholders' grace period with that of post-2018 policyholders and secondly that Zurich relied wholly on a *"failing postal system to deliver critically important information to pre-2018 policyholders whereas post-2018 policyholders are contacted digitally by email or text, guaranteed receipt".* He emphasised that by acknowledging he might not have received the earlier letters, Zurich in its 14 February 2025 letter was admitting the postal service was a *"flawed information delivery system"*.

Our investigator didn't think it unreasonable for Zurich to apply the grace period provided for in the terms of Mr B's policy rather than those that might apply to other later policies. Our investigator also noted that Zurich didn't rely only on the post, it also sent electronic notification about the missed premiums to Mr B's IFA, including within the grace period.

Zurich says it doesn't accept that post was a flawed way of notifying Mr B. It says Mr B would've received the earlier letters had he let Zurich know of his change of address. It noted Mr B's IFA was contacted electronically on several occasions too.

As the matter remained unresolved, it has 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, I've arrived at the same conclusion as our investigator and for broadly the same reasons. I'll explain my reasoning briefly. In doing so I'd mention that my role and my decision is concerned with what is fair and reasonable in the particular circumstances of this case, rather than the merits of Zurich's practices generally.

Mr B's policy cover lapsed due to the 1 December 2024 premium not being paid. It was his responsibility to ensure the premium was paid and he unfortunately did not notice that it had not been paid. It isn't in dispute that the policy grace period was 30 days and that the missed premium wasn't paid within that time. Consequently, Mr B's policy cover had ceased by the time he suffered the health episode for which he wishes to claim. It follows that Mr B wasn't covered at the time and so Zurich wasn't obliged to consider Mr B's claim.

The policy terms did say Mr B could ask to have his cover reinstated after this, but the terms are plain Mr B no longer had rights under the plan and reinstatement would be at Zurich's discretion. The terms for reinstatement don't require Zurich to reinstate cover or consider a claim that occurred at a time when Mr B wasn't covered by the policy.

Mr B has explained the policy premium was missed due to an error. Where existing payment arrangements are changed, errors can of course occur. But the error here wasn't an error by Zurich. It arose from arrangements for which Mr B had responsibility. So having considered the circumstances in which Mr B says the policy premium ceased, I don't see that these give me grounds to say Zurich did something wrong or ought to consider Mr B's claim.

Mr B says Zurich ought to allow his cover to be reinstated and consider his claim because he was not aware the premiums were no longer being paid. But I don't find that this was due to any fault on Zurich's part. I'm satisfied Zurich sent the November and December notices to the address it had on file for Mr B. From what Mr B has said, he had left his former address by October 2024 (when he says it was sold) but he was receiving post from there.

I don't see that it was unfair for Zurich to send notices by post to Mr B, using the address it held for him, or that Zurich could be blamed if Mr B didn't receive a notice sent by Zurich to

Mr B's old address in these circumstances. Regardless of the policy terms, it goes without saying that policy communications couldn't be sent by Zurich to Mr B's new address if Zurich did not have that address. But the policy terms did provide that Mr B was responsible for *"Letting us know if your name, address or contact details change."*

Mr B says Zurich is at fault for sending notices by post rather than some other means. It isn't obvious to me that an email or a text message is more likely, let alone guaranteed, to reach and be read by its intended recipient than a letter. Email addresses and phone numbers can change like addresses and such messages can also be affected by faults.

Putting this aside, in my view it wasn't unreasonable for Zurich here to send notices by post – and I don't agree this was an inherently ineffective communication method. Mr B in fact did receive Zurich's letter at his new address once he gave Zurich that address. Had he updated his address with Zurich when he moved, it seems likely he would've received the notices Zurich sent him. So I don't find Zurich's use of the post to send notices means it was at fault for Mr B not becoming aware the premium due had not been paid. It is very unfortunate Mr B did not receive the notices Zurich sent, but I don't see that Zurich was at fault for this.

Mr B says the grace period of 30 days is unfair given that Zurich offers a 60 day period for more recent policies. But the grace period Zurich applied wasn't unusually short and did not in my view prevent Zurich from informing Mr B of the position in a timely manner such that had his address details been up to date it would've allowed him to act in time to maintain his cover had he wished. Zurich didn't cancel Mr B's cover without first sending him notice that it would do so. What I've seen doesn't persuade me that in this case that notice wasn't timely and wouldn't have been effective had Mr B's address details been up to date.

With this in mind, I don't think Zurich acted unfairly here by applying the terms of the policy. The loss in my view didn't arise from Zurich's terms, but from the direct debit cancellation being overlooked and Mr B not making sure the premium was paid and not updating his contact details at Zurich which would've allowed Zurich to alert him to the non-payment.

I am mindful of the emotional strain and financial burden Mr B has reported suffering as a result of being unable to claim on the policy. I'm sympathetic to the position in which he finds himself. But with all I've said above in mind, I conclude that Zurich was entitled to decline to consider Mr B's claim and hasn't acted unfairly in all the circumstances here. So I'm unable to uphold this complaint. I appreciate my decision will disappoint Mr B and the B trust.

My final decision

In light of all I've said above and for the reason I've given, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B, Mr B and Mrs P as trustees of the B Trust to accept or reject my decision before 28 January 2026.

Richard Sheridan
Ombudsman