

The complaint

Mr P's complained that Legal and General Assurance Society Limited ("L&G") unfairly declined his critical illness claim.

What happened

In 2020, Mr P bought a critical illness policy from L&G. The policy provided that L&G would pay Mr P £75,000 if he was diagnosed with one of the illnesses covered by the policy and the relevant policy definition was met.

In late 2024, Mr P was diagnosed with T-cell lymphoma (a type of cancer). So he made a claim on his L&G policy. But, just a few weeks later, he was told that he'd been misdiagnosed and, in fact, he has Kikuchi-Fujimoto disease - a benign condition. L&G therefore declined his claim as Kikuchi-Fujimoto disease isn't a condition covered by the policy.

Mr P complained to L&G. He said he'd met the policy definition of lymphoma when he'd first contacted them. So he said L&G should pay the claim. In their response, L&G said the original information they'd received about the diagnosis said the diagnosis of lymphoma was likely rather than definite and was pending histology. Histology had later shown Mr P didn't have lymphoma. So they were right to decline the claim.

Mr P didn't think L&G's response resolved his complaint and brought it to the Financial Ombudsman Service. He told us that, as a result of the initial diagnosis, he'd incurred significant costs, which would increase in future. And he'd undergone a round of chemotherapy which may have a long term impact on his health.

Our investigator reviewed the information provided by both parties and concluded L&G didn't need to do any more to resolve the complaint. She was satisfied that Mr P was ultimately diagnosed with a condition that isn't covered by his policy. So she couldn't fairly say L&G should settle the claim.

Mr P didn't agree with the investigator's view. So I've been asked to make a final 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.

Having done that, I'm not upholding Mr P's complaint. I know this isn't the outcome he was hoping for. I hope it will help if I explain the reasons for my decision.

I sympathise with Mr P. I can only imagine how difficult it is to receive a diagnosis of cancer, and to start treatment, only to be told it's actually a completely different condition. And I understand the steps he took – and the costs he incurred – to deal with the consequences of that initial diagnosis.

But my role is to decide whether L&G have dealt fairly and reasonably with the claim he made. The starting point for that is the policy terms.

T-cell lymphoma would be covered by the “cancer” definition in the policy. That defines cancer as:

*“Any malignant tumour **positively diagnosed with histological confirmation** and characterised by the uncontrolled growth of malignant cells and invasion of tissue.*

The term malignant tumour includes leukaemia, sarcoma, pseudomyxoma peritonei, merkel cell cancer and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).”

I’ve highlighted in bold type the key part of the definition in this case. Mr P submits that he had that histological confirmation and sent it to L&G when he first contacted them.

I’ve looked at the initial letter from Mr P’s consultant. That says it is *“likely stage II lymphoma pending histology”*. And I’ve seen that L&G contacted Mr P’s doctors for confirmation of the histology – as they would do in relation to any claim. It was at this point his doctors confirmed he did, in fact, have Kikuchi-Fujimoto disease, not T-cell lymphoma.

So, while I recognise this is an unusual situation, I’m satisfied that L&G took the steps I’d expect them to in any claim to verify Mr P’s diagnosis. During that process, it was confirmed he didn’t have a condition which was covered by the critical illness policy.

Mr P has made the point that his initial diagnosis caused him and his family to incur significant expenses which he would have used the settlement to pay. I’m sorry that’s the case. But it’s not a factor I can take into account when deciding this complaint. The policy doesn’t cover specific costs or losses – it provides a lump sum payment if the policy holder is diagnosed with a condition which is covered. Mr P doesn’t have such a condition. And so I can’t reasonably say L&G should pay his claim.

Mr P has also expressed concerns about the impact having a round of chemotherapy has had on him, both in terms of his health and future financial decisions. I’m not a doctor. So I can’t comment on the medical consequences. But, as I’ve said above, L&G’s obligation is to settle a claim if he’s diagnosed with a covered condition – not if he’s had what turned out to be inappropriate treatment.

Mr P is also concerned about the impact of the initial cancer diagnosis on future applications for policies. Again, I understand why he’d be concerned. And I can’t make any guarantees. But there are many sources of advice available when buying this type of product. And I’d expect any insurer to whom the situation was explained to take the facts into account when deciding whether to offer Mr P insurance and on what terms.

His current policy with L&G also has many years to run, so Mr P will continue to have the benefit of that cover should he need it. But I can’t say it should pay out now based on what might happen in the future. And so I don’t think L&G need to do any more to resolve this complaint.

My final decision

For the reasons I’ve explained, I’m not upholding Mr P’s complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr P to accept or reject my decision before 28 April 2026.

Helen Stacey

Ombudsman