complaint

Mr M and Miss H have complained about Legal & General Assurance Society Limited's (L & G) decision to decline critical illness claims made under three protection policies.

background

Mr M and Miss H hold three protection policies with L & G between them. Policy A started on 28 June 2002 and provided decreasing life and critical illness cover with an initial sum assured of £51,045. Policy B started on 28 June 2002 and provided level life and critical illness cover of £53,955. Both policies had a term of 15 years and covered Mr M and Miss H. On 7 September 2004 Mr M took out policy C which provided decreasing life and critical illness cover with an initial sum assured of £15,000 over a term of 12 years.

In March 2015 Mr M had a heart attack and so he made claims under all of the policies. After receiving medical information, L & G declined the claims because it didn't think the policy definitions had been met. This was because the evidence didn't show that Mr M had experienced any electrocardiograph ('ECG') changes.

Mr M and Miss H complained. They thought the definition applicable to policies A and B was unclear. Mr M understood that the policy definition of heart attack had been updated by the Association of British Insurers ('ABI') by the time he took the policies in June 2002. He believes this adds weight to his view that the previous definition was unclear. He doesn't think he should've been sold a policy with an out of date definition. Mr M and Miss H have also referred to a newspaper article about a heart attack claim made under an L & G policy.

L & G said that the ABI had asked insurers to update the definition applicable to their policies by May 2003. While it wasn't able to update the definition by June 2002 it was able to do so in October 2002. But in any event, it didn't think the earlier definition was unclear. It also explained that the article Mr M had referred to was incorrect as L & G hadn't underwritten the policy mentioned. It said it had contacted the person in question to clear this up.

Mr M and Miss H remained unhappy so they referred their complaint to this service. They accept that the claim isn't payable under policy C in light of the updated definition. But they still think the definition applicable to policies A and B is unclear and should be interpreted in their favour. Mr M and Miss H questioned how L & G had contacted the person referred to in the article if he wasn't a customer of L & G.

Our adjudicator didn't think Mr M and Miss H's complaint should be upheld. She didn't think the policy definition was unclear and because Mr M hadn't experienced ECG changes, she thought the decision to decline the claim was fair. The adjudicator didn't think the article Mr M had referred to was relevant to his complaint. Mr M and Miss H disagreed and asked for an ombudsman to review the complaint.

my findings

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 decided not to uphold this complaint. I realise that this will be disappointing for Mr M and Miss H but I hope that the reasons I've given are clear. I would also like to wish Mr M all the best with his recovery.

As Mr M accepts that his claim isn't payable under policy C, I don't intend to cover this.

In order for L & G to accept a claim under policies A and B, the following definition needed to be met:

"The death of a portion of the heart muscle as a result of inadequate blood supply as evidenced by an episode of typical chest pain, new electrocardiograph changes and by the elevation of cardiac enzymes. The evidence must be consistent with the diagnosis of heart attack."

I've first looked at whether this definition is clear. Mr M has said that the use of a listing comma after *'typical chest pain'* suggests that he wouldn't have to meet all the criteria for a claim to be accepted. But I don't agree. I think in this instance, the use of a listing comma can only mean *'and'*, not *'or'*. I understand this definition was changed by the ABI in its statement of best practice in May 2002 as follows and is the definition applicable to policy C:

'Heart attack

The death of a portion of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- *typical chest pain;*
- *new characteristic electrocardiographic changes;*
- *the characteristic rise of cardiac enzymes, troponins or other biochemical markers;*

where all of the above shows a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered under this definition.'

While this definition now says it should include *'all'* of the criteria, I don't think this means the previous definition was unclear on this point. And it seems to me that the main change to the definition is that other coronary syndromes, which may have similar symptoms to a heart attack, wouldn't be covered.

In order for Mr M's claims to be paid, the medical evidence would need to show that Mr M had suffered death of a portion of heart muscle, evidenced by typical chest pain, ECG changes and elevation of cardiac enzymes. It is important to note that the evidence L & G requires in order to accept a claim for heart attack isn't necessarily the same evidence a medical professional would require before diagnosing a heart attack. And, having looked at the evidence L & G was given to assess the claim, I don't think there's enough to say Mr M had suffered death of a portion of heart muscle.

A medical report was completed by Mr M's treating doctor, who was asked a series of questions about the tests performed and his findings. The doctor confirmed that Mr M had suffered typical chest pain and that he had measured a rise in troponins, a cardiac enzyme. So, it was on this basis that he'd diagnosed a heart attack. But crucially, he said that there were no ECG changes and that an echocardiogram also returned a normal result. L & G says this showed that there was no abnormality of Mr M's heart. And as L & G's definition requires death of heart muscle to be evidenced by new ECG changes, I think its decision to decline the claims was fair.

Mr M has said that there may have been a fault with the ECG used by the ambulance when he was first treated. But L & G hasn't been provided with anything that suggests the ECG

results they were given could be inaccurate. So, I don't think it would be fair to disregard the requirement for ECG changes in these circumstances.

I've taken into account Mr M and Miss H's comments that they shouldn't have been sold policies with out of date wording. But L & G made the changes within the time period specified by the ABI and I don't think the cover Mr M and Miss H received in June 2002 was any less favourable. In fact, the cancer definition applicable using the May 2002 statement of best practice definitions would've been less favourable for Mr M.

I've also taken into account what Mr M and Miss H have said about the newspaper article. But, like the adjudicator, I don't think it's relevant for the purpose of looking at Mr M's claims as each claim is considered on its own merits.

my final decision

For the reasons set out above, I don't uphold Mr M and Miss H's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M and Miss H to accept or reject my decision before 18 January 2016.

Hannah Wise
ombudsman