DRN-4456348

The complaint

Mrs H has complained that Legal and General Assurance Society Limited (L&G) assessed her critical illness claim on an unfair basis – leading them to decline what she believes to be a valid claim.

What happened

In mid-2002, Mrs H bought a policy from L&G, which provided her with £40,000 life and critical illness cover. The policy has now expired.

In 2009, Mrs H was diagnosed with a chronic liver condition, which can worsen over time. The condition can cause various problems, including chronic fatigue and "brain fog".

In 2017, these symptoms led to Mrs H leaving her full-time employment and taking alternative part-time work closer to home. At this time, she made an unsuccessful claim on the policy. This doesn't form part of her complaint. By early 2020, Mrs H found it too difficult to continue her part-time employment and resigned. She hasn't worked since.

Mrs H made a second claim in spring 2021. As the policy didn't cover her specific condition, L&G considered it under the "permanent and total disability" (PTD) definition. This says that PTD will be assessed on an "own occupation" basis if the claimant is in employment immediately before the onset of the disability – or, if not, on their ability to perform a range of daily tasks.

L&G said that, because there was no evidence Mrs H's symptoms were present at the time she left her job, they assessed her on her ability to perform the daily tasks. On that basis, Mrs H didn't meet the policy criteria. So L&G declined the claim.

Mrs H complained. L&G didn't change their position. So Mrs H brought her complaint to our service.

Our investigator considered the complaint and concluded L&G didn't need to do any more to resolve it. She noted L&G had reviewed the medical information received and had seen no mention of Mrs H's symptoms until the end of 2020 – about nine months after she'd left her job. So she thought it was reasonable for L&G not to assess her claim on an own occupation basis. And she said L&G's conclusion Mrs H didn't meet the criteria on an activities of daily living basis was fair because she could undertake the majority of the tasks without assistance.

Mrs H didn't agree with the investigator's view as she didn't think L&G had approached the right doctors for information about her condition. The complaint's now been passed to me 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 Mrs H's complaint. I know this will be an upsetting outcome for her to receive and I'm sorry about that. I hope it will help if I explain the reasons behind my decision.

Mrs H's policy provided cover for a number of specific conditions. For each condition, the policy sets out a definition to determine whether it is covered.

The condition from which Mrs H suffers isn't one which is listed in the policy. So a claim was submitted, and considered, under the "Permanent and Total Disability before age 65" section.

There are two parts to the definition, depending on whether or not the claimant was employed immediately before the claim was made. The relevant section reads:

"The Guaranteed Sum Assured will be payable:

(a) If the Life Assured, before age 65 is not in gainful occupation immediately before the onset of disability, and suffers through illness or accident, a mental or physical irreversible disability, which in the opinion of The Chief Medical Officer of Legal & General, results in the Life Assured being permanently unable to perform, without the direct assistance of another person, four or more of the [activities of daily living]*:*

OR

(b) If the Life Assured, before age 65, is engaged in a in a gainful occupation immediately before the onset of disability and is, by reason of sickness or accident, totally unable to follow her own occupation and in the opinion of Legal & General is likely to remain so permanently. Such decision will be based on all the medical evidence available."

L&G considered both definitions in relation to Mrs H's claim. I understand from what I've seen it's not disputed that she doesn't meet the criteria for part (a), because she can complete the majority of the activities of daily living without support. So I've focused on part (b) and the information about Mrs H leaving her job.

L&G's position is that Mrs H doesn't meet that definition because her medical notes don't evidence the impact symptoms had on her immediately before and after she left her job. Mrs H says that's because she always tried to maintain a positive outlook and not complain how bad she was feeling. And she says it was up to her whether to share her health issues with her employer – whom she never made aware of her condition. She says her medical records are not proof of her illness.

I sympathise with Mrs H's position and understand why she takes the view she does. I've thought very carefully about what she's said about her condition, all the evidence provided and the impact she's described on her day-to-day life before reaching a conclusion about her complaint.

But I have to take into account that businesses like L&G don't – nor are they expected to – approach each claim in a manner bespoke to that claimant. We expect them to deal with claims in accordance with the terms of the policy – and to apply those terms consistently to all claimants.

That means I have to consider the policy conditions I've quoted above. There are several elements on which L&G need to be satisfied before paying a claim.

Firstly, Mrs H needed to be *"…in a gainful employment immediately before the onset of disability."* That is difficult to judge, because there is no single point of onset. Mrs H was diagnosed with the condition in 2009, since when it progressed.

In the circumstances, it was reasonable for L&G to request information to help them pinpoint a date. They didn't receive anything to show that onset occurred in early 2020. And, while I note – and accept – Mrs H's comments about telling her employer her reason for leaving and about her interactions with her medical team, that (unfortunately for her claim) means there's no evidence on which L&G can base onset as being early 2020. I can't say that's unfair.

Nor was it unreasonable in my view for L&G to conclude that Mrs H was not permanently disabled by her condition. I've reviewed the medical information she's provided, which covers the period both before and after she left her employment.

That shows she continued to be treated for the condition, with regular medication reviews and changes suggested when her treatment team thought that might help manage the condition better. I'm satisfied from the evidence I've seen that L&G reviewed this information and also noted the possibility of further options – including ultimately a liver transplant. So I think it was reasonable for L&G to conclude the "permanent" element of the definition hadn't been met.

I've no doubt that Mrs H faces a daily struggle with the symptoms she's described and that that have a significant impact on her life. But, while I know this will be unwelcome news, I think L&G's assessment of her condition against the terms of her policy was reasonable. So I don't think they need to do any more to resolve her complaint.

My final decision

For the reasons I've explained, I'm not upholding Mrs H's complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H to accept or reject my decision before 20 December 2023.

Helen Stacey
Ombudsman