DRN-4169689

The complaint

Mr K's complained that Legal and General Assurance Society Limited ("L&G") have unreasonably refused to deal with the claim made on his employer's group critical illness cover after his father was diagnosed with a type of cancer.

What happened

Mr K benefits from a group critical illness policy provided by his employer. The policy provides cover for him and – if he chooses - for members of his family.

In March 2020, Mr K added his father – who I'll refer to as F, to distinguish him from Mr K - to the policy. Initially, the policy provided £25,000' worth of cover in the event of F being diagnosed with a covered illness. On 1 March 2022, Mr K increased the amount of cover for F from £25,000 to £250,000.

About two weeks after the cover was increased, F consulted a doctor about symptoms he was experiencing. At the end of March 2022, he was sadly diagnosed with cancer.

Mr K and F made a claim on the group policy. F provided L&G with authority to obtain medical information from his doctors. The consent form required L&G to gather this within six months of the date it was signed.

L&G approached F's doctors but didn't receive all the information they thought they needed to assess the claim, so they sought further clarification. Mr K and F objected to this on the basis that:

- L&G were requesting details of F's consultation with his GP when he attended with the symptoms. Mr K and F said this was included in what L&G had already received and was too general a request; and
- L&G had had a consent form covering a six month period, which was ample time to obtain what they needed. F declined to provide any further consent.

They asked L&G to deal with the claim on the basis of the information already received. L&G said they couldn't do this, because they hadn't received what they needed to decide if an exclusion applied to F's claim. If consent to obtain further information wasn't given, L&G said they wouldn't be able to assess the claim.

Mr K complained. L&G didn't change their position. So Mr K brought the complaint to the Financial Ombudsman Service. He told us he thought L&G's information requests were too broad, the complaint hadn't been assessed within a reasonable time and that L&G hadn't followed the law or the Association of British Insurers' (ABI) Code of Practice.

Our investigator considered the complaint and concluded L&G didn't need to do anything more to resolve it. She was satisfied there was no medical information pre-dating either the start of cover, or the point at which the level of cover increased. So it was fair to say L&G didn't have what they needed to decide if the exclusion of pre-existing conditions applied in F's case.

Mr K and F didn't agree with our 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 this complaint. I know this will be very disappointing for Mr K, and for F. I hope it will help if I explain the reasons for my decision. I'd like to assure Mr K that I have looked at everything he – and L&G – have provided. So, if I don't refer to a particular point or piece of evidence, it's not because I haven't thought about it. Rather, I don't consider it changes the outcome of the complaint.

And I think it would help if I clarified what I do. It's not my role to decide whether the claim should be paid. Rather, I have to decide whether L&G's position - that they don't have enough information to assess the claim – is reasonable. And our service is an alternative to using the courts. We don't make the same judgments a court would. So, while I can see Mr K has made a number of comments about L&G acting illegally, that's not something I can decide.

The key issue here is whether L&G have enough evidence to reach a conclusion on whether to pay F's claim. Mr K says they do and to request more is excessive and unnecessary. I can see L&G have told him that they think F's consultation notes are relevant and want to consider them.

There's no dispute that F was diagnosed with cancer. Nor that the diagnosis was made very shortly after there was a substantial increase in the amount of cover. L&G wrote to Mr K in September 2022 and explained they needed to decide whether there were any policy exclusions relevant to the claim. L&G highlighted the following term:

"We will not pay benefit for any insured condition occurring within two years of an insured person's cover starting under the scheme that has resulted from any related condition for which they:

i. Have received treatment

ii. Have, or had, symptoms of

iii. Have sought advice on or,

iv. Were aware of"

And they told Mr K this also applies to any increase in benefit. I think it's reasonable for L&G to consider whether the exclusion applies.

I've studied the medical evidence on the file. This shows F consulted a doctor in mid-March 2022, his diagnosis, and the course of treatment he followed. But I can't see any evidence about when F first noticed anything amiss, or that the mid-March consultation was the first time he had sought medical advice about his symptoms.

I think it was reasonable for L&G to seek evidence to verify this, so they could satisfy themselves whether the claim should be paid, or whether it was excluded.

Mr K has said the request is excessive, and against the guidance given by the ABI, which he says tells medical practitioners they should not provide patient notes. I've considered that guidance, but I think L&G have followed it. The guidance explains practitioners should be

cautious about providing complete medical histories in response to a subject access request (SAR).

But that's not what happened here. L&G requested information covering a specific period – the period during which an exclusion may apply – to help them establish when F first had symptoms. That's clearly relevant to considering the claim. So I don't think it was unreasonable.

Mr K has referred to other decisions made by our ombudsmen, which he says are relevant to his complaint. Those ombudsmen did find insurers' requests to be inappropriate.

We consider each complaint on its own merits. So previous decisions don't set a precedent which I'm bound to follow. But, even if I were, I don't think the decisions Mr K has referenced are relevant here. In those cases, claimants' entire medical history was provided to the insurer, which then used information unrelated to the claimants' illnesses to decline the claim. That's not what's happened in this instance. Rather, L&G are requesting extracts of F's medical history for a specific period, to assess whether the condition was pre-existing at the start of the cover, or when it was increased. I think that's reasonable.

Finally, I've thought about the complaint about how long L&G have taken to request medical evidence. Mr K and F have objected to F providing further consent, because they say L&G should have been able to gather what they needed within the six months contained in the original consent form.

I've thought carefully about this. I've seen that L&G didn't receive medical evidence directly from F's doctors, but via Mr K and F, who had asked to see reports before they were sent to L&G. F was entitled to make that choice. But I have to take into account it did mean that L&G didn't get the information as quickly as they might have done.

The evidence supplied shows that L&G pursued medical evidence from the first week in May – about a week after the claim form was submitted. And this information was assessed as it was received. I'm satisfied from what I've seen that there weren't long periods of delay when L&G could have considered the evidence, but didn't. I can see they were pursuing various routes to get what they felt they needed to assess the claim. So I can't say it was their fault they didn't have what they needed by the time the consent expired.

The claim has now stalled, because L&G haven't received what they need, and F won't renew his consent for any more information. I understand Mr K and F have been frustrated by the length of time it has taken L&G to gather evidence. But, as I've explained above, I think what they are seeking is reasonable to establish whether the claim should be paid, or falls within the policy exclusions. So I can't say they should pay the claim, on the basis of what they have.

It's up to F if he wants to provide further consent to allow L&G to request the information they need. If he does that, I'd expect L&G to assess the claim taking account of the new evidence they gather. But, as things stand, I don't think they need to do any more to resolve this complaint.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K to accept or reject my decision before 29 September 2023.

Helen Stacey
Ombudsman