DRN-4363088

The complaint

Mrs M, Mr T and Mrs T of the T Trust have complained that Vitality Life Limited declined a claim for Total and Permanent Disability under the Serious Illness Cover section of an Essentials plan and cancelled the policy.

What happened

The facts of this complaint and the history of this matter is well known to both parties, so I won't repeat it again here in detail. In summary the trust, via Mr T, submitted a claim for Total and Permanent Disability. Vitality declined the claim as it said that Mr T didn't meet the policy definition. Additionally following several instances where the premium hadn't been paid, it cancelled the policy.

Our investigator felt that the policy should be reinstated, but that Vitality hadn't done anything wrong in declining the claim.

Neither party accepted this. As no resolution has been reached the matter has been passed to me to determine as a priority.

For simplicity I will refer to Mr T rather than to the trust.

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.

I'm aware I've summarised the background to this complaint and the sensitive medical details. No discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. If there's something I haven't mentioned, it isn't because I've ignored it. I've reviewed the complete file and considered the representations made after our investigator's view. I'm satisfied I don't need to comment on every individual argument to be able to reach what I think is the right outcome. For the following reasons I agree with the conclusion reached by our investigator:

- Mr T needs to meet the policy definition in order for his claim to be accepted. It is not in dispute that Mr T is suffering from serious ill health. He has clearly expressed his opinion that he met the criteria for his claim to be paid. I haven't disregarded his view, but it is the medical evidence that is of prime importance in determining this complaint. This evidence doesn't show that when the claim was declined his condition was permanent. Taken together, the evidence of Drs S, H and W, did show that there was a small likelihood of recovery. I accept that the situation may change, and sadly it may be that Mr T's health will not recover. But I must base my decision on the medical evidence at the time the claims decision was made.

- There is a dispute as to the definition that applies, but as the 'permanence' criterion wasn't met, the claim wasn't payable under either definition. Accordingly I don't find

that Vitality treated him unfairly or contrary to the terms of his policy by declining his claim when it did.

- It is clear why Vitality cancelled Mr T's policy, having failed 23 premium payment plans. It felt that it had no reason to believe that a 24th payment plan would be successful. It reached this conclusion not only on the number of failed plans but because Mr T had said he couldn't afford the premiums. I understand Vitality's scepticism and don't find it to be misconceived. Nevertheless although payments have been made by Mr T's family members in the past a direct debit has not been set up to be paid in this way. I find it would be fair for the policy to be reinstated and a final attempt to be made. Mr T will no doubt understand the implications should this arrangement not be successful. Premium payments will need to be made to bring the policy up to date. Should it be required, Vitality should set up a further payment plan, for not longer than 12 months.

- Mr T has submitted further evidence and I understand that Vitality is now continuing to review his claim. Whilst considering this complaint we have passed information between the parties. As this decision is final, it marks the end of our involvement. It follows that the parties should now correspond directly.

- There is nothing before me to support Mr T's contention that Vitality has excessively drawn out the claim or otherwise treated him unfairly.

- Vitality has expressed concerns about some of the actions of the trust (for completeness I should add the trust has also expressed concerns which I have addressed above). Vitality needs time to assess/verify claims and Mr T no doubt understands it may need to wait for medical evidence from third parties particularly in such a complex claim. It is of no assistance to the trust to continually chase Vitality or indeed the physicians from whom Vitality may seek information. This may only delay matters or be seen as unwarranted interference. I say this only by way of comment, as this service has no power to direct the trustees as to their behaviour either with respect to contact with Vitality or on social media. However, Mr T has indicated that moving forward the trust will keep contact on social medical more reserved in some of its phrasing. As the parties have an ongoing relationship, I'm hopeful that this will be beneficial to both.

My final decision

My final decision is that I uphold this complaint in part.

- For the reason given above I don't uphold Mr T's complaint that his claim was wrongly declined in April 2023.

- I require Vitality to reinstate Mr T's policy and set up a payment plan for the premium payments to be brought up to date.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M, Mr T and Mrs T of the T Trust to accept or reject my decision before 2 November 2023.

Lindsey Woloski
Ombudsman