DRN-4305861

The complaint

Mrs B has complained that Legal and General Assurance Society Limited ('L&G') has unfairly declined her claim.

What happened

Mrs B had a critical illness policy, underwritten by L&G. The policy expired in June 2022. In July 2022, Mrs B had a screening for breast cancer. She made a claim to L&G but it turned the claim down on the basis that the policy had already expired when the diagnosis was made.

Mrs B complained but L&G maintained its decision so she referred her complaint to the Financial Ombudsman Service.

Our investigator looked into the complaint but didn't think L&G had done anything wrong or unfairly declined the claim. Mrs B disagreed and in summary, has made the following comments:

- She couldn't make the initial screening.
- Her consultant has confirmed it was likely she had the disease before the policy expired.
- She doesn't think she has been treated fairly.

And so the case has been passed to me for 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 so, I don't think this complaint should be upheld. I'll explain why.

The policy confirms the period of cover starts on the policy start date and ends on the policy expiry date. It says:

> *"The amount of cover is paid if, during the period of cover, the life assured…is diagnosed with a critical illness…".*

So this means that Mrs B had to have had her diagnosis whilst the policy was active.

Based on the timeline provided by both sides, Mrs B didn't receive her diagnosis whilst the policy was active. But Mrs B says her claim should be paid as she had tried to book a screening appointment in April 2022. She wasn't able to have her screening until July 2022, as the earlier appointments weren't suitable for her.

After L&G declined her claim, Mrs B provided a letter from her consultant who confirmed it

was likely that her disease was present whilst the policy was active.

L&G says it can only consider a claim after the policy has expired if it can be shown that the policy holder was symptomatic before the expiry of the policy or there were known problems before the policy ended. Mrs B wasn't symptomatic during the period of cover. And the letter from the consultant gives an opinion on when the cancer would have been present but as it wasn't diagnosed during the active policy period, I can't say Mrs B meets the policy terms.

Having considered everything Mrs B has said, I can understand why she feels aggrieved. But in order to ask L&G to pay the claim, I have to be satisfied that Mrs B's claim meets the policy terms. Mrs B did not have an active policy when she received her diagnosis. And as she had no symptoms during the period of cover, I don't think L&G unfairly declined the claim. So I can't fairly ask it to pay the claim.

My final decision

For the reasons set out above, I don't uphold this complaint.

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

Shamaila Hussain
Ombudsman