DRN-4845292

Financial Ombudsman Service

The complaint

X and Mrs G have complained that The Royal London Mutual Insurance Society Limited have declined X's critical illness claim.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. In summary X complained to this service when Royal London declined a claim he made under his policy for deafness. He felt that the policy definition was ambiguous.

Our investigator didn't recommend that the complaint be upheld. X appealed.

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've summarised the background to this complaint - 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 file and considered the representations X has made with care. Having done so I agree with the conclusions reached by the investigator. I'll explain why.

The relevant regulator's rules say that insurers must handle claims fairly and that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the critical illness policy, relevant regulatory rules and guidance, and the available medical evidence, to decide whether I think Royal London has treated X fairly.

The relevant policy definition is:

Deafness - permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

So the definition sets out the minimum loss required in the better ear for the definition to be met. I appreciate that the definition may have changed, but this is the definition that applies to X and is contained in his policy.

The medical evidence from an ENT surgeon in X's case, dated October 2023 states:

The current audiogram showed a right threshold air conduction of 95-100dB and the left showed 45-50 dB.

It is clear that X suffers from hearing loss. However the evidence doesn't show that there is a minimum threshold of 95 decibels across all frequencies in the better ear.

X has argued that the policy definition leads to ambiguity. However I don't agree. I'm satisfied the policy definition is clear. I don't find it necessary to say whether the definition to be met is in pre or post morbid state. X says that only after hearing loss did he have a 'better ear' and a 'worse' ear. I accept that this is so. But the claim will be assessed when it is made on the basis of the evidence at that time. As indicated, the audiological evidence here doesn't show that the definition was met.

Further the definition is taken from the Association of British Insurer's (ABI) model definitions. I do appreciate that X feels it should be amended, but that representation would need to be made to the ABI. Whilst the definition is extant, I can't conclude that it was unfair for Royal London to include it in X's policy.

In all the circumstances I don't find that Royal London have treated X unfairly, unreasonably or contrary to his policy terms by declining his claim.

I note the impact on X's health that his hearing loss has on him and I'm sorry that my decision doesn't bring him the news he was hoping for.

I have not disregarded X's submission that he is entitled to chronic disability benefit – but at the time Royal London considered this claim he hadn't made a chronic disability claim. So I can't consider that matter further in this decision.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask X and Mrs G to accept or reject my decision before 27 September 2024.

Lindsey Woloski
Ombudsman