DRN-5073787

The complaint

Mr I's complained about the amount of the settlement he received from Legal and General Assurance Society Limited ("L&G") when he made a claim following a stroke.

What happened

Mr I joined his employer's group critical illness scheme in 2018. Initially he had £100,000 critical illness cover. But, in April 2022, he increased the cover to £300,000.

In December 2023, Mr I suffered a stroke. So he submitted a claim to L&G. L&G obtained Mr I's medical records to help them assess the claim.

About two months later, L&G wrote to Mr I confirming they'd settle the claim by paying him £100,000. But they said they wouldn't pay £300,000 because they said the policy excludes cover for what it defines as a "related condition" for two years after an employee joins the scheme or increases their cover. Mr I had been diagnosed with hypertension before he joined. And hypertension was one of the related conditions for stroke.

Mr I complained to L&G. He said he wasn't told the exclusion applied when he increased his cover and that should have been made obvious to him. Nor did L&G contact him to notify him the exclusion applied.

In response, L&G said the policy was a commercial one taken out by Mr I's employer. It was with his employer that L&G had a contract and to whom they had to provide policy information. They said they didn't know what information his employer had provided to Mr I. And, if he wanted a copy of the policy terms, he'd need to get those from his employer.

Mr I wasn't satisfied with L&G's response and brought his complaint to our service. Our investigator reviewed all the information provided and concluded and L&G didn't need to do any more to resolve the complaint. She was satisfied the policy terms were clear and L&G had applied them fairly. And she said that any concerns Mr I had about the information provided when he increased the cover should be raised with his employer.

Mr I didn't agree with the 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 Mr I's complaint. I know this will be disappointing news for him. I hope it will help if I explain the reasons for my decision.

The policy on which Mr I claimed isn't one that he purchased himself – it's a group policy purchased by his employer to provide the benefit of cover to its employees. So – as L&G explained in their final response letter – it's the employer who is the policyholder and the entity entitled to details of the cover.

And it's up to the employer, how it chooses to offer the cover to its employees, what details of the policy it chooses to share, and when. The Financial Ombudsman Service has no jurisdiction over an employer/employee relationship. So, while I appreciate the strength of Mr I's feeling about the quality of the information he was given, it's not something I can comment on.

What I can consider is whether L&G applied the policy terms fairly and reasonably when assessing and settling Mr I's claim.

Employees can usually join their employer's group scheme without making the same medical disclosures they would if they bought an individual policy. So it's usual for the group policy to include an exclusion of pre-existing conditions and what's defined as a "related condition" – put simply, a condition which is linked to the one they later claim for.

The group policy covering Mr I excluded cover for pre-existing conditions. And it excluded cover for related conditions for a specified period of time. Mr I didn't have any pre-existing conditions. But his hypertension fell within the definition of conditions related to stroke.

The relevant section of the policy is part 3 section 2. That says:

"a) We will not pay benefit for any insured condition occurring within two years of an insured person's cover starting under the plan 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.

…

b) The related conditions exclusion shown in Part 3, Section 2 will also apply to any increase in benefit under this policy from the day of the increase."

I'm satisfied that term clearly sets out that the exclusion is, in effect, reset every time there's an increase in the cover. Mr I's stroke occurred less than two years after he'd made an increase. So he's only entitled to the cover he'd had in place for more than two years – which was £100,000.

I know Mr I feels this is unfair. But, as I've explained, I can't say L&G are responsible in this case for providing him with the policy details. So I don't think they need to do anything more to resolve Mr I's complaint

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr I to accept or reject my decision before 10 January 2025.

Helen Stacey
Ombudsman