DRN-5030390

The complaint

Mr M is unhappy that American International Group UK Limited ('AIG') have declined to re-open a claim he made on his personal accident insurance policy.

What happened

Mr M successfully claimed on the personal accident policy he held with AIG following a road traffic collision. Mr M accepted a settlement in relation to the claim. Following further medical investigations Mr M would like AIG to reopen the claim.

AIG declined to do so as they said the policy terms say they'll only consider injuries which arise within two years of the accident. Mr M complained to AIG but they maintained their decision was fair. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. She thought AIG had acted fairly and in line with the policy terms. Mr M didn't agree and asked an ombudsman to review the complaint. In summary he says that he was not at fault for the claim running over the two-year period and that he was receiving ongoing and continuing treatment. Mr M also said the claim had been settled without his agreement. So, the complaint was referred to me to make a 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.

I'm sorry to hear of the impact of the road traffic accident on Mr M and his wife. It's clear they've been through a very difficult time.

The relevant rules and industry guidelines say that AIG has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

The starting point is the policy terms and conditions which form the contract of insurance. The policy terms say:

> Section 2 — Scope of insurance
>
> If you suffer bodily injury after the effective date, which, within two years solely and independently of any other cause, results in death, permanent disability or hospitalisation, we will pay the amount shown in the table of benefits in section 4 to you (as long as you are not a child) or if you die, to your legal representative.

I'm not upholding Mr M's complaint because:

- Based on the evidence that's available I'm satisfied AIG settled the claim in line with the policy terms. The settlement was based on the available medical evidence, including an expert report. That report indicated that Mr M's condition had reached a plateau and there was likely to be no further improvement or deterioration.

- Mr M said the claim was settled without his agreement. However, I've reviewed an email from Mr M which is dated March 2023. It says, 'Whilst I am bitterly and massively disappointed that the sum offered no way compensates for my permanent injury, I am bound to accept your original offer, and would appreciate if arrangements could be made to credit my [redacted] account with the appropriate sum'. Therefore I'm not persuaded the claim was settled without Mr M's agreement as he's suggested.

- Mr M has experienced subsequent issues after the expiry of the two- year period. So, he'd like his claim to be reassessed. I don't think AIG has unreasonably declined that request based on the policy terms which clearly reference the two-year time limit. So, the further issues Mr M has experienced fall outside the scope of cover.

- I don't think it would be fair and reasonable to direct AIG to pay a claim outside the policy terms in these circumstances. There was a delay in Mr M submitting his claim. And I'm not persuaded there were any unreasonable delays caused by AIG which have disadvantaged Mr M. Furthermore, I think AIG reasonably relied on the available medical evidence which indicated Mr M's condition was unlikely to improve or deteriorate.

- Mr M says that AIG was responsible for the claim running over the two-year period. He says that the preliminary application and claim was made well within the two-year period. However, the accident took place in November 2020. The first log of the claim was in December 2021 which is over 12 months after the insured event took place. That's consistent with the other information that's available which includes a letter from Mr M, dated December 2021, in which he confirms he had now completed the claim form and enclosed the relevant medical evidence.

- I've looked at the claims history and I'm not persuaded there were any significant or unreasonable delays on AIG's part. Much of the time taken was driven by obtaining the relevant medical evidence to determine a fair outcome to Mr M's claim. That included obtaining up to date information on Mr M's injuries, his medical history and obtaining expert medical evidence.

- Mr M has also mentioned a claim made in relation to his wife. If Mr M's wife is unhappy with the handling of her claim or the settlement of it she'll need to complain to AIG directly before she can bring a complaint to the Financial Ombudsman Service.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 26 December 2024.

Anna Wilshaw
Ombudsman