DRN-5094895

Financial Ombudsman Service

The complaint

Mr M complains that AIG Life Limited hasn't paid a claim for terminal illness benefit he made on a term assurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

In June 2022, Mr M took out a term assurance policy through a broker. Unfortunately, in April 2023, Mr M was diagnosed with an incurable form of cancer. So he made a claim for terminal illness benefit on the policy.

AIG asked for medical evidence so it could assess Mr M's claim. It took some time for all of the necessary evidence to be received and reviewed. In September 2023, AIG offered Mr M £150 compensation because it felt it hadn't chased up medical evidence enough.

Based on the information AIG ultimately received over a period of a few months, it had concerns that Mr M may not have fully declared his medical history when he took out the policy. And it said that if Mr M had fully disclosed his medical history in June 2022, it wouldn't have offered him cover. It also noted that Mr M's treating oncologist had stated that Mr M's form of cancer had a median life expectancy of two to two and half years.

So on 3 November 2023, AIG turned down Mr M's claim, cancelled the policy from the start and refunded the premiums he paid. It added that Mr M's terminal illness benefit claim wasn't covered by the policy terms in any event, as his consultant hadn't indicated that Mr M's life expectancy was less than 12 months.

Mr M was very unhappy with AIG's decision and he appealed. And, on 10 November 2023, following an internal review of Mr M's claim, AIG let Mr M know that his policy had been reinstated and that it would reconsider his claim. It wrote-off the premiums of around £475 which it had refunded to Mr M a few days earlier.

AIG wrote to Mr M's treating oncologist to obtain further information about Mr M's condition. And it chased the information on multiple occasions. However, the oncologist hadn't responded by July 2024.

Mr M was very unhappy with AIG's position and he asked us to look into his complaint. In brief, he felt that a government form, DS1500, which his treating doctor at the time had filled out in April 2023, was sufficient evidence that his claim met the policy definition of a terminal illness.

Our investigator thought AIG had treated Mr M fairly. He didn't think the medical evidence showed that Mr M's claim met the policy definition of a terminal illness. He understood that the claims journey hadn't been smooth for Mr M. But he didn't think it had been unfair for AIG to require medical evidence to determine whether or not Mr M had misrepresented his health when he applied for the policy. And he felt the compensation of £150 which AIG had

offered Mr M was fair in the circumstances.

Mr M disagreed and so the complaint's been passed to me to decide.

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, whilst I'm very sorry to disappoint Mr M, I think AIG has already made a fair offer to settle this complaint and I'll explain why.

First, I'd like to say how sorry I was to read about Mr M's diagnosis. I don't doubt what a worrying, upsetting and difficult time this has been for Mr M and his family. I'd also like to reassure Mr M that while I've summarised the background to this complaint, I've carefully considered all he's said and sent us. In this decision though, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant considerations, such as industry principles and guidance, the policy terms and the available evidence, to decide whether I think AIG treated Mr M fairly.

The claims journey

As the investigator said, it's clear that Mr M hasn't experienced a smooth claims journey. I appreciate he submitted the terminal illness benefit claim in May 2023 and it took until November 2023 for AIG to provide an initial claims decision. I also understand that following its initial decision to cancel the policy and refund Mr M's premiums, AIG decided to reinstate the policy and reconsider Mr M's claim. And it seems AIG's still not in a position to make a new claims decision.

I can see that when AIG received Mr M's claim pack, it promptly requested medical evidence from Mr M's treating doctors. I think this was an appropriate and reasonable step for AIG to take. When that evidence was received, it indicated that Mr M might have been experiencing symptoms of his condition for around a year by the time he spoke to a medical practitioner in February 2023. If this was the case, it would have meant that Mr M was experiencing symptoms when he took out the policy which he didn't declare at the point of application, despite AIG's health questions. So I can understand why AIG felt it needed additional medical evidence to allow it to assess whether or not Mr M had made a misrepresentation under the relevant law.

The medical evidence AIG received was contradictory and so it needed more information before it could reach a decision. Again, based on the medical evidence I've seen, I don't think this was an unfair position for AIG to take – because, as I've said, there was a suggestion that Mr M had been experiencing symptoms of his condition prior to taking out the policy. And the medical evidence also indicated he hadn't told AIG about another condition he'd been treated for around six months before he applied for the policy. It's unfortunate that this process was spread out over around five months and I can understand why this delay must have been frustrating for Mr M.

Initially, AIG considered that Mr M had made a misrepresentation under the law and so it applied the remedy available to it under the legislation. It said it would never have offered Mr M cover if it had known about his symptoms, so it turned down the claim; cancelled the policy and refunded the premiums he'd paid for cover.

However, seven days later, following the internal review, AIG agreed to deal with Mr M's claim as if there'd been no misrepresentation - it reinstated the policy and it said it would reconsider the claim. In my view, this was a very fair response from AIG – in particular, because its notes indicate it wrote-off the premiums of around £475 which it had already refunded to Mr M and treated the policy premiums as up to date. So even if I had found that AIG had acted unfairly by cancelling the policy in early November 2023 (and I make no such finding), I think its apparent decision to write-off the refunded premiums was very fair and reasonable. And I don't think this caused any material delay in the overall assessment of the claim – as AIG had explained to Mr M already that it didn't think his terminal illness benefit claim was covered.

Once AIG reinstated the policy, I can see that it quickly wrote to Mr M's oncologist to ask for more information. It's repeatedly chased-up this information over several months and has received no response. I don't think I could fairly find that AIG's responsible for any failure by Mr M's treating specialist to respond to its information requests – especially when I can see it's made reasonable and regular attempts to chase things up.

With that said, in September 2023, AIG did acknowledge that it hadn't chased up medical evidence promptly enough when it was first considering the claim. I don't doubt that this caused Mr M unnecessary, additional trouble and upset. It's already offered to pay Mr M £150 to reflect his distress and inconvenience for the delays it caused up until September 2023 – and in my view, this is a fair, reasonable and proportionate award to reflect the impact of AIG's claims handling delays on Mr M. I understand from Mr M that AIG hasn't yet paid this compensation and so it should now ensure that it does so promptly.

The claim decision

The contract terms say that AIG provides cover if a policyholder is diagnosed with a terminal illness. AIG's defined what it means by a terminal illness on page 24 of the policy as follows:

'Terminal illness - where life expectancy is less than 12 months

A definite diagnosis by the attending consultant of an illness which satisfies both of the following:

- *The illness either has no known cure or has progressed to the point where it cannot be cured; and*
- *In the opinion of the attending consultant, the illness is expected to lead to death within 12 months.*

A claim will be considered where terminal illness is diagnosed and this definition is met at any time up to the day cover ends, provided a claim has been submitted while the cover is still active, before the cover ends.'

I think the terminal illness definition makes it clear that in order for AIG to pay a terminal illness claim, not only must a policyholder have an incurable illness, but that their attending consultant must also conclude that their life expectancy is less than 12 months. In my experience, this isn't an unusual term in claims of this nature.

AIG asked for evidence from Mr M's treating oncologist, who provided a claims medical report dated 5 June 2023. AIG relied on the report to conclude that Mr M's life expectancy wasn't less than 12 months. So I've carefully considered the available medical evidence to decide whether I think that was a fair conclusion for AIG to draw.

The oncologist's report clearly states that Mr M's treatment was palliative and that the

diagnosis was terminal. However, the report also asked the consultant '*In your opinion, what is the likely life expectancy for your patient and on what basis has your opinion been reached?'* The oncologist answered that two to two and a half years was the median survival period for patients suffering from the same type of cancer as Mr M, if they were able to receive all available treatments. The consultant stated that Mr M would likely need future chemotherapy, which might include referrals for clinical trials. And AIG was also provided with a copy of a clinic letter from the oncologist, dated 24 May 2023, which stated that while Mr M's illness was likely incurable, it remained treatable with systemic chemotherapy. The letter reiterated that the average life expectancy for someone with Mr M's form of cancer who could go through all lines of treatment would be up to two and a half years.

It seems that when AIG initially assessed the claim, Mr M's attending consultant oncologist didn't suggest that Mr M had a life expectancy of less than 12 months. Instead, the consultant indicated that the average prognosis was up to two and a half years. So I don't think it was unfair for AIG to rely on the consultant's evidence to conclude that Mr M's claim didn't meet the policy definition of a terminal illness.

I appreciate that Mr M was provided with a DS1500 form in April 2023 by a clinical nurse specialist. This was a government form which allowed patients to access certain benefits if they were likely to have less than 12 months to live. I've considered this point carefully. But, as I've set out above, the policy terms state that in order for the terminal illness definition to be met, an attending *consultant* must consider that a policyholder's life expectancy is less than 12 months. In this case, the consultant oncologist treating Mr M didn't indicate that they believed Mr M's prognosis was less than 12 months. So I don't think AIG acted unfairly by placing more weight on the opinion of the consultant oncologist when it assessed Mr M's claim.

As such, while I sympathise with Mr M's position and I'm sorry to cause him further upset, I don't find it was unfair or unreasonable for AIG to have concluded that Mr M's claim didn't meet the policy definition of terminal illness in November 2023. So I don't think it acted unfairly by turning down his claim.

It's clear that Mr M disagrees with AIG's position. But, as I've explained, the evidence shows that AIG has made multiple requests to Mr M's oncologist for more information to allow it to reconsider this claim. It's unfortunate the oncologist hasn't replied to its requests. It's open to Mr M to also ask for more medical evidence in support of his claim which he can send on to AIG for its review. Once AIG has received any new evidence, I'd expect it to review that evidence and communicate its claims decision to Mr M promptly and fairly, in line with its regulatory obligations. But based on available information, I don't think there's enough persuasive medical evidence to show that Mr M's claim met the definition of a terminal illness.

My final decision

For the reasons I've given above, my final decision is that AIG has already made a fair offer to settle Mr M's complaint.

AIG Life Limited must now pay Mr M £150 compensation if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 12 December 2024.

Lisa Barham
Ombudsman