DRN-5155441

The complaint

Ms M as the trustee of the H trust complains that AIG Life Limited turned down a claim Mr H made for terminal illness benefit 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 2019, Mr H took out a term assurance policy. This included cover for terminal illness in specific, defined circumstances.

Unfortunately, in March 2020, Mr H was diagnosed with Motor Neurone Disease (MND). Mr H's treating specialists believed that his life expectancy was less than 12 months. So Ms M made a claim for terminal illness benefit on the policy.

AIG looked into Mr H's claim and it asked for further medical evidence. It also referred the evidence to its Chief Medical Officer (CMO) – a consultant neurologist. The CMO considered the medical evidence but they didn't think it showed that Mr H met the policy definition of 'terminal illness'. On that basis, AIG turned down Mr H's claim.

Sadly, Mr H passed away in July 2020. AIG therefore paid the full policy life benefit.

Ms M was very unhappy with AIG's position and she complained. AIG looked into complaints about its decision in both 2020 and 2021 and maintained its position. And, following a further complaint from Ms M, it issued a further final response letter in March 2024. AIG still didn't think it had acted unfairly when it turned down Mr H's claim.

So Ms M asked us to look into this complaint. She felt Mr H's treating doctors had clearly shown that Mr H's condition met the policy definition of terminal illness and that the terminal illness benefit should have been paid. She said this would have made things easier for Mr H's family to travel and spend time with him.

Our investigator didn't think AIG had handled Mr H's claim unfairly. While she sympathised with Ms M's position, she noted that in order for a terminal illness benefit claim to be paid, AIG's CMO needed to agree with the diagnoses made by a policyholder's treating doctors. In this case, our investigator felt that AIG had shown its CMO had considered all of the available medical evidence when assessing this claim. And she didn't think it had been unfair for AIG to rely on its CMO's opinion to turn down Mr H's claim.

Ms 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 disappoint Ms M, I don't think it was unfair for AIG not to pay Mr H's terminal illness claim and I'll explain why.

First, I'd like to offer my sincere condolences to Ms M for the sad loss of Mr H, following his diagnosis with MND in March 2020. I don't doubt what a very difficult and distressing time this was for Ms M, Mr H and their family.

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, amongst other relevant considerations, such as the policy terms, regulatory principles and the available evidence, to decide whether I think AIG handled this claim fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr H and AIG. The policy provides cover for terminal illness benefit - the full policy sum assured which may be paid upfront in specific circumstances if a policyholder is diagnosed with a terminal illness and if their life expectancy is less than 12 months. The policy defines a terminal illness as:

'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 he cured; and*
- *In the opinion of the attending consultant, the illness is expected to lead to death within 12 months.'*

AIG has also defined what it means by a consultant as:

'A consultant doctor who:

- *specialises in an area of medicine appropriate to the cause of the claim;*
- *is employed at a hospital in an eligible country; and*
- *is treating the person covered for their condition.*

All diagnoses made by a consultant must be confirmed by our Consultant Medical Officer.' (My emphasis added).

In my view, the policy terms make it clear that in order for a terminal illness benefit to be paid, not only must the treating consultant confirm that a policyholder's life expectancy is less than 12 months; that diagnosis must be confirmed by AIG's CMO.

It's clear from the medical evidence provided by Mr H's treating consultant neurologist that Mr H was given a terminal prognosis in March 2020. And the neurologist clearly stated, in their letter to AIG: *'the likely life expectancy for this patient is that statistically he is likely to die within 12 months from the time of diagnosis.'* Given Mr H's treating specialist felt Mr H wasn't likely to survive more than 12 months – and given Mr H did sadly pass away around three and a half months after diagnosis - I can entirely understand why Ms M feels it was unfair and unreasonable for AIG to turn down the terminal illness benefit claim.

But, as I've set out above, the policy terms also say that AIG's CMO must confirm that diagnosis. The CMO – a neurologist - reviewed the evidence first provided by Mr H's doctor and didn't agree that Mr H met the policy terms. They said that survival in people with Mr H's diagnosis was around 28 months. They felt that there were some factors which might

indicate a worse prognosis, but that there were no apparent bulbar or respiratory symptoms in the evidence. So the CMO felt, based on the medical evidence, that Mr H's prognosis might be as much as two years from the date of diagnosis.

AIG went on to ask for further medical evidence, which the CMO reviewed. This included a letter from a respiratory consultant in April 2020, which stated that Mr H was asymptomatic from a respiratory point of view. And an MND co-ordinator noted Mr H's swallowing symptoms hadn't worsened. Mr H's GP records from May 2020 show that a palliative care review had noted Mr H to be *'stable at present'.* Based on the evidence, the CMO still didn't think Mr H's claim met the definition of a terminal illness. And so, in early July 2020, AIG declined the claim.

As Ms M was unhappy with AIG's decision, I can see that AIG wrote to Mr H's respiratory consultant on 9 July 2020 with a request for further information. The consultant responded and confirmed that Mr H's life expectancy was less than 12 months, and that he required non-invasive ventilation and had suspected bulbar involvement from his MND. Sadly, it seems Mr H passed away before AIG had had a chance to review this letter. And therefore, AIG paid a life claim on the policy instead.

Based on all of the available evidence, it seems that AIG's CMO, a neurologist and expert in their field, did fully review all of the medical information provided by Mr H's treating practitioners. And taking into account that evidence, they didn't think Mr H had met the policy definition. I find, on balance, that AIG did appropriately consider all of the evidence before reaching its decision to turn down the claim. Nor do I think it was unfair or unreasonable for AIG to rely on its CMO's opinion to decline Mr H's terminal illness benefit claim in July 2020.

This means that while I've very sorry to cause Ms M further upset, I don't think AIG did anything wrong which it needs to put right. AIG issued a final response in June 2024 to a separate complaint about its earlier communications with Ms M and it awarded her compensation. However, as this decision turns on AIG's decision to turn down the claim and as AIG's letter was dated after Ms M complained to us, I don't think it would be appropriate for me to comment on whether that compensation was fair. Ms M may be able to make a separate complaint about that specific issue to us if she'd like to do so.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms M to accept or reject my decision before 20 December 2024.

Lisa Barham
Ombudsman