DRN-4245746

The complaint

Miss B complains that The Equine and Livestock Insurance Company Limited (EL) has been unfairly requesting additional information from her doctor before it will decide whether to meet her claim.

What happened

Miss B has an insurance policy with EL that provides her with some personal accident cover. In particular the policy will pay her a cash sum if she's permanently and totally disabled.

Miss B was injured in an accident and made a claim for total and permanent disablement. EL said it wouldn't pay the claim and Miss B complained to this service about that decision. Her complaint wasn't upheld, although Miss B was told that if new medical information came to light EL would be expected to re-assess her claim.

Miss B's doctor did further tests and submitted his revised opinion that Miss B met the required parameters for total permanent disability. EL asked Miss B's doctor some follow up questions, and Miss B objects to this, particularly as she hasn't been copied in to all the correspondence between EL and the doctor.

EL said it was entitled to ask follow up questions and that as it was seeking an expert medical opinion it didn't need Miss B to be involved at this point.

Miss B doesn't think that's fair so she asked us to review her complaint.

Our investigator concluded that there was nothing preventing EL from asking for further or clarified information in order to assess the claim fully. She thought that was a fair thing for it to do.

Miss B disagrees, saying that as her doctor has answered "yes" to three key questions about her health EL shouldn't ask for more information, and should instead meet her claim.

I've been asked to decide this complaint.

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.

Firstly I must explain that this decision is only about whether EL can fairly ask follow on questions of her doctor once he's submitted his opinion on her health. It *isn't* about whether EL has fairly decided to not meet her claim followings its receipt of new medical evidence, as, when Miss B complained to us, that hadn't been decided by EL. At the time of writing I don't know if EL has told Miss B whether it intends to meet her claim or not. When it does, Miss B can make a further complaint to EL if she's unhappy about the result. If, after EL responds to that complaint, Miss B remains unhappy, she may be able to bring a fresh complaint to this service.

I'm not going to uphold this complaint. I'll explain why.

Miss B says that as her doctor responded to EL's questions about her health to confirm his belief that she is totally and permanently disabled, EL can't fairly ask any further questions. I don't agree with that. I've looked at the policy terms and conditions and there's nothing in these that suggests EL is limited in any way in the number of questions it can ask in order to fully assess a claim. It's common for follow up questions to be asked during the course of an assessment wherever an insurer thinks something needs clarifying or expanding upon. In this particular case, Miss B's doctor has issued a revised opinion on her health which is almost opposite to his previous report – so it's not surprising EL might have some follow up questions.

Miss B says also that she's been excluded from being part of the response from her doctor because of the timescales set by EL. I don't know if that's the case or not, but even if it is, that shouldn't disadvantage her. The insurer confirmed it was seeking further information following an expert medical opinion. It can only get that directly from Miss B's doctor

My final decision

My decision is that I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 13 October 2023.

Susan Peters
Ombudsman