DRN-4214730

The complaint

Mr B's complained that AIG Life Limited declined to pay the claim he made on his critical illness policy following his diagnosis with multiple sclerosis. And he says AIG delayed in making that decision.

What happened

In summer 2019, Mr B applied for a life and critical illness policy with AIG. Initially, AIG deferred their decision so they could verify some medical information. The policy commenced after this was completed. It provides £600,000 worth of cover.

In spring 2021, Mr B notified AIG he'd been diagnosed with multiple sclerosis. As this is a critical illness for which he could claim on the policy, Mr B submitted a claim to AIG.

AIG requested medical evidence from Mr B's GP and specialist to help them assess the claim. After several months, they decided they needed to obtain information held by another insurer with whom Mr B also held a policy. Mr B declined consent for this. After several more months, AIG declined the claim, as they said they'd not received enough information to allow them to consider it.

Mr B complained to AIG. AIG didn't change their position. So Mr B brought his complaint to our service. Our investigator considered it and concluded it was reasonable for AIG to decide they needed more information to assess the claim. This was in line with the policy terms. But she said they'd taken too long to tell Mr B their decision and should pay him £250 compensation for the delay.

Mr B didn't agree with the investigator's view. So I've been asked 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.

Having done that, I'm upholding Mr B's complaint – but only insofar as it relates to delay by AIG in reaching a decision on his claim. I'll explain why.

When someone makes a claim on an insurance policy, the onus is on them to provide evidence – either personally or by giving consent for a third party to provide it – to support the claim. The insurer then reviews that information to establish whether or not the claim meets the policy terms. If it does, it should pay the claim. If there's some reason why it doesn't – for example, a condition doesn't meet the policy definition, or is excluded – the insurer should explain this to the customer when they decline the claim.

I can see that, in this case, Mr B submitted his claim to AIG in spring 2021. He provided consent for AIG to request medical records from his GP and consultant. These were provided.

The terms of Mr B's policy document say:

"If the person claiming, the owner of the cover or the person covered does not give us the evidence we ask for, or the information they do give us is inaccurate or incomplete, we reserve the right to decline a claim or stop paying one."

AIG say they need more evidence from another insurer before making a decision. Mr B has refused consent for them to approach that insurer. He says AIG have all they need to make a decision and it's unreasonable they've not done so. AIG don't agree.

I've thought very carefully about this. I can see from the evidence provided Mr B has critical illness policies with two other providers – who I'll call Insurer 2 and Insurer 3. He consented to AIG and Insurer 2 sharing information. But he's refused to allow AIG and Insurer 3 to do the same.

Insurers shouldn't ask for wide reaching medical evidence without good reason. But I don't think AIG have done that. They knew about the claim with Insurer 3, because Insurer 3 told them about it towards the end of 2020. The two claims were made within a few months of each other – so it's reasonable to suppose they related to the same condition.

AIG told Mr B they'd received Insurer 3's request to share medical evidence in autumn 2022. And in March 2023, they told him the claim couldn't proceed without his consent to share information with Insurer 3.

Mr B is entitled to refuse his consent to AIG and Insurer 3 sharing information. But I think it's reasonable, having been told about another claim, for AIG to want to review the evidence provided to Insurer 3 – and to share what they received in relation to Mr B's claim on their policy. I'm satisfied they've told Mr B they want to do this – and made him aware of what their decision would be if they couldn't.

I'd expect AIG to reassess the claim if Mr B consents to them obtaining that information from Insurer 3 in future. But, as things stand, I don't think they need to do any more to resolve Mr B's complaint that AIG have declined his claim.

But I do think AIG could have reached that conclusion quicker. They asked for Mr B's consent to information sharing at the end of September. Mr B declined consent promptly. But it was about eight months before AIG confirmed they were declining the claim because they didn't have all the information they thought they needed to consider it. I don't think that's reasonable.

Putting things right

Because I think it was reasonable for AIG to decline the claim, I don't think they need to do anything to put right that part of Mr B's complaint. But I do think they should compensate him for the delay I've identified in communicating that decision. Our investigator thought £250 was a fair sum to compensate for that delay.

I agree with that assessment. I think £250 is a reasonable amount of compensation to recognise Mr B's frustrations at not receiving AIG's decision and for having to chase them to keep him up to date. For the sake of clarity, the award is just in relation to the delay and isn't intended to address Mr B's undoubted distress at the decision AIG made – which, as I've said, I think was reasonable.

My final decision

For the reasons I've explained, I'm upholding Mr B's complaint about AIG Life Limited and directing AIG to pay him £250 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B to accept or reject my decision before 9 November 2023.

Helen Stacey
Ombudsman