DRN-3417503

The complaint

Ms S complains about AIG Life Limited's handling of her critical illness claim payment. She says it paid her an incorrect value following her diagnosis of cancer in January 2021, as her sum assured had undergone an annual increase three days earlier.

To resolve the complaint, Ms S wants AIG to pay her £38,288.45, the difference between the 2020 and 2021 sums assured.

What happened

Ms S took out her policy in 2015 through an independent financial adviser. It was originally taken out with AGEAS, but it was taken over thereafter by AIG. The policy had an initial sum assured of £600,000 for a 38-year term and comprised life and critical illness cover. The policy had an increasing sum assured and premium, each rising by 5% each January.

In March 2019, Ms S moved to a second home overseas. Correspondence between Ms S and AIG thereafter took place via email.

On 2 December 2020, AIG contacted Ms S to inform her that the sum assured would increase to £804,057.39 effective 12 January 2021.

Ms S sadly went on to be diagnosed with a type of breast cancer on 15 January 2021, following a lump she had found in 2020. She made a claim to AIG for critical illness benefit.

AIG accepted the claim on 27 May 2021. It backdated the payment of £765,768.94 to 4 January 2021 and returned £1253.28 Ms S had paid in premiums since that date. The claim was accepted at the date when Ms S underwent a biopsy and the diagnosis was satisfied.

Ms S complained. She said that she had a biopsy overseas at her own request as a precaution due to the lump, but she was told by the doctor that it did not look concerning.

AIG rejected the complaint in July 2021. It said it had correctly paid the claim. The policy wording of 'histological confirmation' meant the cancer had been confirmed through biopsy on 4 January 2021 and so that was when the diagnosis took place, not when it was notified to Ms S in the pathology report of 13 January 2021.

AIG said it took this approach because it had to be consistent with all customers. Though Ms S had a policy with an increasing sum assured, many customers had decreasing term policies alongside mortgage lending – so being accurate about the date of diagnosis was key and it was accepted across the industry that for cancer, the diagnosis comes from the date at which a biopsy takes place.

Ms S brought her complaint to this service where it was considered by one of our investigators. She said she didn't believe AIG could fairly hide behind using an 'industry standard' approach to paying her claim – it ought to comply with the terms and conditions of her contract of insurance. She also felt that a fair and reasonable approach to her claim was not to generalise by looking at standard industry practice, as this was an arbitrary method.

She also said that a biopsy date was unreliable because it could not be said with certainty at that time whether she had cancer or not. Ms S took the view that there must be an analysis which follows a biopsy, because her lump could have turned out to be benign. As it was, there was no way she could have known earlier than 13 January 2021 that she had an invasive cancer, and this was one day after the sum assured rose by over £38,000.

An investigator from this service then reviewed the complaint. He took the view that the earliest medical evidence which met Ms S's policy wording was the pathology report of 13 January 2021. And by this date, the sum assured had increased the day before. He therefore recommended that AIG pay the difference between the two claim payments, with interest and a further £200 for the additional upset Ms S had been caused.

AIG disagreed. It said it had acted in accordance with a report undertaken by the Health Claims Forum, an industry body which had conducted analysis to establish best practice for insurers paying critical illness claims.

This report had set out a diagnosis date for all of the main listed conditions for policies in accordance with the Association of British Insurers' model wording. For cancer, it said the diagnosis date ought to be the date of the biopsy or other test that generates a definite diagnosis of cancer that satisfies the policy definition.

It also said that the biopsy report was dated 5 January 2021 from the biopsy of 4 January 2021 and the pathology report referred to by our investigator was generated based on the biopsy. That report said that the biopsy showed histological confirmation of invasive cancer.

AIG noted that the investigator's reasoning was contrary to industry practice and this could have a detrimental effect on policyholders that have decreasing sum assured. The correct approach to ensure valid claims were paid fairly was to accept them at the date the evidence showed the policy wording was met – and in Ms S's case, this was 4 January 2021.

AIG asked for the complaint to be passed to an ombudsman.

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 send my best wishes to Ms S and I was sorry to learn of her diagnosis.

I agree with Ms S insofar as the importance of the terms applying to her cover, as they form the contract of insurance between herself and (now) AIG.

Ms S's policy wording for her condition says:

> "*Cancer - excluding less advanced cases*
> *Definition - ABI+*
> *Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).*"

The wording goes further and lists exclusions, but these don't apply here.

When deciding what's fair and reasonable in all the circumstances of a complaint, I will take into account relevant law, regulations, guidance, standards, codes of practice and where appropriate, what I consider to be good industry practice at the relevant time. This is in addition to the contractual arrangements between the parties.

With that in mind, I believe the guidance AIG has pointed to sets a quantifiable standard for insurers as to the relevant date of diagnosis for all key conditions contained within critical illness policies. I won't repeat the content of the report here, but I consider it a fair proposal to set the date of a biopsy for a type of cancer as the 'relevant date' of diagnosis *if* the biopsy goes on to confirm histological confirmation of the presence of a cancer of a specified severity which is sufficient to meet the cancer definition in a given policy.

I also do not think an insurer is unfair in principle by using the date of a biopsy as the relevant date for the purposes of satisfying valid claims of cancer. For claims of this nature, there must be a point at which an insurer is liable to pay the claim, if all of the key terms are met. In relation to the biopsy, it is the instance where histological confirmation is provided.

The reason there must be an identifiable point at which a condition exists for the purposes of satisfying a claim is that some policyholders have decreasing sums assured where any delay to a claim could reduce a claim payment. Also, some policies may expire after a condition was known to have existed by way of histological confirmation upon biopsy but before any diagnosis was given by a consultant. Though Ms S has suggested otherwise, this does not affect policyholders where the biopsies produce negative results, because no claim is payable anyway in those circumstances.

Ms S also says that the production of a report thereafter must infer that additional consideration took place in between. I understand why she takes that view and why she has explained that the performance of a biopsy itself is not the same as a cancer diagnosis – as she feels diagnosis means confirmation by an appropriate consultant or specialist. That's since Ms S was told of her diagnosis on 15 January 2011, following the pathology report of 13 January 2011.

As I've said earlier, I believe the fair way to determine this complaint is by reference to the policy itself. Ms S's specific policy wording sets out a 'critical illness' definition, which is:

> "*An illness excluding Total Disability and total permanent disability that:*
> - *we cover under Critical Illness with Term Assurance (see section B2);*
> - *meets our definition of that critical illness in section B2;*
> - ***is diagnosed by a consultant [my emphasis];***
> - *is the first and unequivocal diagnosis of the illness, and*
> - *is confirmed by our Consultant Medical Officer.*"

It also explains at section B1 how AIG:

> "*will pay the benefit if the person covered:*
> - *dies, or*
> - *is diagnosed with a critical illness* ***and [my emphasis]*** *the diagnosis meets our definition of critical illness.*"

Notwithstanding that I do not find it principally unfair to consider the point at which a biopsy confirms malignancy to satisfy the evidence needed to show the existence of cancer of a specified severity (and along with the industry guidance, the date of diagnosis), in this case Ms S's policy terms go further than the presence of defined cancer. Those terms also require

Ms S to satisfy both limbs of section B1. This means the critical illness definition needs to be met, including that it must be unequivocally (and firstly) diagnosed by a consultant.

Therefore, applying Ms S's particular terms to the medical information, the evidence of cancer which was present on the biopsy was not reviewed by Ms S's treating consultant until 15 January 2021. She confirmed as such in her email to AIG of 29 April 2021 where she explained that it was the pathology report which confirmed Ms S's specific type of cancer and its staging, which she conveyed to Ms S two days later.

I have seen no objective evidence that the treating consultant confirmed the diagnosis any earlier than 13 or 15 January 2021. By this time, Ms S's policy's sum assured had changed, in accordance with the 5% increase set out in the policy terms. The increased sum assured was therefore due to Ms S.

To be clear, my findings do not disregard the good practice framework on 'dates of claim' put forward by the Health Claims Forum, the ABI or any other relevant industry body. I have borne this in mind alongside the terms and conditions of Ms S's policy. However, in this case, it would not be fair or proportionate to disregard the requirements of the contract of insurance where those terms form the basis upon which Ms S's claim was validated.

Putting things right

AIG should pay the remaining proportion of Ms S's critical illness claim (£38,288.45) in accordance with the terms and conditions of the policy and based on the sum assured as at 12 January 2021, given Ms S's critical illness was diagnosed as required by the wording after that date.

Interest should be added to the claim payment. This should be at a gross annual rate of 8% simple, less tax (if properly deductible), from the date the claim should've been paid to the date of settlement.

I understand that no further refund of premiums is due to Ms S as these have already been returned with the first claim payment.

Finally, AIG ought to pay Ms S £200 for the upset she has been caused in having to pursue the balance of the claim at a time where she was unwell. She has explained that this has caused an impact on her, and I believe some compensation to account for that distress is warranted in these circumstances.

My final decision

I uphold this complaint. AIG Life Limited should pay Ms S's remaining claim for critical illness benefit, with interest and a payment for upset for the reasons set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms S to accept or reject my decision before 22 June 2022.

Jo Storey
Ombudsman