DRN-4664497

The complaint

Mr and Mrs Z are unhappy with the way in which CIGNA Europe Insurance Company SA-NV handled a claim on a group personal accident insurance policy (the policy), including its decision to decline Mrs Z's claim for permanent total disability (PTD) benefit and delays.

As the complaint relates to a claim for Mrs Z, I'll refer to her throughout.

What happened

The details of this complaint are well known to both parties, so I won't repeat them all again here.

However, by way of summary, Mrs Z made a claim for the PTD benefit under the policy. Ultimately this was declined by CIGNA. Mrs Z is unhappy with this decision. She said CIGNA agreed to arrange for an independent medical expert to report on her condition then subsequently gave up trying to find someone suitable and declined her claim.

She brought a complaint to the Financial Ombudsman Service and our investigator looked into what happened. Our investigator concluded that CIGNA had fairly declined the claim, but recommended CIGNA pay £300 compensation as there had been some avoidable delays.

CIGNA accepted the recommendation. Mrs Z disagreed and raised further points in reply. These didn't change our investigator's opinion so this complaint has been passed to me to consider everything afresh 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.

CIGNA has an obligation to handle insurance claims fairly and promptly. And it mustn't unreasonably decline a claim.

The decision to decline the PTD claim

The policy terms and conditions say:

> We will pay you the appropriate benefit if, during any period of insurance, an insured person sustains a bodily injury which, within 52 weeks, is the only cause of accidental death or permanent total disablement.

It isn't disputed that Mrs Z is an insured person under the policy.

Permanent total disablement means:

> any permanent disability which prevents an insured person doing any work of any kind

When making a claim it's for Mrs Z to establish that she meets the definition of PTD.

In its final response letter dated May 2023, CIGNA has maintained that it acted reasonably by declining the claim for PTD because it says:

- that the accident in 2015 wasn't the only cause of Mrs Z's current condition, although it accepts that it may have aggravated her symptoms.

- there's no medical evidence to support that she's unable to undertake any work of any kind.

I make no finding on whether CIGNA has acted fairly and reasonably by concluding that Mrs Z's condition wasn't solely caused by the accident and relying on this as one of the reasons to decline the claim. That's because I'm satisfied that it has fairly and reasonably concluded that there isn't sufficient evidence to support that she's unable to undertake any work of any kind, which is one of the requirements of successfully establishing a PTD claim.

I'm not a medical expert, so I've relied upon the available medical evidence when determining this complaint.

The medical evidence supports that Mrs Z lives with a number of medical conditions which impact her life and that's not in dispute. I can see that she has had lots of treatment and is on medication.

Mrs Z has provided various accounts over time explaining the impact her medical conditions have on her. For example, finding it hard to carry out some everyday tasks, reduced mobility, voice problems, chronic flatulence, bloating, severe back pain and lack of sleep. I have a lot of empathy for her situation.

However, importantly, the medical evidence doesn't provide much insight into how her conditions - particularly those which can be attributable to the accident – affect her functionality including her ability to undertake any work of any kind.

I'm satisfied from what I've seen that CIGNA did attempt to contact medical professionals involved in Mrs Z's care to ask them questions relevant to the PTD benefit. And when it didn't receive a reply, it attempted to find an independent medical expert to report on Mrs Z's condition to help assess whether she met the PTD definition. However, from what I've seen it looks like none of the experts it approached were able to do so.

Given the number of years the claim was ongoing, I don't think CIGNA unreasonably then took the decision to assess the claim based on the available medical evidence. And I think it fairly concluded that Mrs Z hadn't established that she wasn't able to undertake any work of any kind.

One of the claims settlement conditions set out in the policy terms and conditions says: "if necessary, the insured person must also agree to a medical examination, at our expense, whenever we ask for one". Mrs Z is upset that the decision was taken by CIGNA to decline her claim without obtaining an independent medical assessment.

I understand the point she makes. However, I'm not persuaded that the terms of the policy require CIGNA to arrange a medical assessment in every case. And it isn't standard industry practice for a medical assessment to be arranged and paid for by an insurer every time a

claim is made under a personal accident policy. But if a medical assessment is requested by the insurer, the terms make it clear that Mrs Z is required to attend, and the cost of the assessment and report will be met by CIGNA. That's what it agreed to do in principle here.

Given the available medical evidence, I don't think CIGNA was reasonably required to appoint an independent medical expert in the circumstances of this case but having not heard back from the medical professionals involved in her care, I can see why CIGNA did suggest this. I think CIGNA was trying to act in Mrs Z's best interests.

And when the experts contacted were unable to provide a report, I'm satisfied that Mrs Z was asked whether she could locate or suggest a suitable expert for CIGNA to instruct. Unfortunately, Mrs Z wasn't able to assist in this respect. But in the circumstances of this particular case, I don't think that was unreasonable given the number of experts contacted by CIGNA who said they were unable to help.

When making my findings on this case, I've taken into account that Mrs Z has been awarded a lifetime payment of industrial injuries disability benefit (after three assessments she says), her disability has been assessed to be 25% and she is now a blue badge holder. However, the policy has a specific definition which needs to be met for the PTD benefit to be paid and the qualifying criteria for welfare benefits is different. I'm not persuaded successfully claiming this welfare benefit means she's unable to undertake any work of any kind.

Delays

It took a number of years for CIGNA to confirm its decision to decline the PTD claim. I'm satisfied that some of those days were outside of its control.

However, from the available evidence I've been given, I'm persuaded that there were other times when CIGNA wasn't proactively progressing the claim. And it's not clear why it took so long for it to establish the correct policy terms and that Mrs Z was covered as an insured person.

So, whilst I'm satisfied that the ultimate decision to decline the claim is fair and reasonable, I think the claim should've been more promptly progressed. Mrs Z was vulnerable and going through a difficult time with her health. At times she had to chase CIGNA for updates, and I'm satisfied that the delays CIGNA was responsible for put her to unnecessary trouble and upset. I think compensation in the sum of £300 fairly reflects the impact on her.

I know Mrs Z will be very disappointed with my decision. I hope it reassures her to know that this complaint has been considered by someone who is independent of the parties.

Putting things right

I direct CIGNA to pay £300 compensation to Mr and Mrs Z to reflect the distress and inconvenience caused.

CIGNA can deduct £100 from this sum if it's already paid the compensation offered in its final response letter.

My final decision

I partially uphold this complaint to the extent set out above and direct CIGNA Europe Insurance Company SA-NV to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs Z to accept or reject my decision before 2 May 2024.

David Curtis-Johnson
Ombudsman