DRN-4928764

The complaint

Ms B complains because Zurich Insurance PLC ('Zurich') hasn't paid a personal accident insurance claim.

What happened

Ms B was insured under a group Corporate Accident and Business Travel insurance policy, provided by Zurich.

Ms B suffered an injury and submitted a personal accident claim to Zurich in April 2022. Ms B sent Zurich some medical evidence. In June 2022, Zurich asked Ms B to sign a consent form to obtain a copy of her medical records.

Following extensive correspondence between Ms B and Zurich, Ms B complained to Zurich in December 2022. In February 2023, Zurich told Ms B that it needed to arrange a medical review to assess her eligibility for benefits under the policy but said it was waiting for Ms B's completed UK consent form and was also arranging to send a consent form which was applicable to the country where Ms B now lives. Zurich told Ms B that she wasn't eligible to bring a complaint to the Financial Ombudsman Service.

Ms B approached our service and our investigator ultimately concluded that her complaint was one which fell within our powers to consider. Zurich accepted this, and our investigator looked into what had happened. He concluded that Zurich's position on Ms B's claim was fair and reasonable in the circumstances.

Ms B didn't agree with our investigator's opinion, so the complaint was referred to me as the final stage in our process. I made my provisional decision about Ms B's complaint in July 2024. In it, I said:

'When making my provisional decision, I've taken into account relevant industry rules and guidance – including the 'Insurance: Conduct of Business sourcebook' - set out by the regulator, the Financial Conduct Authority.

I've read and considered all of the information which both Ms B and Zurich have sent to us. This includes Ms B's most recent email of today's date. It's clear that Ms B has put a great deal of time and effort into dealing with this matter, but I won't be addressing each and every point that she has raised, nor am I obliged to. This isn't intended as any discourtesy to Ms B but, rather, reflects the informal nature of our service and my discretion to address only what I consider to be the relevant issues.

Temporary Total Disablement/Temporary Partial Disablement

The Financial Ombudsman Service has an inquisitorial remit. This means I'm not confined or limited to only considering Zurich's position on the claim that was set out in its letter to Ms B of February 2023. I have the power to look at the claim overall and decide what I think Zurich should have looked at when dealing with the matter.

The policy which Ms B is insured under provides for the payment of a weekly benefit for temporary total disablement and/or temporary partial disablement in certain circumstances.

However, the policy also says the following:

> *'**Section 16 – General Provisions***
>
> *…*
>
> ***8. Temporary Partial Disablement Limitation***
>
> *The benefit payable for temporary partial disablement shall not exceed 50% of the insured person's weekly wage.*
>
> ***9. Temporary Total Disablement Limitation***
>
> *The benefit payable for temporary total disablement shall not exceed the insured person's weekly wage.'*

I've seen evidence confirming that Ms B would not have been entitled to or paid a weekly wage – either from the policyholder or from any other third party - at the time of her accident, throughout the deferred period or during the period she is seeking to claim temporary disablement benefit for.

As Ms B had no weekly wage, this means I don't think Ms B has any entitlement to a temporary disablement benefit under the terms and conditions of the policy.

I understand Ms B may have obtained employment with a different third party in the country she moved to if the accident had not happened. But I can only base my decision on the facts as they actually occurred and not on hypothetical scenarios. It wouldn't be fair or reasonable in the circumstances to direct Zurich to pay a temporary disablement benefit to Ms B based on any potential weekly wage that she may otherwise have gone on to earn.

I understand Zurich told Ms B that it would pay a temporary disablement benefit under the policy on the receipt of sick notes, which Ms B subsequently provided. But Zurich did make Ms B aware of the above policy limitations in June 2022. And any incorrect statement by Zurich that it would pay the claim doesn't mean it's fair or reasonable in the circumstances to disregard what I think are clear policy limitations.

I agree with Ms B's argument that it would be unreasonable for Zurich to seek to base any payment of a temporary disablement benefit on the outcome of a medical review undertaken more than two years after the accident occurred. But, for the reasons I've explained above, I don't think Ms B's claim is covered under the policy anyway.

I understand Ms B's comments that the policyholder was supportive of her claim but it's not up to the policyholder to determine whether or not a claim is payable under the policy. If Ms B has any concerns about the suitability of the cover provided for someone in her contractual situation, then that's something she'd need to raise with the policyholder directly, and isn't a dispute which this service has the power to intervene in.

<u>Permanent Total Disablement/Permanent Partial Disablement</u>

The policy which Ms B is insured under also provides benefits for permanent total disablement and permanent partial disablement in certain circumstances. The criteria for qualifying for these benefits is set out in some detail in the policy terms and conditions.

It's for Ms B to demonstrate that she meets the criteria set out under the policy for such a benefit to be paid for her. It's not my role to make medical judgments or to substitute expert medical opinion with my own. Instead, I must decide whether I think Zurich has acted fairly and reasonably in the circumstances when relying on the available medical evidence.

Zurich's position in relation to a permanent disablement claim is somewhat unclear. At one point Zurich maintained that such a claim was only assessable once all treatment for the injury had been completed. At another point, Zurich seems to have been making arrangements for a medical review to assess Ms B's entitlement to permanent disablement benefit to be carried out as early as June 2022.

I've reviewed the available medical evidence and I don't think this demonstrates that Ms B meets the criteria for a permanent disablement claim to be paid to her. I appreciate Ms B has provided evidence from her GP stating that she is unfit for work. But I wouldn't ordinarily consider that GP certificates alone are sufficient evidence upon which to require an insurer to pay a permanent disablement claim, and some of the medical reports which I've seen refer to a fracture sustained in the accident as having 'united'. Ms B has referred to a letter dated May 2022 (which I don't appear to have been provided with by either party) that Ms B says mentions 'possible permanent impairment'. But Miss B needs to demonstrate more than just 'possible' impairment in order for her claim to be paid. So, I think it would be fair and reasonable in the circumstances, if Ms B wants to pursue a permanent disablement claim, for Zurich to now arrange for a specialist medical review and then go on to assess the claim.

Zurich will require consent form(s) to arrange a specialist medical review. Zurich first sent Ms B a consent form relating to her UK medical records in June 2022. While Ms B may not have had any treatment for her injury in the UK that doesn't mean that her UK medical history is not relevant to her claim. Zurich is entitled to satisfy itself that Ms B's injury has resulted solely and independently from the accident and not from any previous medical issue. So, it's not unreasonable for Zurich to require sight of Ms B's UK medical records.

I'd expect a claimant to cooperate with an insurer's reasonable enquiries relating to a claim. If Ms B wants to proceed with a permanent disablement benefit claim, then she will need to sign and return the UK consent form which Zurich sent to her.

Zurich isn't required to gather all of Ms B's medical records in their entirety and for Zurich to attempt to do so would be contrary to what I consider to be good industry practice when considering claims of this nature. It's up to Zurich to decide what medical records it thinks are relevant to the claim and to any medical review. If Zurich wishes to access any additional medical records from the country where Ms B now lives then it will need to provide her with an appropriate consent form to sign. If Zurich does require this information, then I'd expect it to provide Ms B with the relevant consent form within a reasonable period of time.

I don't agree with Ms B's submissions that the consent form which Zurich sent to her was in any way inappropriate or invalid.

I appreciate that Ms B wishes for any medical review to be conducted in-person. I've seen evidence from Zurich confirming that it's unable to arrange this and Zurich has instead said that any medical review would be remote. Remote assessments are not uncommon when insurers are assessing insurance claims involving medical issues and I don't think there's anything inherently unfair or unreasonable about Zurich arranging for a remote medical review in these circumstances.

The consent form which Zurich sent to Ms B doesn't oblige it to arrange an in-person

medical assessment. The consent form specifically states that a medical assessment 'may be' face to face or in person. Zurich isn't obliged to prove an in-person medical review if it's unable to do so, which I'm satisfied is the case here.

I'm also satisfied that it's appropriate for Zurich to appoint an expert of its choosing to carry out the medical review. There are certain circumstances where there's conflicting medical evidence from both parties as to whether an insured person meets policy definitions when I may consider it fair and reasonable for an insurer to appoint an independent expert agreed between the parties. This isn't the case here.

If Ms B wants legal representation and her own medical practitioner present at any such medical review then that's something she'd need to agree directly with Zurich. This isn't standard practice and isn't something which I think it's fair or reasonable for me to intervene in. Neither do I think it's fair or reasonable in the circumstances to direct that Ms B has the opportunity to review any such report before it's finalised.

In the event that Ms B does undergo a medical assessment and disputes its findings, it's open to her to provide her own new medical evidence. If Ms B disputes any eventual permanent disablement benefit claim outcome subsequently provided by Zurich, then she'd need to complain directly to Zurich in the first instance before bringing a new complaint to the attention of our service.

Zurich's handling of Ms B's claim

I understand Ms B had difficulty obtaining a copy of the policy terms and conditions. It was the responsibility of the policyholder – not Zurich – to provide these to her. Zurich did ultimately provide Ms B with the terms and conditions of the policy, with some information removed. I've seen the information that was removed and it isn't relevant to Ms B's claim.

But I don't think Zurich handled this claim particularly well overall, and I don't think it did so in line with industry rules and guidance. I'm satisfied that Zurich should pay Ms B compensation for the impact this had on her.

I think Zurich could have been clearer in its explanations to Ms B as to why it needed a UK consent form, and as to how Ms B could make a claim for permanent disablement benefit. Ms B was provided with conflicting information by Zurich and Zurich has acknowledged that its response times were not as timely as would usually be expected. However, for the most part, I don't think I can fairly hold Zurich responsible for much of the delays which arose after Ms B refused to complete the UK consent form provided to her in June 2022.

However, Zurich had information available to it in January 2023 stating that Ms B received no weekly wage from the policyholder. I think it's fair and reasonable to conclude that Zurich could have clearly told Ms B this meant she had no entitlement to a temporary disablement benefit under the policy at that point. Instead, I think Zurich unnecessarily raised Ms B's expectations and delayed matters by setting out a requirement for her to undergo a medical review which I don't think was appropriate for a temporary disablement claim in these circumstances.

I would also say that it's not for Zurich to determine whether Ms B was eligible to complain to the Financial Ombudsman Service. Only our service can decide whether a case falls within our jurisdiction. Having said that, Zurich was entitled to dispute our jurisdiction when Ms B brought her complaint to us and its position in that regard isn't something I can take into account when awarding compensation.

I understand Ms B says Zurich altered email correspondence relating to her complaint and

falsely claimed there were two insurance policies, rather than one, in existence but I've seen no evidence upon which I could fairly conclude that this was deliberate or intentional on Zurich's part and, ultimately, these issues have no bearing on the outcome of Ms B's claim or complaint.

I have no power to punish or fine a business through an award of compensation and I have no power to award punitive damages. I've taken into account our published guidance on the payment of compensation for distress and inconvenience and I'm satisfied that a payment of £500 would be fair and reasonable in the circumstances.

Other issues

As I don't think Ms B has demonstrated that she qualifies for a permanent disablement claim, I don't think she has demonstrated that she qualifies for a 'Travel to Work Expenses' payment under the policy terms and conditions either. In any event, as I understand it, Ms B wasn't travelling to and from any place of employment during the relevant period being claimed for. And, as Ms B hasn't demonstrated that she qualifies for a permanent disablement claim, I also don't think she has demonstrated that she qualifies for a 'Medical Expenses – Personal Accident' claim.

The 'Supplementary Hospital Expenses' section of the policy covers hospital in-patient expenses incurred within 3 months following the date of return to the country of permanent residence in certain circumstances. This section of the policy doesn't cover the costs of treatment which might have been recommended with 3 months and may or may not be incurred at a later date.

I appreciate Ms B is likely to be disappointed with my provisional findings overall and I'm sorry to disappoint her. I understand this injury has significantly affected Ms B's life and financial situation and I wish her well for the future. But, based on the information currently available to me, I'm satisfied that my provisional directions set out below represent a fair and reasonable outcome in the circumstances.

My provisional decision

My provisional decision is that I intend to uphold Ms B's complaint in part and direct Zurich Insurance PLC to do the following:

- *Arrange for a remote medical assessment for Ms B if she wishes to proceed with a claim for permanent disablement benefit. Ms B will need to complete any consent forms which Zurich requires to access her medical records. Zurich should then consider the outcome of the medical assessment and all the other available medical evidence and assess Ms B's permanent disablement claim;*

- *Pay Ms B £500 compensation for the distress and inconvenience she experienced.'*

Zurich accepted my provisional decision. Ms B didn't and has provided detailed additional submissions on issues including (but not limited to) the consent form sent by Zurich, the appropriateness of a remote medical assessment and Zurich's overall handling of this claim.

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've taken into account all of Ms B's additional submissions, including the commentary she has made on the content of my provisional decision. But much of Ms B's commentary has

either already been addressed in my provisional findings or relates to issues which I don't think affect the outcome of her complaint. So, I've only addressed what I consider to be the key points.

For the avoidance of doubt, Ms B has made it clear that she does wish to proceed with a claim for permanent disablement benefit.

My provisional decision said I've taken into account relevant industry rules and guidance when considering Ms B's complaint. These rules and guidance, generally speaking, set out high-level expectations for how insurers must handle claims. My provisional decision didn't say that there are UK insurance industry guidelines specifically governing consent forms and/or remote medical assessments. My provisional findings in that regard are based on what I think is fair and reasonable in all the circumstances, taking into account the relevant considerations set out under the Financial Conduct Authority's Dispute Resolution ('DISP') rules that govern our service's determination of complaints.

I still don't agree with Ms B's submissions in relation to the consent form Zurich sent to her. I don't think the consent form which Zurich provided relating to the collection of UK medical records was invalid. While I accept Zurich indicated that it also needed medical information from the country where Ms B now resides, this didn't render the consent form which was provided in relation to the UK medical records obsolete and I don't think Ms B's reasons for refusing to complete that consent form were reasonable in the circumstances. It's not for Ms B to decide what consent forms and what medical information is required – that's for Zurich to do. The Department of Health Reference Guide which Ms B has quoted relates to consent to physical examination or treatment, so isn't a relevant consideration here. I remain satisfied that the main reason for the delay in any progression of Ms B's claim after June 2022 was Ms B's failure to complete the consent form which she'd been provided with rather than any failure by Zurich to send different forms to Ms B.

My provisional decision also didn't say that a remote assessment was suitable for Ms B's injuries. As Ms B has correctly pointed out, it wouldn't be appropriate for me to reach any such conclusion, as I'm not medically qualified to do so. Instead, my provisional findings were that it isn't unfair or unreasonable for Zurich to arrange for a remote medical review in these circumstances.

I accept that a remote medical assessment's findings may be limited. But the onus lies on Ms B to demonstrate that she has a valid claim under the policy, and it's not up to Zurich to provide evidence in support of Ms B's claim for her. There may be circumstances where I wouldn't consider a remote assessment to be fair or reasonable in the circumstances – such as, for example, where a consumer has already provided medical evidence which goes some way towards demonstrating that the policy requirements for the payment of a benefit have been met, or where there is conflicting medical information. But, having reviewed all the medical evidence that I've been provided with, I don't think this is the case here.

It's open to Ms B to obtain a medical report based on an in-person assessment from one of the medical professionals she has named at her own cost if she wishes to do so and submit it to Zurich for its consideration. And, as I've already set out in my provisional decision, if Ms B disagrees with the outcome of any remote medical assessment carried out on behalf of Zurich, then it's also open to her to provide her own new medical evidence to dispute that outcome.

The opinions of staff at other insurers aren't relevant to whether I think Zurich's position on arranging a remote medical assessment is fair or reasonable in the circumstances, and Zurich isn't required to apply the American Medical Association guides which Ms B has referred to.

Zurich is entitled to appoint the agents of its choosing to handle claims on its behalf. The agents which Zurich uses cannot arrange for an in-person medical assessment in Ms B's current location. There are no reasonable grounds upon which I could fairly direct Zurich to appoint a different agent who can arrange for an in-person assessment when I don't think a remote medical assessment is unfair or unreasonable in these circumstances.

I don't underestimate the impact of this situation on Ms B and I note the ongoing effects of the accident which she has described. But our service cannot impose penalties on businesses for the consequences of their actions through our awards of compensation. Overall, I'm satisfied that the compensation award recommended in my provisional decision is fair and reasonable in the circumstances for the impact of what I think Zurich's failings were on Ms B.

As a final point, this policy provides for the payment of medical certificate expenses in certain circumstances. If Ms B wishes for Zurich to consider covering the costs of any medical certificates she obtained then she'd need to present a claim for this to Zurich directly in the first instance. The Financial Ombudsman Service has no power to comment on a 'new' complaint issue like this unless Zurich has been given the opportunity to consider the matter first.

For these reasons, as well as the reasons set out in my provisional decision, I'm satisfied that the following outcome is fair and reasonable in the circumstances.

Putting things right

Zurich Insurance PLC needs to put things right and do the following:

- Arrange for a remote medical assessment for Ms B. Ms B will need to complete any consent forms which Zurich requires to access her medical records. Zurich should then consider the outcome of the medical assessment and all the other available medical evidence and assess Ms B's permanent disablement claim;

- Pay Ms B £500 compensation for the distress and inconvenience she experienced.

Zurich Insurance PLC must pay the compensation within 28 days of the date on which we tell it Ms B accepts my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

My final decision

I'm upholding Ms B's complaint about Zurich Insurance PLC in part and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms B to accept or reject my decision before 18 September 2024.

Leah Nagle
Ombudsman