DRN-5145893

The complaint

Mr S complains that AMERICAN INTERNATIONAL GROUP UK LIMITED ("AIG") declined a claim for alterations to be made to his home following him being diagnosed with a serious disability.

What happened

Mr S had a home insurance policy with AIG covering his household buildings and contents. The policy was arranged through a broker.

He became aware he was struggling with his health. He made some changes to his home to make things easier for him. He says those have cost him £50,000. He made a claim from AIG for the cost of these modifications under a section of cover referred to as 'essential alterations' which can pay up to £25,000 when a person suffers a disability.

AIG said it wouldn't cover Mr S's disability as it happened before his policy started.

Mr S brought his complaint to this service. He asks that AIG pays £25,000 for the alterations he's had done. Our investigator looked into it and thought it wouldn't be upheld. She said she thought AIG had acted in line with its policy terms and Mr S had started to become aware of his disability as early as 2016, before his policy had begun.

Mr S didn't agree with the view. He says his disability wasn't diagnosed in 2016, but much later. Because Mr S didn't agree, his complaint has been passed to me to make a final 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.

I'd like to begin by noting I've set out the background above in less detail than the evidence in the file. I want to assure Mr S that I've read and considered all the available information, including his responses and further points he's made to this service.

I'm sorry to hear about Mr S's difficulties and I'd like to extend my sympathies to him.

I'm not going to name his illness or symptoms in this decision. What I'm going to do is examine the policy wording to decide whether I think AIG has acted in line with it, and acted fairly towards Mr S.

The appropriate part of the policy wording is this:

> *"7. Disability costs We will pay up to the sum insured in your schedule [which is £25,000 for Mr S] in total for essential alterations to your home to allow you or a family member to live unassisted following permanent disablement as a result of either an illness or injury which first occurs during the policy period."*

I think this paragraph is clear and straightforward to understand.

From the file, I can see that Mr S has undergone significant amounts of medical investigation over several years. I can see that the illness he refers to is one that is diagnosed post-mortem, but which has symptoms similar to other conditions.

Mr S had those symptoms investigated from around 2016, and a diagnosis of an illness in 2017. I'll explain that the diagnosis of that illness is mentioned as exhibiting symptoms like the illness and disability Mr S is claiming for.

His policy with AIG ran from August 2022-23, although I can see from the file there was an earlier policy with AIG in 2020 through the same broker.

I've thought about what the 'essential alterations' term means for Mr S. And I can see that he's focused on the fact that his medical consultant says he likely has a particular illness, and this was discussed and "clinically diagnosed" in September 2022 during the term of his policy.

But, I'm afraid I don't agree with him that AIG covers diagnosis of his permanent disablement. I reasonably think the section of policy wording above would pay for the alterations when the illness happens during the policy.

As I say above, I think this happened for Mr S in, or about, 2016 which was well before this policy started. It was also a few years before his earlier policy with AIG began.

I can see Mr S feels strongly that his illness wasn't the same as was diagnosed in 2017, but I'm emphasise the point that the symptoms he was suffering were similar to those expected to be present when he was "clinically diagnosed" in 2022.

What this means is, I think it's reasonable I say his illness began before the policy started.

In his responses to the view, Mr S has talked about Consumer Duty. He's commented that he thinks AIG is effectively quibbling over the semantics of its policy wording when it declined his claim. He mentions that "disablement" and "illness" aren't defined in the policy wording.

I've thought carefully about this. The relevant area of Consumer Duty that deals with this is that firms must act in a way that demonstrates honesty, integrity, and transparency. This means providing clear and accurate information, being upfront about risks, and ensuring that customers are not misled at any stage. And firms should operate with integrity, fairness and transparency.

I've mentioned above that I think the 'essential alterations' part of the policy wording is clear and straightforward to understand. AIG hasn't used technical terms in this part of its cover, and instead it's relied on commonly used words. If there was a dispute on those words, we'd look at how they're used or how a dictionary would define and explain them.

Mr S's complaint focuses on when his disablement was diagnosed, rather than when it first occurred. AIG's wording talks about when the illness first occurs and doesn't mention diagnosis, which I think it's fair I say can be a technical, medical term.

I do appreciate Mr S will find my decision extremely disappointing, but I don't think AIG has done anything wrong in rejecting his claim, and I'm not upholding his complaint.

My final decision

It's my final decision that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 7 February 2025.

Richard Sowden
Ombudsman