DRN-5154029

The complaint

Mr G complained that AIG Life Limited declined a claim on his group critical illness policy.

Throughout the claim and complaint process, Mr G has had a representative helping him. In this decision, any reference to Mr G includes the actions and comments of his representative.

What happened

Mr G joined his employer's group critical illness policy on 9 January 2023. Prior to joining the scheme, Mr G had seen a consultant on 4 January 2023. Mr G had reported a recent history of recurrent infections. He also reported a dull ache which had worsened over time.

Mr G saw separate consultants in early-February and early-March. Mr G underwent several different tests and was eventually diagnosed with cancer in late April 2023. Mr G raised a claim with AIG which was eventually declined. This was due to Mr G's cancer being excluded because of it being a pre-existing medical condition. Mr G raised a complaint. AIG didn't uphold Mr G's complaint and added that it was also a pre-existing related medical condition which was also excluded. Mr G was unhappy and so brought the complaint to this service.

Our investigator didn't uphold Mr G's complaint. They agreed with AIG that Mr G's cancer was a pre-existing condition and as such was excluded under the policy terms. Mr G appealed as he didn't think any of his symptoms were as a result of his cancer or a related condition. As no agreement could be reached, the complaint has been passed to me to make a final decision.

What I provisionally decided – and why

I previously issued a provisional decision on this complaint as my findings were different from that of our investigator. In my provisional decision, I said:

"I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Based on what I've seen so far, I intend to uphold Mr G's complaint. I've explained my reasons why below.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether AIG acted in line with these requirements when it declined to settle Mr G's claim.

Mr G has evidenced that he has met the terms and conditions to be able to claim. The onus is on AIG to evidence that an exclusion is valid for them to decline the claim. So, it's important to understand what the policy terms and conditions say. Under the policy, a

pre-existing medical condition is defined as follows:

> *"No Benefit will be payable for any Insured Illness or repeat of the same Insured Illness which the Insured Person:*
>
> - *has received treatment for;*
> - *has sought advice on;*
> - *has experienced symptoms of; or*
> - *was diagnosed with;*
>
> *before entry to the scheme."*

The policy also sets out the following:

> *"No Benefit will be paid in respect of any Insured Illness where a Related Medical Condition existed prior to entry to the Scheme unless the Insured Person has been in the Scheme for two consecutive years or more and the Insured Illness hasn't occurred in that two-year period."*

A related medical condition is defined in the policy terms as:

> *"any medical condition, or symptom, which in the opinion of Our consultant medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the Insured Illness".*

In their claim decline letter to Mr G, AIG stated that Mr G was seen by a consultant in early January following concerning symptoms dating back to early 2022. These symptoms were enough to say the condition was pre-existing and excluded under the policy.

Mr G wrote to his consultant for his opinion. Mr G asked his consultant the following questions:

> *"Were the symptoms Mr G was experiencing on or prior to 9 January 2023 symptoms of his [type of] cancer?*
>
> *AIG state that the [type of] symptoms Mr G experienced in January 2023 and earlier were directly or indirectly associated with, or likely to have led to the occurrence of, Mr C's [type of] cancer. Do you agree?"*

Mr G's consultant provided commentary as to why he didn't agree to both questions.

Our investigator asked AIG if they'd sought the opinion of their consultant medical officer (CMO). At that time, AIG hadn't. However, they requested their opinion and forwarded this to us. AIG's CMO response focused on two of Mr G's symptoms, persistent bleeding and the pain that Mr G reported in January 2023. He's said both these symptoms were caused by the cancer and so he agreed it was excluded as it was pre-existing.

As the CMO has only focused on two of the symptoms, I've limited my review to just these symptoms. AIG's claim handlers aren't medically trained to diagnose when a symptom is related to a condition or not. As the CMO has said both these symptoms are caused by the cancer, only the pre-existing medical condition exclusion is relevant and not the related condition term.

AIG's CMO has said that Mr G experienced persistent bleeding. He said that cancers of this type are vascularly fragile and prone to bleeding on and off episodically and believes this

was the herald infancy symptom of the cancer. Mr G's history as reported by his consultant in a letter dated 4 February 2023, stated "A year ago, he passed blood". I've not seen anything in Mr G's medical records that suggest he suffered from persistent bleeding or that he suffered from on and off episodes of bleeding.

In relation to the pain, AIG's CMO has said that the cancer had spread to Mr G's [body part] and this would account for the pain Mr G was suffering. Mr G underwent an MRI in February 2023. This reported that his [body part] was normal. Whilst I accept that Mr G's [body part 2] was also deemed to be normal during the MRI, it was then retrospectively noted that Mr G's [body part 2] had an increased signal which likely represented Mr G's cancer. There has been no notes of any retrospective change of opinion to the MRI finding from February 2023 to his [body part].

There is a difference of opinion between AIG's CMO and Mr G's consultant as to whether Mr G's symptoms were caused by his cancer. My role is to decide which of these opinions I find most persuasive. Based on the discrepancies above, and that Mr G's consultant is a specialist in the area of medicine, and AIG hasn't confirmed their CMO's specialist area, I think Mr G's consultant's opinion is more persuasive. As such, I don't think AIG are able to rely on the pre-existing medical condition exclusion to decline the claim.

As a result, I'm likely to ask AIG to reassess the claim further using the terms and conditions. AIG are able to seek further medical information to help them in their assessment of Mr G's claim if required.

I'm also likely to ask AIG to pay Mr G some compensation. I appreciate that it must have been frustrating for Mr G to have their claim declined and the distress and inconvenience this would have caused. I've considered everything in the round, and I think Mr G has been caused considerable distress, upset and worry which has taken a lot of extra effort to sort out over several months. In line with our website guidelines, I think £300 compensation is likely to be fair and reasonable."

I set out what I intended to direct AIG to do to put things right. And gave both parties the opportunity to send me any further information or comments they wanted me to consider before I issued my final decision.

Responses to my provisional decision

Mr G accepted my provisional decision.

AIG confirmed they didn't agree with my provisional decision. They maintain that the symptoms experienced prior to joining the scheme were as a result of his cancer. They also added that Mr G's consultant wasn't asked about two of Mr G's symptoms.

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 thought carefully about the responses to my provisional decision. Having done so, while I appreciate it will come as a disappointment to AIG, my conclusions remain the same. I'll explain why.

AIG provided further comments from their CMO. However, they still haven't confirmed their CMO's specialism. The CMO has reiterated that they believe Mr G's symptoms were caused by his cancer. Whilst AIG's CMO's opinion is a valid medical professional opinion, it differs to

Mr G's consultant's opinion.

As AIG haven't provided anything different to what they had already, I'm still more persuaded by the comments provided by Mr G's consultant. They stated that Mr G's symptoms prior to joining the scheme weren't a symptom of Mr G's cancer.

As a result of the above, I find no reason to depart from the outcome I reached in my provisional decision. I find that that AIG has acted unfairly in declining Mr G's claim.

For the avoidance of doubt, I'm not asking AIG to pay Mr G's claim at this stage, only to reassess which may mean commissioning further medical evidence if it thinks necessary.

Putting things right

AIG should do the following:

- Pay £300 compensation for the distress and inconvenience.

- Reassess the claim further using the terms and conditions. AIG may seek further medical information or opinion to help reach a further outcome on Mr G's claim.

My final decision

For the reasons I've explained above, I uphold this complaint and direct AIG Life Limited to put things right by doing as I've said above, if they haven't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 4 April 2025.

Anthony Mullins
Ombudsman