DRN-5469982

The complaint

Mr O has complained that HSBC Life (UK) Limited declined a claim he made under his critical illness policy.

What happened

The background to this complaint is well known to the parties. In summary Mr O had a decreasing term assurance policy with critical illness cover. The policy was taken out in May 2007 for a 25-year term. The sum assured when the policy was taken out was £260,000.

Very sadly Mr O suffered a brain injury whilst being exposed to toxic fumes whilst carrying out his job. He confirmed that he had been left disabled by his injuries and was no longer able to work.

HSBC assessed Mr O's claim under his policy's Total and Permanent Disability definition. It said that Mr O didn't meet the criteria for benefit to be paid at that time. Mr O provided further evidence and HSBC also assessed the claim under the stroke definition but was unable to conclude that Mr O met that definition either.

Unhappy Mr O referred his complaint here. Our investigator didn't recommend that it be upheld. He didn't find that HSBC had treated Mr O unfairly by declining his claim.

Mr O appealed. He submitted some new information – a report dated 22 October 2024 from a Consultant Neurologist. This was shared with HSBC but it didn't change its position.

As no agreement has been reached the matter has been passed to me to determine.

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.

Although I've summarised the background to this complaint - no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts.

The regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the relevant law, the policy terms and the available evidence, to decide whether I think HSBC treated Mr O fairly.

Having done so, and although I recognise that Mr B will be very disappointed by my decision, I agree with the conclusion reached by the investigator. I'll explain why.

Unfortunately, although it is not in dispute that Mr O is no longer able to work in his occupation, in order for his claim to be paid he needed to have a critical illness as defined by

his policy.

HSBC considered assessed his claim under the Total Permanent Disability definition, which is as follows:

The permanent inability of the Life Assured to perform, without the continual assistance of another person, three or more of the following activities of daily living:

1. *Washing: the ability to wash in the bath or shower (including getting into or out of the bath or shower) or wash satisfactorily by other means.*

2. *Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.*

3. *Feeding: the ability to feed oneself once food has been prepared and made available.*

4. *Toileting: the ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.*

5. *Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa*.

The evidence didn't show that Mr O was permanently unable to perform three out of the five activities listed without the continual assistance of another person. Accordingly HSBC didn't conclude Mr O met this definition – it is a high bar to meet. Mr O submitted further evidence which he said showed structural brain injuries. HSBC assessed the claim under the stroke definition. This requires evidence of a cerebrovascular incident, as this wasn't present HSBC didn't find that definition has been met either. I don't find that was unfair.

Mr O submitted a further report to this Service from a Consultant Neurologist. They made a diagnosis of Functional Neurological Disorder (FND). This report was shared with HSBC. It said that FND is not specifically covered under the policy's terms and conditions, but that the permanence of the symptoms had not been commented on and the material provided to Mr O indicated that at least 50% of people who come to understand their symptoms in the spectrum of FND will get better. Accordingly, HSBC's view remained that the medical evidence received to date did not support permanent disability.

Mr O's policy provides cover if the definition of a specified critical illness, or total and permanent disability, is met. Having considered the medical evidence I don't find that HSBC has treated Mr O unfairly, unreasonably, or contrary to his policy terms by concluding he didn't meet any of the policy definitions and by declining his claim on the evidence presented.

I'm very sorry that my decision doesn't bring Mr O welcome news.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr O to accept or reject my decision before 16 June 2025.

Lindsey Woloski

Ombudsman