

The complaint

Mr H complains that American International Group UK Limited (AIG) has turned down a medical expenses claim he made on a travel insurance policy.

Mr H is represented by his son, who I'll call Mr H1.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mr H has travel insurance as a benefit of a packaged bank account.

In October 2024, Mr H was on holiday abroad. Unfortunately, he became seriously ill and was admitted to intensive care for treatment. Mr H1 made a claim on Mr H's behalf.

AIG asked for medical evidence so it could assess Mr H's claim. It obtained copies of his GP records, as well as medical reports from the treating hospital. Based on that evidence, AIG concluded that Mr H's claim was caused by pre-existing medical conditions which it said Mr H hadn't told it about – in particular, diabetes and heart failure. AIG said insured persons needed to tell it about existing and new conditions each year so it could decide whether or not to offer cover and, if so, on what terms. AIG said that if Mr H had told it about his existing medical conditions, it wouldn't have agreed to cover him. So it said Mr H's claim wasn't covered by the policy terms and it didn't agree to pay his medical costs.

Mr H1 was very unhappy with AIG's decision and with its handling of the claim and he asked us to look into Mr H's complaint. He provided evidence which showed Mr H had made a medical declaration to AIG in 2015 – although AIG hadn't offered Mr H medical cover at that time. He said Mr H hadn't realised he'd need to make annual declarations to AIG because he hadn't received any information which explained the need to do so. Mr H1 also provided medical evidence from Mr H1's GP which suggested there wasn't a link between Mr H's hospitalisation and his existing medical history. He told us that once the claim had been turned down, Mr H had had to leave the hospital against medical advice because he couldn't afford to cover the bills. He'd had to recover in a hotel and he'd also had to arrange his own repatriation to the UK.

Our investigator thought Mr H's complaint should be upheld. In brief, he ultimately didn't think AIG had shown it had sent Mr H annual reminders regarding the need to declare existing and new medical conditions each year. So he recommended that AIG should settle Mr H's medical expenses in full and that it should pay Mr H £1000 compensation. AIG disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 2 June 2025, which explained the reasons why I didn't think it was unfair for AIG to turn down Mr H's claim. I said:

'First, I'd like to say how sorry I was to hear about Mr H's illness abroad. It's clear he was very seriously unwell and that this must have been a very worrying time for Mr H, Mr H1 and

their family. I'm also sorry to hear that Mr H's recovery has been slow.

I'd also like to reassure Mr H and Mr H1 that while I've summarised the background to this complaint and their detailed submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think AIG handled Mr H's claim fairly.

The policy terms and conditions

I've first considered the policy terms and conditions, as these form the basis of the insurance contract. Pages 14 and 15 of the policy include a section called 'Pre-existing medical conditions.' This says:

'A medical condition is 'pre-existing' if you had it when the account holder opened the bank account, requested to turn on the insurance benefits or your trip was booked.

Depending on the condition, we may be able to cover it at no extra charge. In some cases, we won't be able to cover you, or you may have to pay extra to get it covered.

If you answer 'yes' to any of the following questions, please call...before your trip. If you don't – and you try to make a claim for any of these conditions – you won't be covered.

In the last 12 months have you:

- a. Been referred to see a specialist, or been added to a waiting list to see one?*
- b. Been referred to or visited a hospital for any tests or treatments? This includes if you're on the waiting list to visit a hospital.*
- c. Seen a medical practitioner more than once for the same condition?*
- d. Been prescribed two or more medications?*
- e. Changed any medication you've been taking?*

Have you received medical advice, treatment or medication for any of the conditions below?

- a. Heart or circulatory conditions. For example, heart failure, angina and valve disease.*
- b. Cerebrovascular conditions, such as strokes or any type of aneurysms. This doesn't include having high or low blood pressure or cholesterol.*
- c. Any respiratory conditions related to smoking. Respiratory conditions affect your breathing, such as emphysema or COPD.*
- d. Any birth defects or genetic conditions that have resulted in a physical disability.*
- e. Cancer.*
- f. Organ transplants.'*

This section of the policy also includes the following:

'If your health changes

You must call...straight away if your answers to any of the questions change to 'yes', or if your health changes in any other way. This includes if anything changes between you booking the trip and travelling. If you don't, it might mean we won't pay a claim related to that illness.'

Section B sets out the medical expenses cover AIG provides. It includes cover for emergency medical expenses, as well as repatriation costs. But this part of the policy also says:

'We won't pay claims for any of the following:

Any pre-existing medical conditions we haven't agreed in writing to cover. Please see Pre-existing medical conditions on pages 14 & 15 for more information.'

I think the policy terms make it sufficiently clear that AIG won't cover claims related to pre-existing medical conditions a policyholder has either when they opened the bank account or when they book a trip, unless it's agreed to cover those conditions in writing. In my experience, most, if not all, travel insurers include similar terms in their policies. And generally, most travel policies provided as a benefit of a bank account require annual medical screening if an insured person has pre-existing medical conditions.

Responsibility for highlighting the need for annual declarations

Our investigator thought the need to make annual medical declarations was a significant term which AIG should have drawn to Mr H's attention each year. And he didn't think AIG had shown it had done so. In brief, that's because he didn't think it had shown that Annual Eligibility Reminders (AER) were sent to Mr H's correct address. AERs explain the main eligibility criteria for each insurance product attached to a packaged bank account - including setting out the circumstances in which an insured person needs to go through medical screening with AIG.

I've seen evidence that an AER was sent to the address it seems Mr H's bank held for him in December 2023. This said:

'If you or anyone covered by your...Travel Insurance policy has a new medical condition or a change to an existing one that's detailed below, you need to let AIG know...if you don't speak to them about new or existing conditions that you haven't declared already, you may not be covered for claims related to these conditions.

Page two of the AER says:

'You must let AIG know about certain pre-existing medical conditions so they can confirm if they can provide cover for them (and if so, if there is a cost). You will only need to give AIG a call and go through the screening process if, prior to travelling, you or anyone insured on this policy answers 'yes' to any of the following pre-existing medical condition questions:

1. In the last 12 months have you or anyone named on this policy been:

- A. Referred to see a specialist or on a waiting list to see a specialist?*
- B. Referred to or attended hospital for any reason (including tests and procedures) or on a waiting list to attend hospital for any reason?*
- C. Seen by a medical practitioner more than once for the same condition?*
- D. Prescribed two or more medications for a medical condition or had any changes to your or their current medications?*

2. Have you or anyone insured on the policy ever suffered a change to health or been diagnosed with any of the following:

- A. Any heart or circulatory condition?*

B. For example: heart failure, angina, valve disease etc.

As I've said, the investigator didn't think AIG had shown the AER had been sent to Mr H's correct address. However, I don't agree that AIG was responsible for sending AERs to Mr H. Generally, we consider banks are responsible for sending AERs to applicable customers who hold packaged accounts with them. That means it was Mr H's bank's responsibility to send Mr H an AER each year and to draw his attention to the need to declare existing and new medical conditions to AIG. So I can't fairly hold AIG responsible if Mr H didn't receive AERs from his bank. Nor can I reasonably conclude that AIG was responsible for sending Mr H annual reminders about the need to declare medical conditions.

AIG's responsibility is to draft its policy terms in a clear, fair and not misleading way. As I've set out above, I'm satisfied the contract terms are sufficiently clear. And I think there was some responsibility on Mr H's part to check the terms before he travelled. If he'd done so, I think it's likely he'd have been prompted to check whether he needed to declare any additional medical conditions. It was Mr Hs' responsibility to check the cover still met his needs. So I can't reasonably uphold Mr H's complaint on this basis.

Mr H's past disclosure

While AIG originally concluded that Mr H hadn't made any previous medical declarations, it's clear that in March 2015, he did go through a medical screening. He disclosed: diabetes; high blood pressure; cholesterol levels and irregular heartbeat. AIG concluded that it couldn't offer cover for those conditions and the screening records: 'not included' next to each condition. So even if Mr H did think he'd already been through screening and didn't need to do so again, I think AIG had already made it clear, from 2015 onwards, that it wouldn't cover any claims related to any of the conditions Mr H declared – including diabetes.

Mr H's GP records also show that in October 2023, he was admitted to hospital with decompensated cardiac failure and a myocardial infarction. So it seems to me that Mr H had had two new diagnoses in October 2023 – in the form of heart failure and a heart attack. He'd also been admitted to hospital. And I can see from evidence Mr H1 has provided that Mr H underwent coronary angiography surgery in December 2023. I think these were significant changes in Mr H's health and that he ought to have been prompted to tell AIG about them, in line with the policy terms so it could decide whether or not to cover them.

I appreciate Mr H1 has provided evidence which states that a cardiologist isn't sure that Mr H had heart failure. The evidence says, 'one year ago, cardiology diagnosed myocardial infarction (heart attack) which was complicated by heart failure at the time, but not after.' However, the evidence also says that 'others' had suggested Mr H had heart failure in March and April 2024. And Mr H's GP records also show that in August 2024, Mr H had a significant history of decompensated cardiac failure, which was treated by IV furosemide. He was also prescribed furosemide by the GP in September 2024. On that basis, I don't think it was unfair for AIG to rely on the totality of the medical evidence to conclude that Mr H had been given a diagnosis of heart failure and had had IV treatment for it around two months before the claim.

AIG went on to carry out a retroactive medical screening to assess what it would have done had it known about all of Mr H's medical conditions before he travelled. I think this was an appropriate and reasonable response from AIG. It's provided us with underwriting evidence which shows that if Mr H had told it about all of his medications and conditions, it wouldn't have offered medical cover for any of those conditions.

Did AIG fairly assess the claim?

AIG assessed the available medical evidence and it concluded that Mr H's claim was directly linked to at least two of his pre-existing medical conditions. These were heart failure and diabetes. Mr H1 disagrees and has provided evidence from Mr H's GP which states that the primary reason for Mr H's hospitalisation was an acute illness, which resulted in hypovolaemia and dehydration – leading to metabolic acidosis. The GP doesn't believe that Mr H's illness was directly caused by the diabetes medication he was taking. So I've gone on to look carefully at all of the available medical evidence to decide whether I think AIG has shown, on balance, that Mr H's claim was due to pre-existing medical conditions.

I must make it clear that I'm not a medical expert. So it would be inappropriate for me to interpret medical evidence to make my own clinical findings, or to substitute expert medical opinion with my own. Instead, I've weighed up the medical evidence both parties have presented to decide whether I think AIG has shown it was reasonable for it to conclude that Mr H's claim wasn't covered by the policy terms.

AIG has provided us with a copy of Mr H's translated ICU discharge report. This sets out a history of Mr H's illness and say Mr H:

'was admitted to the ICU for distributive shock likely due to poisoning from oral antidiabetic drugs in the context of dehydration.'

The report states that Mr H had presented to A&E with general malaise and severe rapid breathing for the previous three days and that he'd reported a previous episode of gastroenterological symptoms which had lasted for 48 hours. It gave a diagnostic impression of 'uncontrolled diabetes mellitus'.

AIG also sent us evidence from its Global Deputy Medical Director, which set out their conclusions as to the reason for Mr H's claim. I've summarised below which I believe to be their key points:

'On investigation at the hospital, his symptoms of malaise and fast breathing were due to metabolic acidosis with a high lactic acid in the presence of multiorgan failure, secondary to oral antidiabetic medication and dehydration.

- Diagnosis from the hospital – decompensated type 2 diabetes, secondary to dehydration and diabetic medications.*
- Background medical history of type 2 diabetes (already on medication prior to travel) alongside a history of decompensated heart failure (already on diuretic medication prior to travel).*
- There are reports in the medical documentation from Spain that the client had had a 48-hour history of vomiting and diarrhoea prior to admission, but on admission to hospital there was no evidence of ongoing vomiting/diarrhoea symptomology nor infective processes being evident on medical reports provided. An infectious cause of the vomiting and diarrhoea is unlikely in this context, as the client had an elevated white blood cell count (and was given antibiotics for this) but in the context of a normal CRP. The client has other contributing factors including dehydration secondary to diuretic medication (which is prescribed for the decompensated heart failure – evidence of recent admission for this in the UK, and recent increase in diuretic medication).*

(Mr H) has contributing factors, including dehydration secondary to diuretic medication (which is prescribed for the decompensated heart failure – evidence of recent admission for this in the UK, and recent increase in diuretic medication) which has been compounded by his diabetic medications and has had a negative impact on his internal organs, including his

kidneys. The underlying reason for his admission to hospital...is pre-existing disease and the medications used to treat them.'

I've weighed up this evidence very carefully. I appreciate Mr H had had a 48-hour episode of gastroenterological symptoms. But the medical report doesn't indicate that these symptoms were ongoing or that this was the reason for Mr H's hospitalisation. Instead, the hospital gave a clear diagnostic impression of uncontrolled diabetes. I'm mindful that the report was written by the doctors treating Mr H. And AIG's Global Deputy Medical Director – a qualified doctor - explained in detail why they were satisfied that the main reason for Mr H's admission to hospital was because of his pre-existing medical history and the medications he took, rather than an acute illness.

So, taking all of the evidence into account and on balance, I don't think it was unfair or unreasonable for AIG to conclude that Mr H's claim was caused by pre-existing medical conditions. It had declined to cover Mr H's diabetes in 2015 and as I've explained, it's shown us it wouldn't have offered Mr H medical cover for his conditions in 2023/2024 either. As such, I don't think AIG acted unfairly when it concluded that Mr H's claim wasn't covered by the policy terms.

Overall, I sympathise with Mr H's position and I'm sorry to cause him further upset – especially given I've reached a different conclusion to our investigator. I understand he's being chased by debt collectors from the hospital for his expenses and I'm sorry to cause him additional worry. I also understand that Mr H had to leave hospital earlier than he should have done because he couldn't afford ongoing medical costs and instead had to recover in a hotel. But I need to decide whether I think it was fair for AIG to conclude that Mr H's claim wasn't covered by the policy terms. And, based on the evidence I have, I think it was. Therefore, I currently don't think it was unfair or unreasonable for AIG to have turned down Mr H's claim and I'm not planning to tell it to do anything more.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

Mr H1 strongly disagreed with my provisional decision on Mr H's behalf, and I've summarised his submissions below:

- They felt I had made an incorrect medical assessment and that I had accepted the word of AIG's medical team over the findings they had presented.
- I'd incorrectly stated that Mr H had undergone coronary angiography surgery in December 2023. However, this wasn't surgery but a diagnostic test. The result of the test had been negative, which was why Mr H's cardiologist had disagreed with a diagnosis of cardiac failure. They felt this error significantly undermined confidence in my investigation.
- They considered there'd been fraudulent misrepresentations by AIG – first because it had rejected the claim on the grounds that Mr H had failed to declare his medical conditions. And secondly because it had used a letter which Mr H had never received or signed for as evidence.
- The AER of December 2023 had been sent to the wrong address and signed for by someone other than Mr H. Therefore, they felt this was a serious breach of data protection regulations.
- They considered the shift from an upfront medical declaration to annual declarations was significant. They felt the fact that the AER had been sent to the wrong address was a breach of regulatory principles.

- They maintained that AIG was responsible for informing Mr H about policy changes and for ensuring clear communications regarding the policy terms, claims and customer service.
- They felt that my reliance on AIG's Deputy Medical Director's evidence over the opinions of Mr H's GP and the treating doctor raised questions about bias in my decision-making. They considered the evidence from the treating doctor didn't identify any pre-existing medical conditions.
- As they weren't initially provided with copies of the evidence I'd relied on in my provisional decision, they felt there may have been procedural unfairness.
- And they said that if the matter was not resolved justly, they were prepared to take legal action.

Our investigator has since provided Mr H and Mr H1 with copies of the key medical evidence I relied upon in reaching my provisional decision. Therefore, I'm satisfied that they've had an opportunity to review that material evidence and respond to it, in line with the principles of natural justice.

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.

Having done so, whilst I'm very sorry to disappoint Mr H, I still don't think it was unfair for AIG to turn down his claim for the same reasons I gave in my provisional decision. I'll go on to address what I consider to be Mr H1's main further points.

First, I understand Mr H has recently undergone surgery. I do hope he's making a good recovery. Although I've again summarised Mr H1's detailed further submissions to us, I'd reassure Mr H and Mr H1 that I've read and considered Mr H1's comments in their entirety. It remains the case though that under our rules, I'm not obliged to comment on each point that's been made. That's because our role is to be a quick and informal alternative to the courts. Therefore, again, my decision focuses on what I believe to be the key issues and evidence.

Responsibility for communications

AIG has a regulatory obligation to communicate with its policy beneficiaries in a clear, fair and not misleading way. In practice, this means that its policy terms must be clearly drafted and set out in an understandable way. And it also means that any communications it sends out must be clear, fair and not misleading.

But it remains the case that AIG wasn't responsible for sending Mr H AERs. The rules about the provision of information for policies which are arranged as part of a packaged bank account are set out in the Insurance Conduct of Business Sourcebook (ICOBS), which sets out the obligations placed on regulated insurers and banks by the regulator.

ICOBS 5.1.3C says:

1. *'Throughout the term of a policy included in a packaged bank account, a firm must provide the customer with an eligibility statement, in writing, on an annual basis. This statement must set out any qualifying requirements to claim each of the benefits under the policy and recommend that the customer reviews his circumstances and whether he meets these requirements.'*

Both we and the regulator consider that the bank which arranged the policies as part of a

packaged bank account is responsible not just for checking a customer's eligibility to use the insurance products when an account is opened, but to send AERs. This obligation was introduced by the regulator in 2013.

For those reasons, I still don't find AIG was responsible for sending Mr H an AER. I'm satisfied it was Mr H's bank's responsibility to send the AER and to ensure that it reached Mr H. Mr H's bank and AIG are entirely separate legal entities and AIG isn't responsible for the bank's actions. I don't think there are any reasonable grounds upon which I could hold AIG responsible for any potential failure of Mr H's bank to send Mr H an AER or for sending it to the wrong address.

If Mr H believes that his bank has failed to send him an AER, or that it's breached data protection regulations by sending an AER to the wrong address, he may be able to make a complaint to his bank about that issue. This would apply to all concerns Mr H may have about the sending of mail elsewhere by his bank.

The medical evidence and claims decision

Mr H says I incorrectly referred to the coronary angiography as 'surgery'. To clarify, whilst I accept this is a diagnostic procedure, I intended to recognise that this was a significant, invasive and uncomfortable procedure.

I must also make it clear that while Mr H1 has now provided us with new medical evidence related to Mr H's cardiac history, it wouldn't be appropriate for me to comment on that evidence as part of this decision. That's because my role is to consider whether I think AIG reached a fair claims decision at the point it issued its final response to Mr H's complaint on 8 November 2024, based on the medical evidence it had at that time. As the investigator has explained, it's open to Mr H to send on any new medical evidence AIG hasn't previously seen to AIG so it can assess whether it alters its understanding of Mr H's claim. If Mr H is unhappy with the outcome of any further claims decision by AIG, he may be able to make a new complaint to AIG - and subsequently to the Financial Ombudsman Service - about that issue alone.

Additionally, I must reiterate that I'm not a medical expert and my role isn't to make clinical judgements or substitute medical opinion with my own. Instead, I've independently and impartially considered the medical evidence AIG considered to decide what medical evidence I find most compelling in deciding whether I think AIG handled this claim fairly.

Mr H1 strongly disagrees that the medical evidence indicates Mr H's admission to hospital abroad was caused by pre-existing medical conditions. I'd like to reassure him that I have taken into account the GP's letter when reaching my decision.

However, it remains the case that the treating hospital's records clearly state that the treating doctor's 'diagnostic impression' was 'UNCONTROLLED TYPE 2 DIABETES MELLITUS'. And they stated that Mr H was '*admitted to the ICU for distributive shock, likely due to antidiabetic drug intoxication in the context of dehydration.*'

So I still don't think it was unreasonable for AIG to conclude that the medical evidence from the treating hospital abroad showed a direct link between Mr H's existing diabetes and his hospital admission. That's because not only did the doctor state that Mr H had uncontrolled diabetes, they also made a causal link between his dehydration and the anti-diabetic medication he takes.

As I've set out above, the evidence shows that in 2015, Mr H had made a medical declaration to AIG of the conditions he had at that time, including diabetes. And AIG had

declined to offer cover for any of Mr H's declared conditions. So even if Mr H did think he'd gone through full medical screening in 2015 and that he didn't need to declare anything more, I think AIG had made it clear enough that it wouldn't cover any claims related to Mr H's diabetes.

This means, on balance, I don't think it was unreasonable for AIG to consider that Mr H's claim was specifically excluded by the policy terms.

AIG's Deputy Medical Director also linked Mr H's symptoms of dehydration to the medication he was prescribed for decompensated heart failure. Mr H's GP records state that in October 2023 and in August 2024, he had a significant history of decompensated cardiac failure. He also had IV furosemide, as well being prescribed a medication in September 2024 which from my understanding indicates that it can reduce the risk of cardiovascular events and kidney failure in patients with diabetes. I don't think it was unfair for AIG to rely on the available medical evidence to conclude that Mr H had a diagnosis of heart failure when it issued its response to his complaint.

Based on the Deputy Medical Director's explanation, I don't think AIG unreasonably drew a causal link between the diagnosis given on Mr H's medical records, the medication it seems he was prescribed to treat it and his hospital admission. But even if I'm wrong on that point, I think it would have been reasonable for AIG to rely on the treating hospital's records to conclude that Mr H's condition was directly related to his existing, excluded diabetes.

AIG's handling of the claim

I appreciate Mr H1 feels AIG made misrepresentations to us and to him while looking into this case. I've already explained why I don't think AIG acted unfairly by concluding that Mr H's condition was linked to a pre-existing medical condition it hadn't agreed to cover. I'm mindful that AIG did wrongly indicate that Mr H hadn't made any form of disclosure of his medical conditions. But I haven't seen any persuasive or compelling evidence which suggests that this was a deliberate action on AIG's part. Instead, given the years that had passed between Mr H going through medical screening and making the claim, I think it was more likely to have been a mistake. And while I understand that Mr H was likely frustrated by this error, I'm not persuaded that it had a significant enough impact on him to mean that an award of compensation should be paid.

Overall, I do sympathise with Mr H's position, and I understand he's in a worrying position. I'm very sorry to cause him further upset and disappointment. But I still don't find it was unfair for AIG to conclude that his claim wasn't covered by the policy terms. And I don't think there are any reasonable grounds upon which I could direct AIG to accept and pay it.

My final decision

For the reasons I've given above and in my provisional 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 H to accept or reject my decision before 3 September 2025.

Lisa Barham
Ombudsman