DRN-5777631

The complaint

Mr M complains that MetLife Europe d.a.c. declined his claim for a hospitalisation benefit under his personal accident policy.

What happened

Mr M's policy with MetLife started on 20 April 2023. He was hospitalised in October 2023 due to a stroke, and he made a claim for a hospitalisation benefit under his policy. Mr M said he suffered a head injury in an accident in June 2023, which caused the stroke and led to the hospitalisation.

MetLife said the medical evidence didn't confirm the stroke was caused by the accident. So, it considered Mr M's hospitalisation to have been due to sickness, rather than an accident. And this wasn't covered for the first 12 months of the policy. But it said it hadn't handled the claim as well as it should have done, so it waived two months of Mr M's premiums.

One of our investigators reviewed the complaint. Having done so, he thought that MetLife had declined Mr M's claim fairly and reasonably, for the reasons it did. But he thought it should pay Mr M £100 in compensation for the distress and inconvenience caused in how it handled the claim.

MetLife agreed with the investigator's recommendation, but Mr M didn't. He said it's clearly stated that the stroke was caused by the accident, and this has been confirmed by his GP. As no agreement was reached, the complaint has been passed to me to decide.

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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of this complaint.

Mr M's policy provides the following relevant cover:

> *"**Accident***
>
> *We will pay the policy benefit shown in your Policy Schedule if, during the term of the policy, an insured person sustains bodily injury caused by an accident, which results in an insured person being admitted to hospital as an inpatient for at least 24 hours.*

Sickness […]

Provided you have held your policy for at least 12 months, we will pay the policy benefit shown in your Policy Schedule if, during the term of the policy, you are admitted to hospital as an inpatient for at least 24 hours caused by sickness […]"

I've set out below some relevant key definitions in the policy terms.

"Accident / Accidental"

"means a sudden identifiable event operating by violent external and visible means, which happens by chance and which could not be expected."

"Bodily injury(ies)"

"means injury during the term of the policy which is caused solely by accidental means and independently of illness, previous injury or any other cause."

"Sickness"

"means any illness or infirmity that is not a bodily injury."

"Illness"

"means any disease, disorder, syndrome, genetic and/or congenital defect for which the insured person has sought treatment, diagnosis, care and/or medical advice, which also includes conditions diagnosed after the date of an accident."

I've read through Mr M's hospital discharge notes relating to the hospitalisation. There's nothing there referencing the stroke being caused by the accident. The diagnosis is recorded as a *"[…] stroke- post thrombectomy"*. Having looked at NHS information online, I can see that thrombectomy refers to the removal of a blood clot.

Mr M's GP also confirmed that there was no record of a consultation from any injuries or accidents in June 2023. There was only an appointment with a GP in September 2023 when Mr M mentioned being involved in an accident a month prior. The notes from that day refer to neck pain, but there's no mention of other injuries. There are also GP notes from April 2024 when Mr M asked if the accident may have caused his stroke. The GP's notes say that they *"would not know if this caused his [stroke] or not"*.

Having considered the medical evidence, I don't think MetLife acted unfairly or unreasonably when it declined Mr M's claim for a hospitalisation benefit. This is because there's no medical evidence to show that the hospitalisation was due to an injury caused by an accident, as per the terms of the policy. So, I think MetLife acted fairly and reasonably when it considered the hospitalisation to have been due to sickness. And Mr M could only claim for this after he'd held the policy for 12 months, which he hadn't at the time.

It's clear that MetLife didn't handle everything as well as it should have done between August and October 2024. It had made a decision on Mr M's claim, but it didn't send this to him until after he chased for this. MetLife has agreed to pay Mr M £100 in compensation for the distress and inconvenience caused. I think this is fair and reasonable in all the circumstances of Mr M's complaint.

My final decision

My final decision is that I uphold Mr M's complaint in part and direct MetLife Europe d.a.c. to pay him £100 in compensation for the distress and inconvenience caused.

MetLife must pay the compensation within 28 days of the date on which we tell it Mr M 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% simple per annum.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 10 December 2025.

Renja Anderson
Ombudsman