DRN-5974649

The complaint

Mr D is unhappy that MetLife Europe d.a.c. (MetLife) declined his personal accident policy claim.

What happened

Mr D has a personal accident policy and MetLife is the underwriter.

In March 2018, Mr D unfortunately had an accident and sustained a number of injuries. Surgery was carried out and later a further operation was carried out to remove a metal implant which was causing significant pain.

Mr D submitted a claim to MetLife in 2023 for total permanent disablement which was declined. In 2025, Mr D appealed the decision. MetLife said the claim was declined as Mr D hadn't met the policy requirements. Mr D hadn't provided any new information, and the claim was made too late.

Unhappy, Mr D brought the complaint to this service. Our investigator didn't uphold the complaint. She didn't think MetLife had declined Mr D's complaint unfairly.

Mr D disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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.

At the outset, I acknowledge and have every sympathy for the difficult time Mr D's experienced as a result of the accident in 2018. I'm sorry for this.

It's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mr D. Rather it reflects the informal nature of our service, its remit and my role in it.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly. I've taken these rules into account when looking at this complaint.

The starting point is to look at the relevant policy terms and conditions as this forms the basis of the insurance contract between Mr D and MetLife.

Page 2 of the policy document sets out what's covered for 'Total Permanent Disablement'. This states:

> '*3. Total permanent disablement*
>
> *We will pay the policy benefit shown in your policy schedule if an insured person suffers a total permanent disablement caused by an accident occurring within 24 months of the date of the accident. The amount of policy benefit payable will be reduced by any other policy benefit already paid in respect of that insured person for the accident that caused the total permanent disablement.*
>
> *Any policy benefit paid for total permanent disablement will bring cover under this policy to an end in respect of the insured person who has suffered total permanent disablement and no further policy benefit will be payable in respect of that insured person. If the insured person is you, we will cease to collect premiums from you and your policy will automatically terminate.*
>
> *The general exclusions also apply.'*

Page 15 of the policy document defines total permanent disablement as:

> *'Loss of the physical ability caused by bodily injury to do at least three of the six tasks listed below ever again. The relevant treating specialists must reasonably expect that the disability will last throughout life with no prospect of improvement.*
>
> *You must need the help or supervision of another person and be unable to perform the task on your own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.*
>
> *The tasks are:*
>
> *• Washing - the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.*
>
> *• Getting dressed and undressed - the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.*
>
> *• Feeding yourself - the ability to feed yourself when food has been prepared and made available.*
>
> *• Maintain personal hygiene - the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.*
>
> *• Getting between rooms - the ability to get from room to room on a level floor.*
>
> *• Getting in and out of bed - the ability to get out of bed into an upright chair or wheelchair and back again.'*

Based on the above, I think the policy terms are clear for total permanent disablement.

I note that, in 2020 and in 2023, MetLife paid Mr D's claim for hospital admission and for fractured bones under this policy following the accident in 2018.

Mr D claim in 2023 was for total permanent disablement. Mr D sent all relevant medical information so the claim could be considered by MetLife. As this information referred to Mr D

suffering ongoing pain and mobility challenges in his daily life, an independent examination was conducted to determine Mr D's ability to conduct daily tasks.

The report stated that Mr D was able to carry out four of the six tasks. To meet the definition of total permanent disablement, Mr D was required to show that he was unable to perform three or more of the daily tasks listed above, on his own, and even if special equipment had to be used and medication was prescribed.

I've considered all of the information provided. For the avoidance of doubt, I'm not medically qualified so it's not for me to reach any determinations about Mr D's medical diagnosis or to substitute expert medical opinion with my own. Instead, I've weighed up the available evidence to decide whether I think MetLife acted fairly and reasonably in declining his claim. And having done so, I don't think Mr D's claim has been unfairly declined. I say this because MetLife requested an independent examination to understand Mr D's ability to perform daily tasks. The assessment was conducted by an occupational therapist, independently. This is what would have been expected. MetLife followed the recommendations of the report in 2023.

In 2025, Mr D subsequently appealed MetLife's decision to decline the claim in 2023. He said he was unable to perform the daily tasks as listed in the policy terms and conditions. However, MetLife declined the claim again. It said it was more than 24 months since the claim had been considered and over seven years since the accident in 2018. The policy states: '*We will pay the policy benefit shown in your policy schedule if an insured person suffers a total permanent disablement caused by an accident occurring within 24 months of the date of the accident.'*

I note Mr D's comments that MetLife accepted his claim in 2023 when that was also outside of the 24 months since the date of the accident. Mr D says MetLife gave him false hope by asking for more medical evidence. However, when Mr D appealed the claim in 2025, MetLife says no *new* medical information had been sent to it. Mr D sent a letter and attached medical information that was previously sent. So, the appeal was declined because there was no new medical information, and because it was also over the 24 months. Whilst I understand this provided Mr D with false hope, MetLife did consider the information. And I appreciate that ultimately Mr D would like his claim to be paid, but unfortunately, he hasn't shown that he met the policy requirements. I therefore don't find MetLife's decline of the claim to be unfair or unreasonable.

Based on this, I don't think the claim was unfairly declined when the appeal was made. I appreciate that Mr D says his condition has deteriorated and I also realise his understandable strength of feeling on this matter. However, overall, the terms and conditions of the policy are clear.

Having taken everything into account, I'm not persuaded that MetLife has unfairly declined Mr D's claim or that it was done so outside the requirements of the policy. I'm sorry to disappoint Mr D. But it follows that I don't require MetLife to do anything further.

My final decision

For the reasons given above, I don't uphold Mr D's complaint about MetLife Europe d.a.c.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 6 January 2026.

Nimisha Radia

Ombudsman