

The complaint

Mr W has complained that he was mis-sold an insurance policy by Hiscox Insurance Company Limited.

What happened

Mr W first purchased a loss of licence top up policy to protect him if he was off work due to long term sickness from his occupation as a pilot in 2020. He renewed the policy each year through his employer's benefits portal. The policy was written specifically for his employer – a commercial airline I'll call A and was designed to make a lump sum payment.

Mr W became absent from work in December 2023.

When Mr W made a claim in 2024 Hiscox said that long term sickness meant sickness for 36 months or more. Unhappy, Mr W raised a complaint. Hiscox didn't change its opinion so Mr W referred his complaint to our Service.

The investigator didn't recommend that it be upheld. Mr W appealed. He said that if the definition of long-term illness had been made clear he would have taken the other policy on offer on the portal at the same time.

As no agreement was reached the matter was passed to me to determine. I issued a provisional decision saying as follows:

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

I'd like to reassure Mr W that whilst I've summarised the background to this complaint, I've carefully considered all the submissions the parties have made. In this decision though 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 relevant regulator's rules say that insurers must handle claims promptly and fairly. And when communicating information to a customer it must make sure that it is clear, fair and not misleading. Having considered, amongst other things, the contract terms, regulatory rules and the available evidence I don't think Hiscox treated Mr W unfairly. I will explain why.

Firstly it seems that Mr W accepts he didn't meet the criteria for his claim to be met. It is not apparent from the information before me when/if he returned to work, but at the time he submitted his claim there was no evidence that the licensing authority had issued a long term fitness assessment. Hiscox said that the claim had not been declined and that it would review any further evidence. So I'm not persuaded that Hiscox treated Mr W unfairly with respect to the claim itself.

Mr W's complaint centres on the policy wording. He believes there is a lack of clarity and an out-dated definition of long-term illness.

I note that A has confirmed that any sickness over a 28 day period was considered to be

long term sick. But what is relevant here is the long-term benefit policy terms and conditions.

The policy doesn't define long term benefit under its definitions section. However under the 'What is covered section' it says the following:

We will pay you up to the maximum sum insured in the event you suffer bodily injury or an illness during the period of insurance which results in a long-term unfitness assessment being issued by the Licence Issuing Authority within 12 months from the date of loss.

In the event of a long term unfitness assessment not being issued within this period we will review all the medical evidence available and consider making payment of the benefit as stated in the schedule of insured persons if, in the opinion of our medical adviser, you are unlikely to obtain restoration of your licence(s)/certificate(s) within 36 months from the date of settlement of the claim.

In the event of the licence(s)/certificate(s) being restored within 18 months from the date of settlement of the claim we may require you to repay us a pro rata proportion of the benefit paid.

Benefit payment is subject to the excess period stated in the schedule.

Hiscox explained that it introduced a way of assessing long term unfitness as where there is no reasonable prospect of the licence being restored for at least 36 months from the date of claim. In other word it considers the loss of licence for more than 36 months to be permanent. I think that is fair. Importantly it is set out in the policy document that Mr W had access to. Mr W has confirmed to this Service that he always reads policy documentation. And although the policy is annual, I note that Mr W had selected the same policy annually since 2020.

Additionally this definition is set out in the Insurance Product Information Document (IPID) – a summary of the insurance cover provided. This document was sent to the portal some weeks after Mr W selected the insurance cover but wasn't accessed by Mr W. Of course, if Mr W had decided the policy wasn't what he wanted having read the documentation he could have raised the issue with Hiscox at that time.

I haven't disregarded the evidence that Mr W has submitted from other pilots and indeed his observation about the 2026 changes to the time of the presentation of the IPID. But in the circumstances here I don't find that the policy was mis-sold or that the documentation was misleading or unclear at the time this policy was purchased. This being so there is no basis for me to require Hiscox to take any action.

I invited the parties to provide any further comments or evidence for me to consider but advised that unless the information changed my mind, my final decision was likely to be along the lines of my provisional decision.

Hiscox made no further comments. Mr W made further comments which I will address below.

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'm grateful to Mr W for the detailed representations he has made in response to my provisional decision which I have carefully considered. But having done so I'm not

persuaded to change my provisional decision.

Mr W has confirmed that he fell ill in December 2023 an unfit letter being issued by an Aeromedical Examiner in mid-December 2023. He was cleared as fit by the Examiner in April 2025 – resulting in an unfit period of one year, four months and a day. I have not seen these reports but accept Mr W's testimony in this regard.

Mr W provided email correspondence from the Licence Issuing Authority that it no longer issues long-term unfitness assessments and that the only letter that would be sent by the authority would be an unfit letter. It added that if there was a requirement for a 'long-term unfit letter' to be issued then they would advise the need to seek assessment with an Occupational Health Physician to get a long-term ill health report. So Mr W believes that my provisional decision was based on an incorrect factual premise.

I accept that it is unfortunate that the policy refers to a document no longer produced – only an Unfit letter would be sent. I would have expected Hiscox to consider an Unfit letter from the Licence Issuing Authority in its place or consider the advice as referred to above. That would have been fair and reasonable.

But the policy term referred to goes on to explain what will happen if the document isn't issued:

In the event of a long term unfitness assessment not being issued within this period we will review all the medical evidence available and consider making payment of the benefit as stated in the schedule of insured persons if, in the opinion of our medical adviser, you are unlikely to obtain restoration of your licence(s)/certificate(s) within 36 months from the date of settlement of the claim.

So I don't find that Mr W was prejudiced by the policy wording or precluded from making a claim. Indeed Hiscox has indicated that it didn't decline his claim and offered for his case to be reviewed by an aviation medical expert in order to determine whether Mr W met the criteria for the payment of long-term benefit. Given Mr W has now confirmed his period of 'unfitness' it would seem that he wouldn't meet the policy criteria as his licence has been restored. But I make no finding on this point, and it is open to him to submit any medical evidence to Hiscox for review.

For completeness I would add that I have not disregarded Mr W's submission the IPID was provided too late to inform his purchase decision. But I must determine complaints by what is fair and reasonable in all the circumstances. These include the fact that Mr W read the policy document and had the same provisions in the IPID in previous years. So, for the reasons given I'm not persuaded that seeing the IPID earlier in the relevant policy year would have made a difference to his purchase decision.

I am very sorry that my decision doesn't bring Mr W the news he had hoped for, but I don't find that Hiscox treated him unfairly or unreasonably.

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 W to accept or reject my decision before 8 May 2026.

Lindsey Woloski
Ombudsman