complaint

Mr T is complaining about AIG Life Limited because it's declined to pay a claim on his critical illness insurance policy.

background

Mr T had a critical illness insurance policy with AIG that ended in October 2013. The policy included cover for total and permanent disability (TPD).

Sadly, Mr T hasn't been able to work for a number of years and he claimed on the policy in August 2013. AIG declined to pay out because it didn't think the medical evidence showed he was totally and permanently unable to work before the policy ended.

Our adjudicator didn't recommend the complaint be upheld. She also felt the medical evidence didn't show Mr T met the policy definition of TPD before it ended. Mr T disagreed, making the following key points:

- He hasn't been unable to work for a number of years and was totally and permanently disabled before the policy ended.
- This is shown by the fact he's been able to successfully claim state disability benefits.
- AIG should have sent him a claim form sooner. If he claimed earlier, he thinks AIG should have paid out.
- He also provided a recent letter from his doctor, which was accompanied by copies of various other letters referring to his ongoing situation.

my findings

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, I agree with the adjudicator's conclusions for much the same reasons. I'm not upholding this complaint. I have considered all of Mr T's submissions carefully, but I won't attempt to address every point he's raised in this decision. Instead, I'll concentrate on what I think are the key issues.

I can see Mr T has been unwell for a number of years. But for me to say his TPD claim should be paid, I'd need to be satisfied the available medical evidence shows he was totally *and* permanently unable to work *before the policy ended in October 2013*. The fact he may now meet this criteria, as the latest letter from his doctor seems to indicate, doesn't mean that was the case more than two years earlier.

In the context of this complaint, I'm taking the term *permanent* to mean there were no reasonable treatment options available that offered the prospect of improving Mr T's health to the point where he might be able to return to work in the future.

I think it's also relevant to explain the criteria for claiming TPD benefit on a critical illness insurance policy is different to that for state benefits. One of the key differences is that a condition needs to be considered permanent for a TPD claim. The payment of most state benefits is subject to ongoing review and doesn't normally require a condition to be permanent. So the fact Mr T was able to claim state benefits, doesn't necessarily show he had a valid TPD claim on the policy.

I've reviewed the medical evidence carefully and I don't think this shows Mr T had a payable TPD claim before the policy ended. In particular, it doesn't appear a firm diagnosis of his condition had been made at that time. And without knowing exactly what was wrong with him, I think it would have been very difficult for anyone to say there were no available treatments or that he'd never be fit to work again.

The evidence recently provided by Mr T's doctor shows he was referred to a number of different medical professionals, including an endocrinologist, a rheumatologist, a haematologist and a physiotherapist, all after the policy ended. Although he doesn't appear to have attended some of these appointments meaning the results aren't known, I think the correspondence provided suggests ways of potentially improving his situation were being considered. If that was the case, I don't think he could realistically have been considered totally and permanently disabled at the time.

I appreciate Mr T is in a very difficult situation and that I've not reached the decision he's been hoping for. But on balance and irrespective of what his doctor is saying about the current situation, I don't think the medical evidence shows he was totally and permanently unable to work as required by the policy before it ended in October 2013. So I'm satisfied AIG was entitled to decline his claim.

I note Mr T says he should have been advised to submit a claim sooner, but I can't see this would have led to a different outcome. If the medical evidence doesn't show he met the policy definition at the date it ended, I don't think an earlier claim would have been payable either.

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 T to accept or reject my decision before 8 April 2016.

Jim Biles
ombudsman