

complaint

Mr L's unhappy with how Aviva Insurance Limited has dealt with his claim for permanent total disablement ("*PTD*") under a mortgage payment protection insurance policy.

background

Mr L was involved in an accident many years ago and suffered injuries to his shoulder, back and neck as a result, as well as depression. He went off work and made a claim for disability benefit under the policy which Aviva paid in full. Aviva then looked at a claim for PTD benefit and, after assessing the information, it agreed to pay 40% of the full policy benefit for PTD.

Mr L felt Aviva should have cleared his mortgage balance in full and he eventually complained to us.

Our adjudicator recommended the complaint be upheld. He felt the evidence showed Mr L met the PTD definition in the policy. He asked Aviva to pay the benefit in full, with interest, plus £300 in recognition of the distress and inconvenience Mr L had experienced because of its actions.

Aviva didn't agree with the adjudicator. It said Mr L needed to be unable to work in any role to which he was suited and not just be unable to work in his normal occupation. It said the state assessment Mr L underwent for industrial injuries benefit showed he was "*only 40% disabled due to the injuries he sustained*". Aviva didn't think it was fair to have to assess the claim of 2001 using more recent medical evidence.

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've decided to uphold this complaint. I'll explain why.

Under the PTD head of cover, the policy says:

"If You become permanently, totally Disabled, solely as a result of an accident, and the condition lasts for a continuous period of at least 78 weeks, and at that time is considered by a doctor to be beyond hope of improvement, We will pay an amount equal to the outstanding balance on all Your insured Agreements subject to a maximum of £50,000 in aggregate."

"*Disabled*" is defined as the policyholder being unable to do the duties of their previous occupation or a similar occupation to which they're suited in view of their training, education and ability. They'll need to provide, the policy says, satisfactory proof of disability, including a doctor's certificate.

Aviva accepted Mr L was disabled, for a time at least, because it paid him the maximum number of monthly disability benefit payments (12) under the policy. So, in that time, there's little doubt Mr L was totally disabled in line with the policy terms.

After the maximum number of disability benefits was paid, Mr L wanted to claim PTD benefit. So the issue I need to consider is whether the evidence shows Mr L was disabled beyond that point, to the extent his disablement was permanent and total as per the policy.

In response to the PTD claim, Aviva ultimately paid 40% of what it felt was the full amount of benefit that could be paid under the policy. It then increased the payment because it had worked out the full amount of benefit incorrectly. Aviva said it made both offers as a gesture of goodwill and outside the strict policy wording.

Looking carefully at the medical evidence, I think it likely Mr L's claim was payable in full within the terms of the policy at the time. For example, Mr L has provided an industrial injuries disablement benefit report from May 2001. The assessor, a doctor, found Mr L had multiple injuries and depression following his accident. He said Mr L had suffered a 40% degree of disablement as a result. This was an increase on the 27% degree of loss he had been found to have in a similar report of November 2000.

In May 2002 another assessment was carried out by a different doctor. He also found Mr L had suffered a 40% degree of disablement following the accident. From that point, the level of disability was found to have increased and, by 2004, was assessed at 47%. In 2005, the assessment was declared to be final.

I think that although the assessments were carried out for the purposes of working out state benefits, they're helpful in showing the level of disablement Mr L was suffering with. Aviva seems to have accepted that, since it based its payment of 40% of the full benefit on the assessments.

If Aviva didn't think it could rely on the reports, it was open for it to get more information about Mr L's level of disablement. For example, it might have arranged for one or more independent medical examinations by a specialist in the field of Mr L's injuries/illnesses. In the absence of any alternative evidence, I think it's fair to rely largely on the findings of the industrial injuries disablement benefit reports from the time.

I don't agree with Aviva's suggestion that a level of 40% disablement equates to a payment of just 40% of the full benefit. That would suggest that someone would need to be declared 100% disabled before being able to claim full PTD benefit – which I don't think is fair. I think the level of disablement needs to be considered along with the nature of Mr L's work – or similar and suitable alternative work he could perform – to decide whether he meets the policy requirements.

40% represents a significant level of disablement in my view, especially when considering Mr L's previous line of labour-intensive work which he had performed for many years. In the circumstances, it seems this would have meant Mr L couldn't perform the duties of his previous occupation.

Aviva says Mr L needed to be unable to perform an occupation he was suited to, not just his previous occupation. The suggestion being he was still able to perform a suited role. That said, I can't see that Aviva has properly addressed what alternative roles Mr L might have been able to perform due to his training, education and ability. Or on what basis it might think he could perform those roles, if there were any. In the absence of such information, I find that Mr L met that part of the definition too.

Aviva doesn't think it should be asked to medically assess a claim from 2001 using evidence from years later. There are two points here. Firstly, it does appear that Mr L didn't complain until several years after Aviva made its decision on the claim. Although he wouldn't have needed to complain in the first place if Aviva had dealt with his claim fairly initially. Secondly, the adjudicator didn't ask Aviva to simply assess the claim – he asked it to pay the claim. Taking all of the available information into account, I also think Aviva should have paid Mr L's claim in full rather than in part. So there's no need for Aviva to carry out any more medical assessments at this stage. Instead, I require Aviva to pay the claim, subject to the remaining policy terms.

I also think Aviva has handled Mr L's claim poorly. As well as coming to a decision that was unfair, which denied Mr L benefit payments at an already difficult time for him, Aviva accepts it incorrectly referred to his hearing condition in assessing the claim. This only served to confuse matters and caused Mr L distress and inconvenience. Aviva also paid 40% of the wrong amount, resulting in a lower payment to Mr L than it should have made, which made things worse. It corrected the mistake, but only after Mr L raised the issue.

Overall, I think Aviva should pay Mr L £300 as compensation for the frustration and inconvenience it has caused him.

my final decision

For the reasons given, I've decided to uphold this complaint. I require Aviva Insurance Limited to:

- pay Mr L's PTD claim in full from the date it first paid the claim in part, in line with the remaining policy terms; and
- if the claim was payable to Mr L direct, add interest at the simple rate of 8% a year on the shortfall between the amount of PTD benefit Mr L was paid and the full amount of PTD benefit he should have been paid. This should be worked out from the date benefits were paid to the date of full payment; and
- ensure Mr L is otherwise put back in the position he would have been in had the claim been paid in full from the start; plus
- pay him £300 as compensation for the frustration and upset caused by its handling of the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 22 January 2016.

Nimish Patel
ombudsman