DRN-4423357

The complaint

Miss M and Mr P are unhappy that Aviva Insurance Limited declined a claim Miss M made on her mortgage protection policy.

What happened

Miss M and Mr P have a mortgage protection policy. It offers cover if a policyholder is prevented from working due to an accident or sickness. Miss M had claimed on the policy and returned to work. However, she stopped working and made a claim on the policy.

Aviva declined the claim on the basis that they weren't persuaded that Miss M had returned to work for 90 days in a row between the two claims. Miss M complained but Aviva maintained their decision to decline the claim was fair. So, Miss M complained to the Financial Ombudsman Service.

Our investigator looked into what had happened and didn't uphold the complaint. He didn't think Aviva's decision to decline the claim was unreasonable, based on the available evidence. Miss M asked an ombudsman to review her complaint.

I asked Aviva to provide me with further information, reminding them of the ombudsman's powers in DISP 3.5.8 which allows me to make directions about the issues on which evidence is requested, the extent to which evidence should be oral or written and the way in which it is presented. Aviva didn't respond to the request for further information.

So, in October 2023 I issued a provisional decision. I said:

> I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.
>
> The decision to decline the claim
>
> The relevant rules and industry guidelines say that Aviva has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.
>
> The key point I need to consider is whether Miss M has provided sufficient evidence to demonstrate that she returned to work for 90 days or more, as required by the policy terms.
>
> Miss M says she returned to work on 17 November 2018 and spent two days practising and building up to going back to work after a prolonged absence from her work as a dance and fitness instructor. Aviva says the evidence suggests that she returned on 19 November 2018 and has also referred to a medical certificate which says Miss M was unfit to work from 16 November 2018 until 6 January 2019.
>
> On balance, I'm persuaded that Miss M's version of events is most likely. Given the nature of her work it seems likely she'd need to spend some time preparing and practising for her return to work. For example, she's explained she spent time preparing the format and content of the classes she planned to teach and doing

associated administrative tasks. I think that's plausible given the nature of her business and given how long she had been off work for.

I've thought about what Aviva has said about the fit note issued for the period of time when Miss M was returning to work. Miss M has explained the note was advisory. My understanding is that this note was provided towards the end of Miss M's previous claim. I also understand that Miss M was returning to work after a prolonged absence. And she was self-employed in a physical and active job. I don't think the fact that she worked during the period of the fit note persuades me that she wasn't working as she described. She's provided a lot of other evidence which suggests she was. So, I haven't found Aviva's arguments on this particular point persuasive, bearing in mind the facts of this particular complaint.

I've thought about Aviva's arguments that there is no way to verify Miss M's version of events. But, based on the evidence Miss M has provided, I think she's done all she reasonably can to demonstrate evidence of the work she was doing. That includes providing evidence of the various classes she was running and other business activities she was involved in.

Customer service

Miss M has also complained about the delays in handling her complaint. Aviva hasn't addressed this within their final response letter and didn't respond to my request for more information about their position on this aspect of Miss M's complaint. I've considered all of the points Miss M has raised about the customer service during her claim but I'll only comment on those points which I think are central to the outcome of this complaint.

I'm aware that Miss M has raised concerns about the service she received from a different insurer which caused delays in her making her claim to Aviva. But I can't hold Aviva responsible for those delays and any information provided by them.

Miss M made a claim to Aviva in December 2020 but she didn't receive a decision about the claim until July 2021. Aviva upheld a complaint about this in July 2021. As Miss M's complaint to the Financial Ombudsman Service wasn't made until December 2022 I don't think I can consider what happened between December 2020 and July 2021 as a complaint wasn't brought to the Financial Ombudsman Service within the 6 month time limit.

I can understand why it was then frustrating to be asked for more information in July 2021 but I do think that was a reasonable request as Aviva had noted the issue with the date of Miss M's first class being 19 November 2018. When Miss M provided more information in early August 2021 this was reviewed and referred to the underwriters. Mr P had to chase for updates and it took until September for the outcome to be communicated to Miss M and Mr P. I understand Aviva also issued a final response letter on this point to Miss M in September 2021 and so the 6 month time limit I've referred to above will also apply. So I can't consider those points further.

A further appeal was escalated to the underwriter in January 2022, following further information being provided. Based on the notes Aviva was having difficulty accessing the information sent due to IT issues. Aviva then decided to get more information from Miss M's GP. It's unclear why that was felt necessary at this point in the claims journey and why it was necessary to determine whether Miss M had a valid claim as the key issue was the days worked. The GP didn't respond until March despite

chasers by phone by Aviva. The information was received towards the end of March 2022 and referred back to the underwriter. Miss M was then told in April 2022 she needed to provide information from her counsellors, although again it's unclear why this was required at this point in time and why it wasn't requested earlier. Aviva then declined the claim on the basis of the 90 day period not being met.

I can understand Miss M's frustration, given that she'd first started the claim in December 2020. Mr P was dealing with the claim on her behalf as she was finding it stressful and upsetting. I do think the claim could have been handled with more urgency given the overall customer journey Miss M had experienced since December 2020. It's also unclear from the information provided why Aviva decided to obtain more medical information in 2022, given their reasons for declining the claim.

I'm intending to award £500 compensation as I don't think Miss M received good customer service and the delays had a considerable impact on her. I think it caused her significant distress, worry and upset over a period of several months. She was also aware that Mr P was having to chase Aviva and deal with requests for information. As I've outlined above I can only consider the impact of the distress and inconvenience caused by the issues in this particular complaint. So, I'm only considering the delays after the final response was issued in September 2021.

Putting things right

I'm intending to direct Aviva to put things right by:

- Reassessing Miss M's claim in line with the remaining policy terms. The claim should be assessed on the basis that Miss M returned to work for 90 days as required by the policy terms. The reassessment should take place and be communicated to Miss M within 28 days of Aviva being notified that Miss M has accepted my final decision

- Paying Miss M £500 compensation for the impact of poor customer service.

Aviva didn't respond to my provisional decision. Mr P and Miss M accepted my provisional decision. However, they did express concern that Aviva might decline the claim for other reasons. So, I need to make a decision.

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.

As there have been no further representations there is no reason for me to reach a different conclusion to those I've outlined above and in my provisional decision. For those reasons I uphold Miss M and Mr P's complaint.

Putting things right

Aviva needs to put things right by:

- Reassessing Miss M's claim in line with the remaining policy terms. The claim should be assessed on the basis that Miss M returned to work for 90 days as required by the policy terms. The reassessment should take place and be communicated to Miss M within 28 days of Aviva being notified that Miss M has accepted my final decision.

- Paying Miss M £500 compensation for the impact of poor customer service

My final decision

I'm upholding this complaint and direct Aviva Insurance Limited to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss M and Mr P to accept or reject my decision before 29 November 2023.

Anna Wilshaw
Ombudsman