DRN-4692163

The complaint

Ms G has complained that Aviva Life & Pensions UK Limited decline a claim for critical illness.

What happened

The background to this complaint is well known to the parties so I won't repeat it in detail here. In summary Ms G had a critical illness policy with Aviva. The plan was for a period of 14 years and ended in July 2022. Sadly, Ms G was diagnosed with cancer in October 2022. Aviva declined a claim for critical illness on the basis that the plan wasn't in force when the diagnosis was made.

Our investigator didn't recommend that the complaint was upheld. Ms G appealed. She said that had she said that had she had a mammogram performed between January 2022 and the end of the policy period it would have undoubtedly led to the same biopsy requests, and ultimately the same diagnosis that resulted from the biopsies taken in October/November 2022. She felt that it was a mere quirk of timing that her mammogram was not scheduled to be performed earlier than September 2022. Further, she said that as the consultant confirmed that the cancer may well have been growing for 12 months, it may well have started growing around September 2021 and would therefore have been caught by a mammogram scheduled from that point onwards.

Ms G said too that if Aviva wasn't going to pay her claim, it should at least refund the premiums she paid for 14 years.

As no agreement has been reached the matter has been passed to me to determine.

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 aware I've summarised the background to this complaint and some sensitive medical details. No discourtesy is intended by this. Instead, 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. If there's something I haven't mentioned, it isn't because I've ignored it. I've fully reviewed the file and considered the representations Ms G made after our investigator's assessment. I recognise that Ms G will be disappointed by my decision, but I agree with the conclusion reached by our investigator. I'll explain why.

The relevant regulator's rules say that insurers mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Ms G's policy and the available evidence, to decide whether I think Aviva treated her fairly.

A claim will be accepted under Ms G's policy if the policy definitions are met. The cancer definition is:

Cancer – excluding less advanced cases

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

I haven't disregarded the letter from Ms G's treating consultant dated January 2023 advising that he would expect the cancer had been developing over a period of approximately 12 months. It is understandable why Ms G feels it may well have been present during the life of the policy. But it is clear that for a claim to be met there must histological confirmation. This will determine if cancer *is* present and if so meets the policy definition – that is, it doesn't fall withing the 'less advanced cases' list. It is the proof that Aviva needs to show a claim is payable. Unfortunately, here Ms G didn't receive this histological confirmation until some months after the policy had ended. I'm not able to say on the evidence before me that a mammogram between January 2022 and the end of the policy period would have led to the same histological confirmation.

I appreciate that Ms G feels that Aviva has wriggled out of her claim based on a technicality. But I don't find it was unfair for Aviva to require the clear policy term to be met and for the histological evidence to be present to demonstrate this. Aviva is not required to meet claims outside the period of cover. Of course, if there was clear histological confirmation that cancer *had* been present during the period of cover, and a policyholder hadn't claimed, perhaps because they were undergoing treatment, it might be reasonable for Aviva to meet a claim. But that isn't the case here. In the circumstances I don't find that Aviva treated Ms G unfairly, unreasonably, or contrary to the policy terms by declining her claim.

Ms G has said that if Aviva isn't going to meet her claim, she would like a refund of the premiums she has paid over the last 14 years. But if an eligible claim had been made during the period of cover it would have been met. Aviva has been on risk and so it follows that there is no basis for me to require it to refund the premiums that Ms G paid. I'm very sorry that my decision doesn't bring Ms G more welcome news.

My final decision

For the reasons given above my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms G to accept or reject my decision before 24 April 2024.

Lindsey Woloski
Ombudsman