DRN-5095525

The complaint

Mr A is unhappy that Aviva Life & Pensions UK Limited declined a claim he made on his life insurance policy. He claimed for permanent and total disability due to visual impairment and sarcoidosis.

What happened

Mr A has a life insurance policy which also offers cover for certain critical illnesses or permanent disability. Mr A claimed on the policy for Total and Permanent Disability (TPD) but the claim was declined as Aviva said there wasn't evidence that Mr A was carrying out all the occupational duties he'd described on his claim form. So, they said they'd assessed the claim on the basis of 'Definition D' in the policy (relating to activities of daily living).

Mr A complained to Aviva. In their final response letter Aviva said that Mr A was out of time to make a complaint as he'd not raised concerns about the decision to decline the claim. Mr A referred his complaint to the Financial Ombudsman Service. Aviva's position is that they are happy to consider a new claim for TPD under the Activities of Daily Living definition under the policy.

Our investigator said that the Financial Ombudsman Service could consider Mr A's complaint. She went on to consider the merits of Mr A's complaint, but she thought Aviva had acted fairly when declining the claim.

Mr A asked an ombudsman to review his complaint. In summary, he says he was in full-time employment immediately before the onset of his illness and wasn't able to perform the material and substantial duties of his normal occupation. He says he was working as a director of his own company at the relevant time. The complaint was referred to me to make a decision.

In July 2024 I issued a provisional decision upholding Mr A's complaint in part. 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 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.
>
> <u>The policy terms and conditions</u>
>
> The relevant policy terms and conditions define disability as when the Life Assured is:
>
> > Unable to perform the material and substantial duties of the normal occupation in which the Life Assured was engaged immediately prior to the onset of the disability and that the disability is expected to last throughout life, irrespective of when the cover ends or the Life Assured retires.
>
> However, this definition is replaced with a different definition if the Life Assured is not

engaged in a gainful occupation. The terms and conditions say:

> Definition of Disabled A, B or C will not apply to the plan if the Life Assured is not engaged in a full-time gainful occupation. The Loss of Independent Existence Benefit (i.e. Definition of Disabled D) will apply to the plan until the Life Assured again becomes engaged in a full-time gainful occupation, when the definition of Disabled will revert to that specified in the Plan Schedule.

'Definition D' says:

If it is specified in the Plan Schedule that Definition of Disabled D applies to the Plan, total and permanent disability is such that before the Term Expiry Date the Life Assured is unable to perform at least three of the Activities of Daily Living (as defined below) both with or without the use of mechanical equipment, special devices or other aid and adaptations in use for disabled persons. This inability is expected to last throughout life, irrespective of when the cover ends or the Life Assured retires.

Did Aviva fairly decline the claim?

I'm not persuaded the claim was fairly declined. I don't think Aviva have adequately demonstrated that it was fair and reasonable to rely on Definition D as opposed to Definition B.

Aviva hasn't provided any detailed information in support of their conclusion that Mr A wasn't in gainful employment immediately prior to his claim. They've referred to evidence they obtained from Her Majesty's Revenue & Customs, surveillance information and interviews. I've been provided with some summaries of this information, but it's not detailed and doesn't clearly explain why Aviva considered Mr A not to be working.

I've not been provided with the information that Aviva obtained from HMRC or any commentary on why this information demonstrated that Mr A wasn't working prior to the claim being made.

Furthermore, I've not been provided with a complete copy of the evidence from the surveillance carried out. I've been provided with the claim's notes but no detailed commentary or explanation as to this information demonstrated Mr A wasn't working. It's unclear what the scope and extent of the surveillance was or whether it was provided to a medical expert for review before the claim was declined.

I've been provided with a letter from Mr A's accountant. In this letter they confirm that they weren't contacted by Aviva for information about Mr A's circumstances. I've not been provided with a copy of correspondence which demonstrates Aviva did contact the accountants or Mr A's business partner. This letter confirms that Mr A was a company director and subsequently became employed under the PAYE system following a change in his health. This information would have been available to Aviva at the time they assessed the claim and it is unclear what enquiries were made by Aviva at the time.

Taking into account all of the above, I'm not persuaded that Aviva have demonstrated that the claim was fairly declined on the basis that they fairly assessed the claim with the alternative definition of disability relating to activities of daily living.

Mr A has raised a number of other points in relation to the overall service he received from Aviva. I don't think there's compelling evidence that Aviva has deliberately

deleted phone records. Aviva has explained that they didn't routinely record calls to the claims and underwriting departments at the relevant time. I don't think that's an unreasonable explanation. Having looked at the claims handling notes I haven't identified any significant delays in handling the claim. Although it took some time to make a claims decision this was due to the complexity of the claim and the need to obtain various pieces of medical evidence and other information to validate the claim.

Putting things right

I'm intending to direct Aviva to put things right by reassessing the claim on the basis that in 2013 the definition of disability was 'Disability B' which refers to the inability to carry out the material and substantial duties of a policyholder's normal occupation. The claim should also be assessed in line with the remaining policy terms. If Mr A is unhappy with the outcome of the claim reassessment, he may be entitled to make a further complaint to the Financial Ombudsman Service.

Aviva responded to say that they considered the complaint to be outside of the Financial Ombudsman Service's jurisdiction due to the time limits. Our investigator contacted Aviva to say that she had issued an opinion on jurisdiction before considering the merits of the complaint. I also reviewed the jurisdiction argument again and our investigator provided my thoughts on jurisdiction to Aviva. She explained the next step would be for me to make a final decision.

Aviva also provided a lot of further information in relation to their assessment of the claim and reiterated that their position was that the claim had been fairly declined. Mr A also commented on the further information. In summary, he didn't think the information had provided was new or should alter the outcome. However, as Aviva had said they didn't intend to revisit the matter Mr A said the claim should be paid with interest.

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've reviewed the further evidence and information provided by the parties and it hasn't changed my thoughts about the overall outcome of this complaint. I'm upholding Mr A's complaint in part for the reasons I'll go on to explain.

I'm not persuaded it was fair and reasonable for Aviva to use Definition D when assessing the claim. Aviva didn't think Mr A had demonstrated he was working in gainful employment prior to the claim. However, I'm persuaded he provided enough information, on balance, to demonstrate that he was working prior to his incapacity.

Whilst I appreciate there were gaps in the information Mr A provided, I think there was enough evidence to suggest that, on balance, he was working in the capacity he described and within the industry he described. For example, Mr A provided a contract of employment and other information which supported that he was in employment. Based on the evidence that's available to me I think Aviva ought to have assessed the claim on the basis that Mr A was working in the role he described on his claim form.

I've taken into account the information Aviva has provided about the surveillance material. But I'm not persuaded, taking into account the wider evidence, that this means it was fair and reasonable for Aviva to decline the claim. In reaching that conclusion I bear in mind the wider medical evidence relating to Mr A's health, including his eyesight. So, whilst the surveillance evidence does provide some further insight about Mr A's functionality, I'm not

persuaded it gives sufficient insight about his functionality and ability to work in the occupation he declared on the claim form. Therefore, I remain of the view that Aviva should reassess the claim against the criteria set out in Definition B.

I appreciate that Mr A would prefer the claim to be settled in full as Aviva have said they don't intend to revisit their position. However, if Mr A decides to accept my decision Aviva is required to carry out a further review of the claim. It's not my role to assess Mr A's claim on Aviva's behalf. And, in any event, I think the fairest way to resolve this complaint is for the claim to be reassessed with the alternative definition I've referred to.

Mr A has also provided more information from HMRC and his accountant in support of the fact that he was working and earning an income. He'll need to provide that information to Aviva if he wants it to be considered by them when the claim is reassessed.

Putting things right

Aviva need to to put things right by reassessing the claim on the basis that in 2013 the definition of disability was 'Disability B' which refers to the inability to carry out the material and substantial duties of a policyholder's normal occupation. The claim should also be assessed in line with the remaining policy terms. If Mr A is unhappy with the outcome of the claim reassessment, he may be entitled to make a further complaint to the Financial Ombudsman Service.

My final decision

I'm partly upholding this complaint and direct Aviva Life & Pensions UK 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 Mr A to accept or reject my decision before 28 November 2024.

Anna Wilshaw
Ombudsman