DRN-5103368

The complaint

Mr and Mrs P complain that Aviva Life & Pensions UK Limited hasn't paid a terminal illness benefit claim they made on a term assurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

In December 2009, Mr and Mrs P took out a term assurance policy which provided them with cover for 15 years and which is due to expire in December 2024. The policy includes terminal illness benefit.

Sadly, in February 2024, Mr and Mrs P made a terminal illness benefit claim on the policy. Mr P had been diagnosed with cancer a few years before but had been given a prognosis of less than 12 months.

Aviva said that Mr P's claim wasn't covered by the policy terms. That's because the contract required terminal illness claims to be made more than 18 months before the end date of the policy. As there was only 10 months of cover remaining at the time Mr P made the claim, Aviva said it didn't meet the policy definition of terminal illness.

Mr and Mrs P were very unhappy with Aviva's decision. They said that Mr P had been given a life expectancy of less than 12 months in 2021. While he'd received treatment which had extended his prognosis, they felt Aviva had benefited as a result. And they were also unhappy because they were aware that in later policies, Aviva had removed the 18-month clause from the terminal illness provisions. They felt Aviva should have made them aware of this and given them the chance to take out alternative cover.

Subsequently, Mr and Mrs P provided us with evidence from one of Mr P's treating team which they said showed that Mr P had been given a life expectancy of less than 12 months in 2021. We sent this evidence on to Aviva. It told us that even if the evidence had been received in 2021, it likely wouldn't have been sufficient for it to have paid the claim and that it would likely have needed more information.

Our investigator didn't think Aviva had treated Mr and Mrs P unfairly. She thought it had been fair for Aviva to rely on the terms of the contract Mr and Mrs P had taken out with it. She accepted that Mr P's claim had been made less than 18 months before the policy was due to end. But she thought that even if the claim had been made earlier, it had been reasonable for Aviva to conclude that the terminal illness definition wouldn't have been met, given Mr P had undergone treatments which had impacted on his prognosis.

The investigator also explained that she couldn't take into account the new evidence from Mr P's treating team, as it hadn't formed part of the evidence available to Aviva when it made its initial claims decision or when it looked into Mr and Mrs P's complaint.

Mr and Mrs P disagreed with the investigator's view. Mr P said he'd fought the disease for

over three years. While he accepted he'd made the claim within the last 18 months of the policy, he said he'd supplied clear evidence that his life expectancy had been less than 12 months three years before he made the claim. He set out the very serious illnesses and complications he'd suffered from during that time. He considered Aviva was using a get-out clause and he didn't think it had applied the policy terms fairly to the circumstances of his claim.

The complaint's been passed to me to decide.

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.

Having done so, whilst I'm very sorry to disappoint Mr and Mrs P and I know how upsetting my decision will be for them , I don't think it was unfair for Aviva to turn down their claim and I'll explain why.

First, I was very sorry to hear about Mr P's diagnosis and how his health has been impacted over the years. It's clear this has been a very distressing time for Mr and Mrs P and their family.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles and guidance, the policy terms and the available evidence, to decide whether I think Aviva handled Mr and Mrs P's claim fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr and Mrs P and Aviva. Page six sets out the policy definition of 'terminal illness benefit as follows:

'Terminal Illness Benefit will be payable where, other than within the eighteen months prior to the End Date, the Life Insured is diagnosed as suffering from an advanced or rapidly progressing and incurable condition (the "Terminal Illness") such that the life expectancy of the Life Insured is no greater than 12 months from the date the condition is notified to us by the Planholder. In determining that diagnosis, we will consider the views of the Life Insured's medical adviser; consult the views of our medical adviser; and take the typical life expectancy for someone diagnosed with the Terminal Illness into account.'

In my view, the policy terms make it clear that terminal illness claims will only be considered if they're made more than 18 months before the end date of the policy. So in this case, Mr P would have needed to make a claim before 22 June 2023. But the claim wasn't made until February 2024. So under a strict application of the policy terms, Mr P's claim was made too late.

I appreciate Mr and Mrs P feel that Aviva should have let them know that it had newer term assurance policies which didn't include the 18 month clause. But I think Aviva's entitled to rely on the contract terms it agreed with Mr and Mrs P in 2009, which was intended to provide cover up until 2024.

However, I've also thought about what I consider to be fair and reasonable in all the circumstances. And, generally, I think it would be reasonable for an insurer to consider whether there's persuasive medical evidence which shows that a policyholder could have made a valid terminal illness claim before they actually did.

Aviva acknowledged that Mr P may have been given a life expectancy of less than 12 months in 2021. But it considered what Mr P had said about his treatment and a report from his oncologist. And taking into account those treatments, it said that even if a claim had been made earlier, it wouldn't have been able to accept Mr P's claim. So I've gone on to consider whether I think this was a fair conclusion for Aviva to draw.

Mr P's provided us with a copy of a discharge summary dated June 2024 which was completed by his consultant doctor. The summary shows that in 2021, Mr P's illness relapsed. He was placed on nearly 12 cycles of a treatment. The summary report says that Mr P's disease was stable. He was then placed on further treatment and again, his disease was noted to be stable. And he received chemotherapy and immunotherapy which placed him in remission. Mr P later learned that his treatment had failed and his cancer had spread. While Mr P underwent further treatment, in February 2024, his disease was found to have spread again. Mr P says that sadly, he's now been placed on palliative care.

It's clear that Mr P has been through an extremely difficult time; he's undergone a range of treatments and he's told us that he's suffered from a number of serious complications. I understand that he's known for over three years that his illness was incurable. But I don't think it was unreasonable for Aviva to conclude that Mr P wouldn't have met the policy definition of terminal illness earlier than the time of claim. That's because the evidence shows that Mr P was receiving a range of treatments aimed at improving his prognosis and increasing his life expectancy. And it also seems that Mr P's disease was put into remission during this period as a result of the treatment.

The policy terms say that Aviva will take a number of considerations into account when deciding whether or not a terminal illness claim benefit is payable, including the opinions of a policyholder's treating doctor and its own medical advisers. I accept that the definition doesn't specifically refer to ongoing treatments. But I don't think it's unreasonable for Aviva to take the information a treating doctor provides about the way a disease is progressing and the treatment a patient is receiving when it assesses a claim. And based on the available evidence, the nature of Mr P's treatments and the stability of his illness at times, I don't think it was unfair for Aviva to consider that there wasn't enough information to show he would have met the policy terms before June 2023.

I do have a great deal of sympathy with Mr and Mrs P's position. I know they've been through a very upsetting, worrying and difficult time. But I don't think Aviva acted unfairly when it concluded that Mr P's claim isn't covered by the policy terms. So I'm not telling it to pay his claim.

Mr P's clinical nurse specialist has provided subsequent evidence in support of Mr P's claim. As the investigator explained, this information didn't form part of Aviva's original consideration of the claim and it wasn't available to Aviva when it assessed Mr P's complaint and issued its final response letter. Aviva has told us that even if part of the evidence had been sent to it in 2021, it still would have needed more evidence to fully assess whether or not Mr P met the policy definition of a terminal illness.

A financial business must be given a chance to fully consider new evidence and provide a response. Under our rules, if a consumer's unhappy with the outcome of any review of new evidence, they need to make a new complaint to the financial business about that particular issue before we can potentially help with it. Mr and Mrs P haven't complained to Aviva about its response to the new evidence that's been provided – although I can entirely understand why they may feel they're currently not able to do so – which means Aviva hasn't had a chance to look into and issue a response to that particular point. And therefore, while I appreciate how frustrating this must be for Mr and Mrs P, I can't reasonably make any finding on whether or not I think this new evidence should have altered Aviva's position.

Overall, while I'm very sorry to disappoint Mr and Mrs P, I'm not directing Aviva to take any action.

My final decision

For the reasons I've 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 Mrs P and Mr P to accept or reject my decision before 29 November 2024.

Lisa Barham
Ombudsman