DRN-5213576

The complaint

Mr J complains about Aviva Life & Pensions UK Limited's decision to decline his claims for critical illness and permanent and total disability benefit under his level term assurance policy.

What happened

The history to this complaint is well known to the parties, so I won't repeat all the details here. In brief summary, in 2003, Mr J took out life insurance. The policy includes critical illness and disability benefit, permanent and total disability benefit and waiver of premium benefit. The policy term is 25 years.

Aviva initially considered a claim from Mr J in early 2023. Mr J originally claimed for a heart attack under the critical illness benefit. Aviva reviewed Mr J's claim against the policy's heart-related events and procedures and sought the opinion of its Chief Medical Officer (CMO), concluding that Mr J did not meet any of the relevant definitions.

However, it was clear from Mr J's evidence that he'd become increasingly unwell since early 2020, suffering from a number of illnesses and conditions. So Aviva looked to see if a claim under permanent and total disability was payable. Mr J's claim was assessed against five functional assessment tests: walking, bending, communicating, reading and writing. To qualify, Mr J needed to be totally and permanently unable to perform three of the five tests, without the help of another person but with the use of appropriate assistive or corrective aids or appliances.

Based on the information Mr J provided, and having consulted its CMO, Aviva didn't think Mr J would fully fail three of the five tests. It noted that surgery for carpal tunnel syndrome and for spinal radiculopathy correction was outstanding, offering potential for improved functionality, mobility and reduced pain. It said that as treatment options were still available the test for permanency had not been met. These decisions were communicated to Mr J in May 2023.

Mr J was very disappointed and sought to have his claims reconsidered. He provided further information and evidence from his GP and treating specialists. Aviva agreed to review the claims, subject to the receipt of additional medical information. It asked Mr J to provide an updated medical consent form, so that it could contact his treating specialists directly. But when this was not forthcoming, Aviva issued a final response letter reiterating its position and reminding Mr J that an updated consent form was required before further consideration could take place.

Mr J brought his concerns to the Financial Ombudsman Service, but our investigator didn't uphold his complaint. So Mr J asked for an ombudsman to issue a final decision.

To clarify, the scope of my decision is limited to the issues considered in Aviva's final response letters of February and March 2024 – that is, the claims decline decisions made up

until that time. I'm aware Mr J has voiced concerns about the sale of his policy. However, Aviva did not sell Mr J the policy, so I won't be commenting any further on that matter.

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, I'm not upholding this complaint. I know this will be unwelcome news for Mr J and I'm sorry about that. I'll explain my decision, focusing on the points and evidence I consider material to the outcome. So, if I don't refer to a specific point or piece of evidence, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

The file I've reviewed contains medical and other information which both pre- and post-dates Aviva's final response letters. I recognise Mr J has a number of challenging health issues which significantly impact his life. And I appreciate he's been unable to work since 2020 and is in receipt of personal independence payment (PIP). For a claim to succeed, Mr J must meet the policy definitions for critical illness and/or permanent and total disability, as set out in his policy.

Critical illness claim

Aviva assessed Mr J's claim against the critical illness policy definitions for heart-related events and procedures - heart attack, heart valve replacement, coronary artery bypass surgery, coronary artery angioplasty and open heart surgery. It concluded none of the relevant policy definitions had been met.

I've reviewed the medical records and other information Mr J's provided. In 2021, Mr J was admitted to hospital with chest pain. He was subsequently diagnosed with myocarditis, non-ischaemic cardiomyopathy and intermittent left bundle branch block. In 2022, he had a CRT-D device (cardiac resynchronisation therapy with defibrillator) fitted.

Mr J was unhappy that Aviva hadn't contacted his cardiologist prior to making its initial decision. He asked Aviva to do this. I've noted a letter dated September 2023 from consultant cardiologist Mr C to Mr J's GP, Dr G. The letter confirmed the above diagnoses and said:

> *'It's very clear that from a cardio perspective he is doing well but equally clear that from every other perspective he is not doing well.'*

Mr C also acknowledged that Mr J had mentioned to him difficulties with his insurer regarding his critical illness claim. He noted:

> *'…I certainly share his view that he has an important cardiac condition which is a critical illness. I guess it all comes down to exactly what the policy says. Certainly if his insurance company were to approach me for a medical report I would be happy to provide one.'*

There's no dispute that Mr J has a cardiac condition. But I've not seen evidence to show that Mr J's condition meets any of the specified heart-related critical illnesses set out in his policy. I don't suggest that Mr J's condition isn't concerning for him or serious - simply that he did not have a heart attack as defined by the policy or undergo any of the other specified procedures. So I don't think Aviva acted unfairly in declining his critical illness claim.

Permanent and total disability claim (PTD)

Again, it's not disputed that Mr J has a number of conditions that cause him significant day-to-day struggles. His life has altered considerably over the past few years. For a claim for PTD to succeed, Mr J must be unable to perform three of the five functional assessment tests (FAT). The loss of functionality must be permanent and irreversible. The specific tests in Mr J's policy are:

> *'**Walking**. Able to walk 200 metres on the flat without having to stop or suffering severe discomfort.*
> ***Bending**. Able to get into or out of a standard saloon car and able to bend or kneel to pick up something from the floor and straighten up.*
> ***Communicating**. Able to answer the telephone and take a message.*
> ***Reading**: Having the eyesight required to be able to read a daily newspaper.*
> ***Writing**: Having the physical ability to write legibly using a pen or pencil.'*

Mr J originally completed a FAT assessment form in April 2023, identifying problems completing all the specified tasks. The medical evidence Mr J provided was reviewed by Aviva's CMO. He wasn't confident the evidence supported failure in three tasks. The CMO noted that Mr J was, at the time, awaiting surgery in relation to carpal tunnel syndrome and radiculopathy correction. He said that successful decompression in most cases leads to restored hand function as it once was, which he would expect to translate to overall improved functional performance. Similarly, he anticipated that the radiculopathy correction – designed to reduce pain, restore mobility and increase confidence in movement – stood every chance of improving function, particularly with walking and bending tasks.

As treatment options remained available to Mr J, Aviva said the policy terms had not been met and it was appropriate to wait for Mr J to have the further treatment before reassessment. Based on the evidence, I think it was reasonable for Aviva to conclude that the test for permanence had not been met.

I'm aware that Mr J asked Aviva to review his claims in November 2023. Aviva agreed to do so, subject to receipt of additional medical information. Mr J provided an updated FAT assessment form and letter from his GP. Aviva had agreed to write to his treating specialists but needed an updated medical consent form to do so. However, when the updated consent was not received, Aviva issued its final response letters to Mr J.

I appreciate Mr J has found his dealings with Aviva very challenging. But overall, I think Aviva assessed the claims fairly, relying on the initial evidence and opinion of its CMO to conclude that Mr J hadn't met the policy terms necessary to qualify for either a critical illness payment or PTD. I'm therefore not going to ask Aviva to do anything further in respect of this complaint.

Finally, I'm pleased to hear the issue of consent has now been resolved and Aviva is in the process of gathering updated evidence to reassess Mr J's claims. I hope this process can be completed as speedily as possible.

My final decision

For the reasons given above I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr J to accept or

reject my decision before 21 February 2025.

Jo Chilvers
Ombudsman