

The complaint

Mr A complains Aviva Insurance Limited unfairly declined his claim for treatment.

What happened

Mr A took out a private medical insurance policy in February 2024. And the cover was underwritten by Aviva.

The policy was taken out on a moratorium basis, which means in the first two years of the policy, there is no cover for the treatment of any medical condition or symptoms that existed in the five years before the policy started. Once the policy has been in place for two years, Mr A could claim for treatment of pre-existing conditions or symptoms, if he had a trouble-free period of two consecutive years after joining.

The relevant term in this complaint is as follows.

“We do not cover treatment of any pre-existing condition, or any related condition if you had:

- *symptoms of*
- *medication for*
- *diagnostic tests for*
- *treatment for, or*
- *advice about*

that condition in the five years before you joined the policy.”

Mr A submitted a claim for treatment on 21 March 2024. He stated his symptoms to be difficulty breathing particularly during exercise, disturbed sleep and loud snoring. He said a doctor had confirmed visible asymmetry of the nose and nostrils. And he stated the symptoms *“have intensified past these last few months. Otherwise I have been dealing with this progressively worse for a long time”*. He said the symptoms first started in 2020 and more recently in July 2023.

Aviva said it declined the claim as Mr A had the symptoms during the five year moratorium period between February 2019 and February 2024.

Mr A submitted a further claim on 28 March 2024 after using Aviva’s virtual GP service. Mr A said his symptoms were difficulty breathing during exercise, interrupted sleep and severe snoring. He said the GP concluded he was suffering with chronic nasal obstruction and visible signs of a deviated septum and nostril asymmetry. He said his symptoms started in March 2024. He answered ‘no’ to previous instances of the symptoms or condition. And ‘not applicable’ to the date the symptoms first started.

Aviva said it needed Mr A’s GP to complete a form and to provide his medical records from February 2019 onwards.

There was a delay in Mr A's GP providing his medical records. Aviva received these in September 2024, and noted there was no mention of Mr A having seen his GP about his symptoms during the moratorium period.

Aviva declined the claim in October 2024. It said this was because Mr A had previously stated his symptoms started during the moratorium period, and so the claim was not eligible.

Mr A complained. He said he'd previously had blocked nostrils, but thought this was common during the cold season. And he said he'd not had any treatment for the symptoms from his GP since 2004.

Aviva responded to the complaint and said it thought the claim had been fairly declined, as it had relied on the first account Mr A gave about the history of his symptoms.

Unhappy with the response from Aviva, Mr A brought his complaint to this service. He said he was unaware of the deviated septum prior to it being diagnosed in March 2024. And he said Aviva had not given clear reasons as to why his claim was declined. He also pointed out that he is not medically trained and was not in a position to determine whether his previous symptoms related to the condition he was claiming for.

An investigator here looked into what had happened and said he didn't think Aviva had declined the claim unfairly.

Aviva made no comment on the investigator's view. However Mr A disagreed. In summary he said:

- unfair assumptions were made about his medical awareness - he did not know what was causing his symptoms;
- he was unaware of the deviated septum before the policy started;
- Aviva should rely on the information provided in his second claim, not the first, as when he made the second claim he had received more medical information; and
- if Aviva will not cover the condition, his policy is useless and he should receive a refund.

As Mr A disagreed and asked for a decision from an ombudsman, the case has 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.

The relevant industry rules say an insurer must handle claims promptly and fairly and shouldn't unreasonably reject a claim.

Having considered this complaint, I'm not upholding it. And I'll go on to explain why.

Mr A's cover is based on moratorium underwriting terms. The policy terms state there is no cover for a condition or symptoms where symptoms existed in the five years before the policy started.

Mr A provided details of the same symptoms in both claims – difficulty breathing, sleep issues and snoring. However the dates of him experiencing these symptoms differed between his two claims made a week apart. In the first claim Mr A said his symptoms first started in 2020, began again in July 2023, and intensified in the few months prior to making the claim. However in his second claim, he said the symptoms started in March 2024 and he'd had no previous instances.

When Mr A made his second claim, Aviva requested information from his GP. The records showed Mr A had not consulted about any of the symptoms relevant to this claim during the five years prior to taking out the policy. And so I think it's fair in the absence of any medical records, that Aviva relied on what Mr A had reported himself about his symptoms.

I'm satisfied Aviva set out clear reasons for declining both of the claims as it referred to the relevant policy terms and dates in its communications. And as Mr A provided different dates for the onset of the same symptoms in his two claims, I think it reasonable that Aviva relied on the information Mr A gave originally. I say this because Mr A has not provided a persuasive explanation as to why he gave differing dates for his symptoms between the two claims. And I think it's most likely he gave more accurate information in his original claim, as when making the second claim, he had the knowledge of the reasons Aviva had given for not accepting the first.

Mr A has said he had more medical information when making the second claim, as he had seen the virtual GP. However I'm not persuaded that this consultation changed Mr A's knowledge of when he had personally experienced his symptoms.

I've also considered what Mr A has said about his lack of medical knowledge and not knowing whether his symptoms were due to a common cold or allergies. However I don't think this makes a difference here. When making a claim Mr A is not required to know the cause of any symptoms. Rather he was asked to state the symptoms he'd had and the dates he'd experienced them. And I'm satisfied based on the evidence I've seen, that Mr A was aware of those details, and provided them most accurately when making his first claim.

As I've not found that Aviva declined Mr A's claim unfairly, I'm not directing it to refund any of his policy premiums.

I note Mr A has said the policy is useless to him if it won't cover this condition, however I disagree that's the case. The purpose of the policy is to cover the treatment of unforeseen medical conditions, which did not exist during the moratorium period. So although a claim was declined relating to Mr A's nasal symptoms, Aviva was still on risk for other eligible claims Mr A may have needed to make.

I'm aware Mr A has since cancelled his policy. However this happened after Aviva issued its final response, so I've not considered how Aviva dealt with the cancellation as part of this complaint.

My final decision

For the reasons I've given, it's my final decision that I do not uphold this complaint. And I make no award against Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 9 September 2025.

Gemma Warner
Ombudsman