

The complaint

Mrs B's complained that Aviva Life & Pensions UK Limited unfairly declined the claim she made on her employer group policy after her husband was diagnosed with a rare form of blood cancer.

What happened

Mrs B's employer offers its employees the benefit of a group critical illness policy. In addition to covering the staff themselves, staff members can opt for their partners to be covered by the policy. Mrs B opted to add Mr B in mid-2020.

In 2023, Mr B was sadly diagnosed with myeloproliferative neoplasms (MPN) and myelodysplastic syndrome (MDS) overlap syndrome - a rare form of blood cancer. He has since passed away. Mrs B made a claim to Aviva. Aviva declined it, on the basis that Mr B had been diagnosed with essential thrombocythemia (ET) in 2019. So they said he'd had a pre-existing condition at the time he was added to the policy. And pre-existing conditions are excluded from cover.

Mrs B complained. She said that Mr B's doctor had told them that ET wasn't a critical illness and there was no reason to suppose it would be life limiting. So they couldn't have made a claim on the policy at the time Mr B was added. And she was claiming for MPN/MDS – which Mr B didn't have until 2023.

In their response, Aviva said that, contrary to the doctor's view, they classed ET as a critical illness which would have met the cancer definition in the policy in 2019 because it was malignant. They referred to the fact that they'd paid a number of other claims for MPN/MDS where ET had been diagnosed.

Mrs B didn't accept Aviva's decision and brought her complaint to the Financial Ombudsman Service. Our investigator reviewed the information provided by both parties and concluded Aviva didn't need to do any more to resolve the complaint. He was satisfied the medical evidence showed ET is a malignant blood cancer, of which MPN is one type. So he was satisfied ET met the cancer definition set out in the policy and didn't fall within one of the exclusions. And it was fair for Aviva to say Mr B had cancer before he was added to the policy.

Mrs B didn't agree with the investigator's view. So I've been asked to make a final decision.

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 that, I'm not upholding Mrs B's decision. I know she'll find that news distressing and I'm sorry about that. I hope it will help if I explain the reasons for my decision.

The starting point for considering any claim is the policy terms. The policy defines cancer as:

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

The term malignant tumour includes:

- *leukaemia*
- *sarcoma*
- *lymphoma...*”

I’m satisfied that Mr B’s doctor described his ET as a malignant cancer and that none of the exclusions applied.

The policy also sets out that the following isn’t covered:

“We will not pay a lump sum benefit for a member or a child who has a critical illness or operation if that same critical illness or operation:

- *was pre-existing at any time prior to the date their cover commenced under the scheme.....”*

There’s no dispute that Mr B was diagnosed with ET before he was covered by the policy. The crux of the complaint is whether it’s reasonable to say – as Aviva have done – that this is the same condition as he claimed for. It’s Mrs B’s position that it wasn’t – so the claim should be paid.

To support what she has said, Mrs B has submitted evidence, including statements from two of Mr B’s doctors – Dr V and Dr A. I’ve considered these.

Dr V’s statement sets out that ET is a chronic condition and a slow growing form of cancer. He goes on to describe the “*evolution*” of MPN/MDS, which he says is very rare and “*not a typical disease progression pathway*”. While I appreciate Mr B’s situation was rare, I’m satisfied Dr V has described a development of MPN/MDS from ET.

Similarly, although Dr A describes the MPN/MDS as a new condition, he does say that ET can progress to MPN/MDS.

On the basis of these medical reports, I can’t say that it was unreasonable for Aviva to conclude that Mr B had the cancer he was claiming for before he was added to Mrs B’s policy. And that means it was fair for Aviva to conclude it was excluded.

Mrs B has submitted that Aviva have breached the Consumer Duty imposed on financial businesses because they’ve not “*acted to deliver good outcomes for retail customers*” and have caused her additional distress at a time when she was grieving the loss of her husband.

I’ve no doubt Aviva’s decision made an already distressing situation worse for Mrs B. But the Duty means they should take steps to try and minimise any negative impact they have on their customers. It doesn’t mean that they can’t take steps to validate a claim – or that they have to decide a claim in the customer’s favour.

I’m satisfied from what I’ve seen that Aviva took the same steps they would in any claim of this type to validate it. They gathered medical evidence and reviewed submissions made by

Mr and Mrs B. I've explained above that I think the conclusion they reached was reasonable, and was made in line with the policy terms.

I do recognise that Mrs B found the process upsetting. But I can't say that's because Aviva didn't deal appropriately with the claim. And so, while I appreciate it isn't the outcome Mrs B was hoping for, I don't think they need to do any more to resolve Mrs B's complaint.

My final decision

For the reasons I've explained, I'm not upholding Mrs B's complaint about Aviva Life & Pensions UK Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 2 December 2025.

Helen Stacey
Ombudsman