

## The complaint

Mr D has complained that Aviva Insurance Limited has declined a claim he made on a private medical insurance policy.

## What happened

Mr D took out the policy on 3 July 2023 on a moratorium basis. That means that any pre-existing medical conditions (PEMCs) he'd had in the previous five years are excluded from cover if they re-occur within the first two years of holding the policy.

Mr D made a claim in May 2024 and Aviva declined it on the basis that he had experienced symptoms in the period prior to purchasing the policy.

Our investigator thought that Aviva had acted reasonably in declining the claim, in line with the policy terms and conditions. Mr D disagrees and so the claim has been passed to me for a 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.

I've carefully considered the obligations placed on Aviva by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Aviva to handle claims promptly and fairly, and to not unreasonably decline a claim.

Looking at the policy terms, they state:

*'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.*

*However, we will cover that condition if you do not have:*

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

*that condition during a continuous two year period after your initial date of cover.'*

Mr D's claim was for surgery for chronic rhinosinusitis (which I'll call condition B). As he was making a claim within two years of taking out the policy, Aviva needed to make checks to ensure that the condition wasn't pre-existing.

Mr D says he wasn't diagnosed with condition B until May 2024. However, as per the policy terms above, it's not just a diagnosis that is relevant. He also wouldn't be covered if he'd had any symptoms of the condition during the moratorium period.

He says that the symptoms Aviva has sought to rely on to decline the claim are unrelated to condition B but instead relate to another condition he had called sarcoidosis (condition A), which he was diagnosed with in October 2023.

Therefore, I've looked at the available evidence to determine whether it was reasonable for Aviva to conclude that Mr D had been experiencing symptoms of condition B, prior to the inception of the policy.

The policy doesn't cover PEMCs that were present in the five years before the start of the policy. So, in this case, Aviva would be looking back to July 2018.

The GP didn't initially send Mr D's medical records going back to 2018. They only provided them from 24 July 2023. Nevertheless, Aviva assessed those available records to conclude that condition B was pre-existing. That's because some of the medical entries give a start date for symptoms that pre-date the start date of the policy.

On 7 August 2023 the GP notes record an 8-week history of symptoms, meaning that Mr D would have begun experiencing these symptoms on or around 12 June 2023, just prior to buying the policy on 3 July 2023. That's the reason that Aviva originally gave for declining the claim. The fuller medical note states:

*'History: 8w feeling of congestion, runny nose and cough. Though most likely due to allergy.....congestion getting worse and worse. Sneezing ++. When coughs thick fluid comes out. Both nostrils congested. Last year had similar symptoms which got worse and he ended up in hospital with pneumonia. Has symptoms of post nasal drip. Coughs all the time.....clear mucus from nose. No haemoptysis or blood in nasal discharge. Cough getting slightly worse.'*

Whilst Mr D says that any mention of a prior cough or wheezing relates to condition A, the symptoms of post-nasal drip, mucous trails and congestion are things that the consultant later includes when providing a diagnosis of condition B.

The consultant has provided a letter in support of Mr D's claim dated 5 September 2024 in which he states that the diagnosis of condition B has no relationship to his pre-existing condition A. However, whether or not there is a link between the two conditions isn't really the issue here. Aviva's primary reason for declining the claim is that it considers that Mr D had been experiencing symptoms of condition B in the period before buying the policy.

The difficulty is that the symptoms for condition A and condition B can be overlapping, which has added complexity to the situation. Mr D saying that references to the majority of symptoms prior to 3 July 2023 were due to condition A and that other symptoms have wrongly been attributed to condition B when they were actually due to time-limited common colds.

In terms of when the symptoms of condition B started, I consider that the most weight should be placed on information provided by the consultant.

There's a clinic letter from the consultant dated 15 May 2024 in which he provides the diagnosis of chronic rhinosinusitis. It is stated that Mr D has *'had a terrible time with nasal obstruction and this has been a problem for six months since an episode of pneumonia. Since then he has described nasal obstruction worse on the left than the right rhinorrhea, post nasal drip and a decreased sense or smell as well as facial pressure and pain.'* It goes on to mention condition A as a distinct issue but then states that *'He had mucous trails and congestion much in keeping with chronic rhinosinusitis.'*

It seems clear that the symptoms described relate to the diagnosis of chronic rhinosinusitis. So, taken at face value, the symptoms specific to this condition started following a bout of pneumonia. The report doesn't say how soon the symptoms started after the pneumonia. However, I consider it must have fairly soon afterwards, otherwise it's unlikely that it would have been used as a reference point.

Going by this report, Mr D had mentioned to the consultant that he'd had the pneumonia some six months previously, which would be November 2023. However, there is nothing in his medical records to show that he had pneumonia at that time or at any time after 24 July 2023.

There's an entry in his medical records dated 24 July 2023 stating that he has a history of pneumonia and that his current problem is 'chronic rhinitis'. There's another entry dated 7 August 2023 which states: *'Last year had similar symptoms which got worse and he ended up in hospital with pneumonia'*. There's also an entry on 22 August 2023 stating that he *'Had pneumonia this year'*. So, the medical records are slightly contradictory. However, I've seen a letter from the hospital to the GP which mentioned that he had an admission in March 2023 for pneumonia, prior to purchasing the policy. Therefore, as the symptoms of condition B started soon after he'd had pneumonia, that would also be prior to him taking out the policy.

There's a medical entry from 19 October 2023 talking about symptoms having a duration of seven months, which ties-in with the symptoms starting around March 2023.

I've thought about everything that Mr D has said. However, based on all of the medical information available to Aviva, overall, I'm satisfied that it assessed that evidence reasonably to conclude that the symptoms of condition B were pre-existing.

I note Mr D's point that a renewal notice from May 2025 doesn't include any medical exclusions, which he sees as a direct contradiction of Aviva's stance in declining this claim, although I assume renewal was offered on the same moratorium basis as previously. Regardless of that, this decision is only looking at whether Aviva has done anything wrong in declining the claim – and I'm unable to conclude that it has.

I'm sympathetic to Mr D's situation and I appreciate how strongly he feels about this matter. However, I consider that Aviva acted reasonably in declining the claim, in line with the policy terms and conditions.

### **My final decision**

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 15 December 2025.

Carole Clark  
**Ombudsman**