DRN-5723921

The complaint

Mr C has complained that Aviva Insurance Limited declined a claim he made under his group personal accident policy.

What happened

Unfortunately, on 19 August 2022 Mr C was involved in an accident, causing injury to his shoulder and knees. As a result of this he had surgery in September 2024 following which he was off work. He claimed for disablement benefit under the policy. Aviva declined the claim. It said that it did not meet the policy terms – as the disablement wasn't within 24 months of the date of the accident.

Unhappy Mr G referred his complaint to our service.

The investigator didn't recommend that it be upheld. They didn't find that Aviva had treated Mr C unfairly by relying on the terms of the policy.

Mr C appealed. He is represented but for simplicity of reading I shall just refer to the representations as being made by Mr C.

Mr C didn't feel the outcome was fair. He said that the two-year gap in claiming disablement benefit was simply a result of NHS wait times.

As no agreement has been reached the matter 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.

In this decision I've focused on what I find is the key issue here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts.

The regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the relevant law, the policy terms and the available evidence, to decide whether I think Aviva treated Mr C fairly.

I'm grateful for the representations Mr C has made, but I have reached the same conclusion as the investigator. I'll explain why.

The policy terms are key here; they form the basis of Mr C's contract with Aviva. As far as relevant to this complaint they say:

We will pay the amount shown in The Schedule to You, for Accidental Bodily Injury to an Insured Person occurring during the Period of Insurance which, within 24 months of the date

of the Accident, solely directly and independently of any other cause results in any of the benefits listed below:

(1) Death
(2) Capital Benefits
(3) Temporary Total Disablement
(4) Temporary Partial Disablement.

Mr C claimed for temporary total disablement benefit from 27 September 2024 following surgery. I understand that the surgery was a result of injury sustained in the accident. But importantly here the period of disablement was outside the 24 months stipulated in the policy term.

I do appreciate Mr C's point that his wait for surgery was due to NHS waiting times. But despite my natural sympathy I don't find it would be fair to require Aviva to overlook the clear policy term, or disregard part of it, because of this.

As Mr C didn't meet the policy requirement for benefit to be paid, I don't find that Aviva has treated him unfairly or unreasonably by declining his claim.

For the avoidance of doubt, I don't find that the late notification of the claim is relevant here.

I'm sorry that my decision doesn't bring Mr C welcome news.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 30 October 2025.

Lindsey Woloski
Ombudsman