

The complaint

Mr and Mrs H complain because Aviva Insurance Limited ('Aviva') hasn't paid a claim under their travel insurance policy.

All references to Aviva include the agents appointed to handle claims and complaints on its behalf, including the assistance company which Mrs H was dealing with while her and Mr H were abroad.

What happened

Mr and Mrs H are insured under a travel insurance policy underwritten by Aviva, provided as a benefit of their packaged bank account. Mr and Mrs H say they've held this policy since approximately 2008.

Mr H declared a pre-existing medical condition which he experienced in 2011 to the business who underwrote the policy at that time. Mr H was told he'd have no cover for the pre-existing medical condition for one year, but that it would be covered under the policy from May 2013.

The terms and conditions of Mr and Mrs H's policy changed in 2017, when Mr and Mrs H were told that any pre-existing medical issues which had already been declared would automatically be migrated onto the new policy.

The policy terms and conditions changed again in 2021.

Unfortunately, in 2023, Mr H was admitted to hospital abroad and needed medical treatment, which meant Mr and Mrs H had to extend their stay. They made a claim under their policy with Aviva, who said Mr H's pre-existing medical condition was no longer covered.

Unhappy, Mr and Mrs H complained before bringing the matter to the attention of our Service.

One of our Investigators looked into what had happened and said she didn't think Aviva had acted unfairly or unreasonably in the circumstances. Mr and Mrs H didn't agree, so the complaint was referred to me as the final stage in our process. I made my provisional decision about Mr and Mrs H's complaint in July 2025. In it, I said:

'I'm sorry to hear about Mr and Mrs H's experience abroad. I have no doubt it must have been a very stressful time, and I wish Mr H good health for the future.'

Aviva, as the underwriter of Mr and Mrs H's policy, is the business responsible for the decision to decline their claim. Aviva is also the business responsible for ensuring that any changes to Mr and Mr H's policy were drafted in a way that was clear, fair and not misleading.

Mr and Mrs H's bank is an entirely separate and distinct business to Aviva (and to the agents which Aviva used in this case), and I'm satisfied Mr and Mrs H's bank didn't have any input

into Aviva's decision to decline their claim. Generally, we'd consider that the bank is the business responsible for sending details of any policy changes and annual eligibility statements about requirements such as declaring pre-existing medical conditions to packaged bank account holders.

When making my provisional decision about this complaint, I'm only considering Aviva's actions and the regulated activities which Aviva is responsible for.

Travel insurance policies like this one generally operate in a similar manner to short-term insurance contracts and require the policyholder to make certain annual declarations about their health, amongst other eligibility requirements. This isn't unfair.

However, insurers must act in line with relevant industry rules which include handling claims fairly and not unreasonably rejecting a claim. And, if an insurer is seeking to rely on a significant policy exclusion (such as an exclusion relating to pre-existing medical conditions) to turn down a claim, then this exclusion should be clearly highlighted to the policyholder. I've taken these industry rules into account when making my provisional decision.

The terms and conditions of Mr and Mrs H's policy which applied at the time of this claim say there's no cover for any medical conditions that the policyholder hasn't told Aviva about. The policy defines a medical condition as:

'...any illness, injury or disease where in the 12 months before purchasing your Pack or booking a trip (whichever is later) an insured person has:

- been prescribed medication, including newly prescribed or repeat medication:...*

The medical evidence which I've seen suggests that Mr H was prescribed repeat medication for the medical condition which he experienced in 2011 in the 12 months before this trip was booked. Aviva says Mr H didn't tell it about this, which would mean the claim isn't covered under the terms and conditions of the policy.

However, my statutory remit is to make a decision based on what I think is fair and reasonable in all the circumstances. This means I'm not bound to strictly apply the policy terms and conditions if I don't think this would result in a fair and reasonable outcome. And, as I've already mentioned above, an insurer should highlight any significant policy exclusions relating to pre-existing medical conditions to a policyholder in a manner that is clear, fair and not misleading.

I understand, and it doesn't seem to be in dispute, that Mr H's pre-existing medical condition was first confirmed as being covered under this policy from May 2013. And I've seen documentation from Mr and Mrs H's bank confirming that they weren't required to redeclare this pre-existing medical condition when the policy terms and conditions changed in 2017.

So, although I appreciate Aviva has no record of Mr H's pre-existing medical condition being declared since 2017, I'm satisfied based on the information I've seen that Mr H did have cover for this medical condition up until 2021 when the policy terms and conditions changed again. If Aviva doesn't agree with my findings in this regard, then this is something it would need to engage with Mr and Mrs H's bank about.

In 2021, Aviva said it was changing the terms and conditions of Mr and Mrs H's policy again, and that Mr and Mrs H would need to check the annual eligibility statement for the insurance. Aviva says Mr and Mrs H should then have contacted it upon receipt of an annual eligibility statement in March 2021 which asked them to redeclare any pre-existing medical conditions.

I've carefully considered the content of the March 2021 annual eligibility statement. It said, in standard font, 'If you have an existing medical condition, including recent referrals or investigations you'll need to let us know'. It also said, in larger and different coloured font;

'Existing medical conditions must be declared to the insurer. If you do not do this, your claim may be affected...There's no cover for any existing medical conditions for any insured person unless declared to and accepted by the insurer in writing...'

However, the 2021 annual eligibility statement also said, in larger and different coloured font:

'! Let us know about any changes to your health before you travel'

And it went on to say the policyholder should contact Aviva if there had been a change in the status and control of any previously accepted medical conditions since the date of the last screening, or if the policyholder had developed any new conditions in the last 12 months.

I'm not satisfied that the overall content of the 2021 annual eligibility statement was clear in communicating to Mr and Mrs H exactly what they needed to tell Aviva about, and whether this was all previously declared pre-existing medical conditions, or whether it was only previously declared pre-existing medical conditions that had since changed.

In cases where there is any ambiguity or uncertainty in the content of documentation, I think it's fair and reasonable to interpret that documentation in the manner which is most favourable to the policyholder. In this case, this would mean interpreting the 2021 annual eligibility statement as requiring Mr and Mrs H to tell Aviva only about previously declared pre-existing medical conditions which have since changed.

Mr and Mrs H say Mr H's medical condition hadn't altered since his diagnosis in 2011 and Aviva has provided no medical evidence which contradicts this. This means, based on the information I've seen, I'm satisfied there had been no change in the status and/or control of Mr H's previously declared pre-existing medical condition since the date of the last screening in 2017 (when the details of the 2013 medical screening were automatically migrated onto Mr and Mrs H's new policy at that time), and this wasn't a new medical condition which had developed in the 12 months leading up to 2021.

So, not only do I think the 2021 annual eligibility statement wasn't clear, I don't think there had been any changes to Mr H's pre-existing medical condition at that time which he reasonably needed to make Aviva aware of.

I've also considered the content of the February 2022 and January 2023 annual eligibility statements. These contained the same information as the March 2021 annual eligibility statement which I've quoted above, so it follows that I don't think the 2022 or 2023 documentation was clear or that Mr H had a changed or new pre-existing medical condition which he ought reasonably have redeclared to Aviva in those years either.

Overall, based on the specific circumstances of this individual complaint where Mr H's pre-existing medical condition was covered from 2013 to 2021, and based on the wording of the 2021, 2022 and 2023 annual eligibility statements, I don't think it's fair or reasonable for Aviva to rely on the policy's pre-existing medical exclusion to turn down Mr and Mrs H's claim.

I understand Mr H didn't have to pay for certain medical costs abroad but if Mr and Mrs H have any outstanding costs connected to this claim then Aviva should now consider these. Aviva is entitled to ask for reasonable evidence of the costs from Mr and Mrs H and any subsequent dispute about the amount (if any) of the claim to be paid would need to be the

subject of a new complaint with Aviva in the first instance before the matter could be considered by our Service.

I've also thought about how Aviva handled this claim. I'm satisfied that Aviva was generally reasonably proactive and didn't cause unnecessary or excessive delays. While Aviva assured Mrs H that she would be given help and support, it clearly told her on a number of occasions that it couldn't confirm cover until it had obtained Mr H's GP records, which I'm satisfied it acted to access within a reasonable timeframe. However, I think Aviva's unreasonable decision to subsequently decline this claim caused Mr and Mrs H distress and inconvenience at an already worrying time when Mr H was recovering after a period of serious illness. So, I think it would be fair and reasonable in the circumstances for Aviva to pay Mr and Mrs H £250 compensation for the impact of this on them.'

Both Mr and Mrs H and Aviva accepted my provisional decision. However, Aviva pointed out that Mr and Mrs H will need to update their medical screening annually going forward, as the current policy terms and conditions require a medical upgrade to be in place to cover pre-existing medical conditions and these medical upgrades only last for 12 months.

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.

As neither party has provided any new information or additional evidence, I see no reason to change my provisional decision. However, I wish to specifically draw Mr and Mrs H's attention to the importance of what Aviva has said about ensuring that an annual medical upgrade is in place on their policy going forward.

Putting things right

Aviva Insurance Limited needs to put things right and do the following:

- reassess any outstanding claim costs which Mr and Mrs H may have in line with the remaining terms and conditions of the policy, without reference to the pre-existing medical condition exclusion;
- pay Mr and Mrs H £250 compensation for the distress and inconvenience they experienced.

Aviva Insurance Limited must pay the compensation within 28 days of the date on which we tell it Mr and Mrs H accept my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

My final decision

I'm upholding Mr and Mrs H's complaint about Aviva Insurance Limited and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H and Mr H to accept or reject my decision before 3 September 2025.

Leah Nagle
Ombudsman