

The complaint

Mr L has complained that Aviva Life & Pensions UK Limited declined a critical illness name he made under his group policy.

What happened

Mr L joined his employer's group scheme on 1 April 2024. Sadly in November 2024 he had a heart attack and in turn made a claim under the policy.

Aviva declined the claim. It relied on a policy exclusion regarding associated conditions. It said this was applicable as Mr L had an associated condition prior to joining the scheme and the claim was made within the first two years of joining.

Unhappy, Mr L referred his complaint to our service. The investigator didn't recommend that it be upheld. They didn't find that it was unfair for Aviva to decline the claim based on the associated condition exclusion. They also didn't find that Aviva had caused excessive delays.

Mr L appealed. He said that according to a NHS survey published in May 2023 Aviva would potentially be declining 67% of heart attack claims. Mr L felt that Aviva should have highlighted at inception that the policy is not suitable for those with cholesterol readings at more than 5. Accordingly, he felt that the policy didn't meet its customers' needs.

As no agreement has been reached the complaint has been passed to me to determine.

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'd like to reassure Mr L that whilst I've summarised the background to this complaint and the submissions he has made, I've carefully considered all the evidence before me. In this decision though I've focused on what I find are the key issues 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 relevant 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 contract terms, regulatory rules, and good industry practice to decide whether I think Aviva treated Mr L fairly. Having done so, and although I recognise that he will be disappointed by my decision, I agree with the conclusion reached by the investigator. I'll explain why.

Firstly, I think it is important to point out that I'm not considering the sale of this policy. The policyholder is Mr L's employer (I'll call "H") not Mr L, although he is eligible to make a complaint about his claim as the policy was taken out for the benefit of the employees of H.

For completeness therefore I would say it is not apparent to me what H's requirements were at the time of the sale, or what was discussed.

Be that as it may, I do have sympathy for the arguments that Mr L has made. However the issue for me to determine is whether Aviva unfairly declined his claim.

The correct policy terms for the date of the claim were the 2023 edition (I understand that Mr L was given an earlier edition by H when he joined the scheme). The 2023 provided the following exclusion for associated conditions (as far as relevant here):

We will not pay a lump sum benefit for a member or a child if they had an associated condition at any time prior to the date their cover commenced under the scheme.

For the critical illness of 'heart attack' the exclusion applied only during the first two years after joining the scheme (or increasing benefit).

Associated conditions are defined in the policy as follows:

Any symptom, condition, illness, injury, disease or treatment which is either;

- recognised by reasonable specialist medical opinion to be related to the occurrence of a critical illness or operation, or*
- is listed in the "associated conditions" column of the critical illness/operation table which begins on page 4*

The associated conditions listed as applicable to heart attack were:

Any disease or disorder of the heart, diabetes mellitus, hypertension, hyperlipidaemia or any obstructive/occlusive arterial disease.

Mr L wasn't diagnosed with hyperlipidaemia, and this was made clear by his GP surgery in its response to Aviva. However Aviva's Consultant Medical Adviser confirmed that the results in Mr L's medical history following a blood test in September 2022 were consistent with hyperlipidaemia. He wrote "*The total cholesterol was 6.2 (<5.0), Triglycerides 2.6 (<2.3), LDL 3.42 (<3.0) and non-HDL cholesterol 4.6 (<4.0). All these values are in excess of acceptable laboratory ranges and therefore constitute hyperlipidaemia even though a diagnosis was not made. The lack of diagnosis is irrelevant in terms of the pathogenicity of these readings.*"

Aviva explained to Mr L that it had also discussed his claim with a Cardiologist Consultant Medical Adviser who advised that hyperlipidaemia is a recognised risk factor for a heart attack and that Mr L's cholesterol was raised, even though not treated with medication.

So on the basis of the evidence before me I find that it was fair for Aviva to conclude that the first bullet had been met – that is Mr L had a condition recognised by reasonable specialist medical opinion to be related to the occurrence of a critical illness. As his heart attack was within the first two years of cover, I can't say that Aviva treated Mr L unfairly or contrary to his policy terms by declining his claim.

I do note that the definition of *Associated Conditions* is expanded in the 2023 policy terms, but I don't find that makes any difference here. This is because the first bullet set out above is applicable here and was set out in both the 2021 and 2023 policy terms.

I've thought carefully about the argument Mr L has made about delays in assessing his claim. I have no doubt that waiting for an answer was very stressful. But I don't find that there were any undue delays by Aviva in assessing the claim. It required medical records, and these were requested promptly and the GP surgery paid. Some information was missing - but again this was chased expeditiously.

There is no doubt that Mr L suffered a critical illness, and I understand that he would have expected that this was covered by his group policy. But given the policy terms and specific exclusion referred to above, I don't find Aviva treated Mr L unfairly by declining his claim.

I am sorry that my decision doesn't bring Mr L welcome news.

My final decision

For the reasons given 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 L to accept or reject my decision before 13 November 2025.

Lindsey Woloski
Ombudsman