DRN-5761756

The complaint

Ms M has complained she was mis-sold a Life and Critical Illness Cover ('CIC') policy by Aviva Life & Pensions UK Limited ('Aviva'). She has also complained about the ongoing service and that her critical illness claim was wrongfully declined. To put the matter right, Ms M wants her claim under the policy to be paid, £50,000 plus £25,000 for the distress and inconvenience she had been caused.

What happened

Ms M took her policy with Aviva on 9 October 2012.

Ms M made a claim under the critical illness element of the policy, but this was declined so Ms M raised a complaint. In Aviva's letter to Ms M of 12 December 2023, it said;

- Ms M's illness wasn't one specified under the policy cover.
- This was because Total Permanent Disability benefit and Loss of Independent Existence benefits were excluded under the special provisions which Ms M agreed to.
- It provided details about the adviser if Ms M wanted to make a complaint about the suitability of the policy.

Correspondence continued and Aviva issued a response on 19 February 2025 to further complaint points;

- It confirmed which third party business Ms M should complain to if she thought the policy had been mis-sold.
- It should have been made clearer in 2023 that the adviser was acting as an appointed representative of that third party business at the time and apologised for the lack of clarity and should have given her full contact details of the firms involved.
- It awarded £100 as an apology.

Ms M escalated the matter and Aviva wrote to Ms M again on 5 March 2025;

- It reassured Ms M it wasn't its intention to be dismissive of her situation or requests.
- In 2023 it had provided details of the business it understood was liable for the sale of the policy and it couldn't see Ms M had made contact again after its letter of 12 December 2023 until February 2025.
- It established that the information given in 2023 about the advisory business was incorrect and had provided the correct details in its letter of 19 February 2025 plus the payment of £100 to compensate for this.

Ms M was disappointed with the outcome and Aviva wrote to her again on 16 May 2025;

- It was correct that the signed Declaration pre-dated the policy start. The Declaration allowed the adviser to submit the application and Aviva could request medical

evidence if needed. It couldn't locate a call stating Aviva didn't hold a signed Declaration but acknowledged that call could have taken place.

- The correct agency information applied to the policy.
- The correct underwriting conclusion was made about the special provisions that applied to the policy. Ms M had recently been told exclusions didn't apply but this was incorrect. It offered Ms M £200 for the misinformation she had been given.

Unhappy with the outcome, Ms M brought her complaint to the Financial Ombudsman Service. In her most recent assessment, our investigator didn't think Aviva needed to do anything more. She said;

- She clarified she couldn't use external links or use Ms M's passwords. It was for Ms M to provide any relevant information.
- She didn't think the witness statement given by Ms M's ex-partner made a difference to the outcome so didn't refer to it.
- Ms M's separate complaint about the third-party adviser mis-selling the policy had been decided separately by an ombudsman.
- She couldn't consider a complaint about Aviva's handling of the complaint as it wasn't a regulated activity.
- This service had already addressed Ms M's concerns about a data protection issue in February 2025. Aviva had paid £100 to Ms M because of that.
- If Ms M had a complaint about Aviva withholding information further to a Subject Access Request ('SAR'), she needed to raise it with Aviva before this service could consider it.
- The investigator wouldn't respond or comment on a data breach concerning Aviva's sharing of Ms M's personal data with a third party as they would be addressed by the Information Commissioner's Office ('ICO').
- While Aviva wasn't responsible for the sale of the policy the investigator considered whether it acted fairly and reasonably in its role as policy provider.
- Ms M's complaint about her claim being denied had been considered by this service under a separate reference but was made too late under the rules that apply.
- Ms M had signed the 'Declaration to Aviva Life & Pensions UK Limited' ('Declaration') document on 5 October 2012. Ms M says this pre-dated the policy start date and wasn't acceptable. But the terms explained the policy wasn't in force and Ms M was signing to submit the application which her adviser would do electronically. It was common industry practice, so Aviva hadn't done anything wrong.
- While Ms M had complained the exclusions and terms weren't discussed with her, that was the role of the adviser and not Aviva.
- Ms M said she never received the terms and conditions or exclusion details of the policy. But these were sent and Aviva couldn't be held responsible for postal issues. Aviva wouldn't have known Ms M didn't receive the paperwork.
- Aviva would only request medical reports prior to the setting up of the policy if it needed to. Based on the information provided on application Aviva automatically accepted the policy with an exclusion. It hadn't acted unfairly by not requesting a medical report.
- How Aviva chose to underwrite its policy wasn't something the investigator could consider.

- There was no evidence to suggest the exclusion of the policy wouldn't have been included even if Aviva had obtained a medical report. Ms M would likely have sought cover from other providers if she had been aware of the exclusion, but Ms M didn't follow up with either her adviser or Aviva if she hadn't received the policy documentation.
- Aviva had incorrectly told Ms M there weren't any exclusions and that it didn't have a copy of the Declaration but had paid £200 because of this. However, the outcome wouldn't have been any different as there was always an exclusion on the policy.
- Three different policy proposals were generated but this would have happened every time the adviser made any adjustments. And Aviva issued the documents to Ms M.
- Aviva didn't provide the correct agency code for a third party – the adviser worked for two businesses.
- Aviva had provided Ms M with incorrect information about her policy, but it had paid her £200 in addition to the £100 paid earlier. The investigator thought this was a fair amount and Aviva took steps to ensure Ms M had the correct policy information.
- The investigator didn't think Aviva had treated Ms M unfairly by not offering disability support but if Ms M wanted a decision about whether Aviva had breached the Equality Act 2010 she would need to go to court.
- Aviva had responded to Ms M's complaint within the time limits and even if it hadn't, Ms M could still bring her complaint to this service.

Correspondence continued but agreement couldn't be reached.

As the complaint remains unresolved, it has been passed to me for a decision in my role as ombudsman.

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.

After doing so, I've reached the same conclusion as the investigator and broadly for the same reasons. I'll explain why.

Ms M has provided many supporting documents, telephone call recordings and voice notes etc in bringing her complaint which includes submissions from other parties including health professionals and similar. And Ms M has raised her concerns about other parties, including the adviser. But that particular complaint has been dealt with under a separate complaint reference, and I have issued my final decision, so I won't be commenting any further on the mis-sale of the policy. Ms M has also raised a complaint about the rejected claim but that has already been dealt with separately by this service.

And I should make clear at the outset I will only be considering Aviva's actions here and whether it acted fairly and reasonably as the policy provider and in its dealings with Ms M. In one of Ms M's recent submissions she has said she wanted a new claim assessment on original terms, removal of the policy exclusions, payment/interest and compensation for the harm caused. But this decision is limited to Aviva's role as the policy provider, and I will not comment on every point Ms M has raised and asked us to investigate. I will only address what I consider to be points relating to the crux of the complaint against Aviva.

I would like to say how sorry I am to hear of Ms M's previous life experiences and her ongoing significant health problems. I appreciate how difficult things are for her and how

important the outcome of this complaint is to her. However, when looking at the circumstances surrounding Ms M's complaint, my role is to be impartial and consider what's fair and reasonable. This means taking into account – *but limited to* – Aviva's role and its obligations as set out by the Financial Conduct Authority ('FCA').

Ms M has complained that Aviva breached some of the regulator's rules and Principles as well as the Equality Act 2010 in its dealings with her. These have a wide application, and I have therefore considered all of Ms M's points about the firm's regulatory obligations when deciding what I consider to be a fair and reasonable outcome to the complaint.

Declaration pre-dating policy being written

Ms M met with her adviser on 5 October 2012. At that meeting Ms M signed the 'Declaration to Aviva Life & Pensions UK Limited'. Ms M says this was just generic consent and not an agreement to take the policy. She was told it was a GP access request. However, that document allowed her adviser to electronically submit the application to Aviva on her behalf. Ms M says the signature was misused to bind her to exclusions that were only generated after the event. And she says Aviva accepted a signature that wasn't contemporaneous with the agreed terms, so the contract is unenforceable.

Ms M's concerns are that the Declaration document pre-dated the writing of the policy. By signing the Declaration Ms M agreed that;

> 'The Company's liability will not commence before it has been assessed and formally accepted the application, received any outstanding documentation or information and received the first premium, or an acceptable method of collecting it. If the application is not accepted at normal terms, the Company will advise me of its revised terms and await my agreement before starting the cover. The Company will tell me when the cover is in force.'

So, by signing the Declaration, the policy wasn't in force – it was instead pending assessment and acceptance by Aviva after the application was made. And I can see from an email that the adviser contacted Aviva on 8 October 2012 at 17:36 asking that the policy should start from 9 October 2021 and that the 'dd date 1st and the decs were faxed just now.' I take this to mean that the direct debit for the premiums was to be the first of the month and the Declaration Ms M signed had recently been faxed.

I wouldn't expect a life and CIC policy to start until the business assessed the risk – based on the circumstances of the customer given in their application – and the customer had to give their agreement to the submission of the application by the adviser and assessment by Aviva. And that is what Ms M did in signing the Declaration.

Ms M has concerns that the policy number was written on the Declaration after it was faxed through to Aviva. But this is what I would expect to see as it's clear the policy number wouldn't be known at the point the adviser faxed the application through to Aviva. Ms M says her signature was used to bind her to exclusions that she didn't agree to and she more recently questioned whether the signature was hers. But over and above Aviva providing the policy documents, which included the special provisions, it was the adviser's role to ensure it was Ms M's signature being used, make sure she was aware of those exclusions and assess whether the policy was still right for her.

So, I don't find Aviva has done anything wrong in that I don't find it unusual for a Declaration to pre-date the inception of the policy being applied for. The application itself had to be considered by Aviva in advance of it accepting the policy application and was followed up with additional policy documents being provided to Ms M.

Provision of the policy documents

Ms M says that she didn't receive a copy of the policy documents that detailed the exclusions, but Aviva says they were sent.

Further to the above statement in the Declaration, it went on to say that Ms M would receive;

- '…a Confirmation Schedule from the Company confirming details of the application received by the Company.
- I must check these details are correct and complete.
- If any of the details are incorrect or incomplete I must amend and return the Confirmation Schedule within 14 days. In such cases, the Company reserves the right to amend the terms or decline the cover.
- I agree that the contract will comprise the Confirmation Schedule, Plan Schedule and the Plan Conditions.'

So, Ms M was put on notice that Aviva would write to her with further details of the policy – whether that be at normal terms or revised – and she would need to take action to confirm their accuracy or contact Aviva if any of the details weren't correct. Those Acceptance Terms for the Term Assurance are recorded as being printed on 8/9 October 2012 and its clear from those Acceptance Terms that Aviva could provide Ms M Life and CIC cover but with special provisions. Those provisions were;

> 'Special Provisions
>
> Any critical illness claim on the life of [Ms M] will be excluded from the policy if it is caused by or results from; -
>
> *Total Permanent Disablement & Loss of Independent Existence'

I've seen a copy of Aviva's document dated 9 October 2012 and which was addressed to Ms M showing the cover it was able to provide. Ms M has said she didn't receive this.

I can see the letter sent was correctly addressed to Ms M's home address. While I accept some mail does go missing, most correctly addressed post does reach the intended recipient. Aviva hasn't told us of any record of returned mail. So, while I appreciate Ms M says she didn't receive the letter enclosing the policy document Acceptance Terms, on balance, I'm persuaded that the letter in question was printed on 9 October 2012 and sent to Ms M shortly afterwards. In other words, I think it's more likely than not, that this is what happened. And as Aviva isn't responsible for the safe delivery of mail, I can't blame Aviva for the fact that Ms M wasn't aware of the special provision exclusions of the policy because of any failure of a third-party postal service.

Aviva wrote separately on 8 and 10 October 2012 with confirmation of the set up of her direct debit instruction, the latter confirming the first direct debit for the premium would take place on 1 November 2012. And although the correspondence is undated, copy correspondence suggests Ms M was sent a 'cooling off notice' and 'notice of cancellation' which are separate from the Acceptance Terms and must be provided to the consumer before they are bound by a contract so would have been sent around the time of the sale.

And Aviva wrote to Ms M again on 16 October 2012 with an update about the Term Assurance policy and which included a copy of the Plan Conditions Alteration Document. Aviva further wrote to Ms M on 22 October 2012 with an update on her policy and

improvements to the CIC. So, overall, from the evidence presented to me it's clear Aviva had the correct address for Ms M and while it's understood that some post does go missing, I think it's more likely than not Ms M did receive some, if not all, documentation from Aviva. And if Ms M received later correspondence, further to the letter of 9 October 2012 which she says she didn't receive, or hadn't received the information she was expecting to receive – as outlined in the Declaration that Aviva would send Ms M Acceptance Terms for Term Assurance – then I would have expected Ms M either to contact Aviva or have asked her adviser to chase it. But there's no evidence Ms M took such action.

Ms M was also to pay monthly policy premiums of £14.45 for a period of 25 years which were debited from her bank account shortly after the policy started on the first of each month and with effect from 1 November 2012. So, she would have seen from her bank statement that the policy was live and could have chased for a copy of the Acceptance Terms if she hadn't received them or didn't agree that the policy had been set up in advance of receipt of those Acceptance Terms.

Ms M has said that three different policy proposals were generated, none of which were fully explained, and she wasn't given the opportunity to understand their contents. Aviva has explained that different policy documents will be generated if, as an example, the adviser adjusts the terms of the policy such as the cover. This would cause the provision of a new proposal. It would then be for the adviser to ensure the customer understood the policy terms and suitability. I find Aviva's response to this point to be compelling. I think it would be logical that new policy terms would be produced if the requested cover, or similar, was altered so from the information provided I don't find that the provision of more than one proposal to be unusual.

Aviva's decision not to ask for medical records

Ms M has complained that Aviva didn't ask her GP for medical records prior to the policy being issued. In signing the Declaration Ms M agreed to;

> '…the Company seeking information, including medical reports, from any doctor I have consulted about anything that effects my physical or mental health and I authorise the giving of such information. This consent shall remain valid for a period of up to six months after the start of the contract and I agree that if I have not disclosed all information relevant to my application, the Company may need to reconsider the terms offered to me or cancel my application.'

Because of Ms M's signature on the Declaration, Aviva was allowed to contact Ms M's GP or similar if it wanted to find out more information about her medical history or conditions than she had already provided during the application. Ms M has complained that Aviva didn't obtain a medical report from her GP. Ms M has referred to another product provider asking her GP for a medical report and she says that if Aviva had done the same it would have had sufficient evidence that the special provisions weren't needed and the exclusions were unnecessary.

But Aviva wasn't under any obligation to seek a medical report if it didn't think it was needed. The above inclusion in the Declaration didn't mean Aviva *would* seek medical evidence but that it *could* request such information if it needed to. However, upon review of the medical information Ms M did provide, Aviva concluded it was willing to provide cover but with exclusions which I'm satisfied it reasonably made Ms M aware of in the provision of the Acceptance Terms. The assessment post application was automated and not looked by an underwriter so Ms M's responses to the medical questions didn't trigger the need for an additional assessment that may have involved requesting medical details from Ms M's GP.

Aviva was acting in its role as underwriter of the policy so was ascertaining the level of risk it was prepared to take in providing cover for Ms M bearing in mind her declared medical history. It was for Aviva to decide how much risk it was prepared to take in providing that cover, and it is not the role of this service to interfere with that. I can only consider whether the outcome of Aviva's decision treated Ms M fairly and reasonably, and I can't agree that it didn't as I'm satisfied it made her aware of those exclusions. It wasn't under any obligation to seek further details about Ms M's medical circumstances prior to agreeing to provide cover if it concluded it didn't need to.

So, I don't agree Aviva has done anything wrong here. And while I accept Ms M may have looked elsewhere for a different policy if she had been aware of the exclusions, I haven't seen evidence she could have taken a policy with a different provider that didn't include similar exclusions.

But Aviva did misinform Ms M that no exclusions applied to the policy. While the outcome wouldn't have been any different – in that special exclusions did apply to the policy – clearly this was incorrect and no doubt would have caused Ms M considerable confusion. However, Aviva has apologised for this error and paid Ms M £200 which I think is fair and reasonable under the circumstances.

Incorrect agency code

The policy was sold to Ms M by an adviser who was an appointed representative of a business I shall call 'Business T' in my decision. Ms M says Business T said the adviser wasn't ever one its appointed representatives and as that business didn't receive any commission for the policy then Aviva accepted business from an unauthorised entity. But in its response to Ms M's complaint about this Aviva clarified on 19 February 2025 that the sale was made with the appointed representative of Business T. However, it accepted this should have been made clearer in 2023.

And looking at the regulator's register, I can see the adviser was an appointed representative of Business T from February 2010 to October 2013. And the adviser was also linked to another business for a similar period from February 2010 to July 2013. So, he was involved in both businesses at the time of the sale. The agency code of the former was applied to the policy and despite Ms M being misinformed of this at times, I am satisfied the correct agency was applied to the policy.

It's evident from Ms M's voice note she kindly made for me she feels strongly about this. However, I don't find this point has a significant bearing on the outcome of Ms M's complaint about Aviva's role as policy provider. While I accept Ms M has concerns saying there has been concealment and Aviva accepted business when it shouldn't have, I think it should be borne in mind that ultimately the insurance contract itself is between the policy holder and the policy provider so whatever reservations Ms M may have about the correct agency code for the adviser, that wouldn't have invalidated the contract between Ms M and Aviva.

Even if there was an administrative error with the wrong agency code being used – which I don't think was the case – I'm satisfied that in this case, both parties willingly entered a contract in providing/taking the policy. Ms M was provided with a life and CIC policy by Aviva which is what she was looking for at the time, even if her claim on that policy didn't work out as she had hoped. So, while I recognise Ms M's concerns, I don't find they impact on the outcome of her complaint about Aviva acting as policy provider.

Ms M has also said that Aviva disclosed her personal details including her address and medical information to a third party who then contacted her which had a big impact on her family. Any concerns about this need to be directed at the ICO and I understand that Ms M

has done this. Saying that, I would like to add I am extremely sorry for Ms M and her children that this happened which undoubtedly must have been very upsetting. If Ms M has any concerns about her welfare or safety, she should raise this with the relevant authorities.

Ms M has said that Aviva failed to make reasonable adjustments for her under the Equality Act 2010 when it had knowledge of her circumstances and poor health. But it is important I clarify that this service is unable to make a finding as to whether a business has breached a piece of legislation. That is a purely legal consideration and only a court of law can make a finding as to whether Aviva has breached the terms of the Equality Act, or any other piece of law. However, as mentioned above, I can consider whether Aviva has acted fairly and reasonably in its role as policy provider and I haven't seen anything to cause me to conclude that it hasn't.

Ms M made a SAR to Aviva in April 2025. She says data was missing from the information provided and that Aviva withheld the adviser's name. But as confirmed by the investigator, if Ms M has concerns about this then she will need to raise them with Aviva in the first instance to allow it the opportunity to address any complaint about that before it can be considered any further. So, it's not something I can look at in my decision.

That being said, I appreciate Ms M is of the opinion that any continuing and potentially further information she gathers as a result of her SAR – or from elsewhere – will add weight to her arguments raised about Aviva. But from the information and evidence I have been provided, I am satisfied I have sufficient information for me to make a fair and reasonable decision about the crux and merits of this particular complaint, hence me issuing this final decision. And once a final decision is issued, the merits of that complaint can't be reconsidered by this service.

And in consideration of this complaint, as referred to above, while Ms M has provided detailed and lengthy submissions, I have only considered the information and evidence that I consider relevant to the crux of and outcome to this complaint. I should make clear I can't address other points and issues Ms M has made and continues to make on the basis she considers they are relevant and will alter the outcome to her disputes with Aviva.

Our approach is inquisitorial, not adversarial, and the purpose of the decision is to provide a report of my determination as to what is fair and reasonable in the circumstances, not a point by point response to the submissions made by the parties to the complaint. To be clear, and fundamental to the outcome, I am satisfied I have sufficient information and evidence for me to make my decision. And in doing so, I haven't considered the need to seek more information from the parties or have doubts that pertinent information or evidence is missing.

I appreciate Ms M now has a complete lack of trust for Aviva, as well as the other financial businesses involved, and the relationship has broken down. This is understandable bearing in mind Ms M's disappointment and upset when her claim on the policy – which she took in good faith in case of the situation she now finds herself in – was rejected. After which Ms M started looking into the background and didn't agree with what took place around the sale was right and after. And Ms M was misinformed on occasion, or didn't receive the answers she was looking for, which further caused her to lose faith.

The outcome is that Ms M isn't confident in believing anything she is told at face value and believes there is a hidden agenda. But I would like to reassure Ms M I have looked at what I consider to be are the relevant facts and pertinent evidence surrounding Ms M's complaint. My role is impartial and independent of the parties – which I hope is a comfort to Ms M – and I am satisfied Aviva has acted fairly and reasonably in its role of policy provider and I haven't seen anything to suggest it wasn't acting with good intent.

I fully appreciate Ms M is likely to dispute this and I would like to say again I have a great deal of sympathy for Ms M. She is in a very difficult and troubling position, and I am very sorry to hear of the circumstances Ms M finds herself in as well as her poor health. But I must be fair to the parties and I haven't been given any evidence for me to conclude Aviva has done anything wrong over and above the issues it has already acknowledged and paid Ms M for the distress and inconvenience caused.

In conclusion, I am satisfied Aviva acted fairly and reasonably in its role of product provider;

- The pre-dated Declaration allowed for Ms M's application to be submitted to Aviva for assessment and this is what I would expect to see.
- I am also satisfied Aviva provided Ms M with the policy documents that detailed the exclusions.
- Aviva wasn't obliged to seek Ms M's medical records in order to offer her insurance cover on agreed terms.
- Aviva has corrected the information given about the agent/code and the contract is between the policy holder and the policy provider.
- I have detailed the complaint points I can't consider, either because they have already been dealt with by this service, are better dealt with by another agency or need to be referred to Aviva in the first instance. And I hope I have been clear in my assessment that this final decision can't be revisited, irrespective of any further information Ms M finds and considers to be new or adds more weight.

I fully recognise Ms M's understandable strength of feeling about her complaint. It clearly means a lot to her, and I can see why, but for the reasons given I don't uphold the complaint. While Ms M will no doubt be disappointed, I hope my decision goes some way to allowing Ms M to be able to draw a line under her complaint which clearly has been very difficult for her.

My final decision

For the reasons given, I don't uphold Ms M's complaint about Aviva Life & Pensions UK Limited

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms M to accept or reject my decision before 29 December 2025.

Catherine Langley
Ombudsman