DRN-5842591

The complaint

Mr and Mrs F as trustees of the F Trust (Mr and Mrs F) complained that Aviva Life & Pensions UK Limited declined a claim on their relevant life insurance policy.

What happened

A relevant life insurance policy was taken out in February 2023 with Mr F as the covered individual. I'm sorry to hear Mr F suffered from a heart condition in December 2024. I wish him all the best for his future treatment and recovery. He raised a claim on his policy which Aviva declined as they didn't think the policy terms and conditions had been met. Mr and Mrs F were unhappy and brought the complaint to this service.

Our investigator didn't uphold the complaint. He didn't think Aviva had unfairly declined the claim. Mr and Mrs F appealed. They didn't think Aviva could rely on the medical evidence from his consultant. They also didn't think Aviva had considered the manual element of his employment.

Prior to our investigator's outcome, Mr F had had a follow-up with his consultant. Mr F had provided this to Aviva to consider the claim further. Aviva declined the claim again as they still didn't think Mr F had met the policy terms and conditions. Aviva agreed we could include the latest decline in the complaint.

Our investigator issued a further outcome but still didn't uphold the complaint. They still didn't think Aviva had unfairly declined the claim. Mr and Mrs F appealed. They didn't think the investigator had considered their previous points. As no agreement could be reached, the complaint has been passed to me to make a final 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.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether Aviva acted in line with these requirements when it declined Mr and Mrs F's claim.

Having done so, and whilst I appreciate it'll come as a disappointment to Mr and Mrs F, I've reached the same outcome as our investigator.

At the outset I acknowledge that I've summarised their complaint in far less detail than Mr and Mrs F have, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I'm satisfied I don't need to comment on every individual point to be able

to reach an outcome in line with my statutory remit.

As a starting point, it's important to understand what the policy terms and conditions say. The policy sets out that a claim is covered when the following is met:

"*Employee significant illness benefit*

Our criteria

*We'll pay this if the **life covered** meets the definition for one of our defined employee significant illness conditions during the **policy term**, survives for at least 10 days, and the condition results in the retirement or anticipated retirement of the **life covered**.*"

The definition for the relevant employee significant illness condition is as follows:

"***Severe heart condition** – of specified severity*

A definite diagnosis by a consultant cardiologist of the failure of the heart to function as a pump, evidenced by either of the following:

- *clinical impairment of heart function resulting in permanent loss of ability to perform physical activities to at least class 3 of the New York Heart Association (NYHA) classification of functional capacity (i.e. heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain): or*

- *ejection fraction measurements showing a permanent reduction in the heart's efficiency to a level of 40% or less. Measurements of ejection fraction should be demonstrated through either MRI scans or echocardiograms, but not a mixture of the two.*

The following are not covered:

- *all other forms of heart disease.*"

Following his claim, Aviva requested a medical report from Mr F's treating consultant. In this report, the consultant advised that Mr F had the following:

"*No exercise limitation, no breathlessness, no chest pain on exertion"*

Mr F has said he was informed by a consultant at the time that he was deemed to be NYHA class 3. He also didn't think it was fair to rely on the consultant's report as they spent five minutes with him and didn't perform any tests.

I've not seen any evidence in his medical records that Mr F was classed as NYHA level 3. An insurer can only rely on the medical information their provided with to assess claims. I don't think it's unreasonable for Aviva to have relied on the medical report they received. Based on the information in the report, I don't think it was unreasonable for Aviva to have declined the claim based on Mr F's health against the policy criteria. If Mr F is unhappy with the information in the report, he would be able to discuss it further with the relevant consultant. However, Mr F had a further consultation in July 2025. This information now supersedes the consultant's report. Following the consultation, Mr F's consultant confirmed the following:

- "*His ejection fraction on his recent echo was 42%"*

- *“I would put him in NYHA class 2”*

Whilst I empathise with Mr F’s situation, I still don’t think Aviva have unfairly declined the claim. As set out above, under the policy definition, Mr F needs to have an ejection fraction of 40% or less, but his is 42%. Or he needs to be class 3 under the NYHA classification of functional capacity but he’s currently class 2.

Mr F has raised about the manual nature of his employment. Again, I empathise with his situation, but this isn’t a criterion of the policy. Mr F needs to meet the definition as set out in the policy above.

I’m very sorry that my decision doesn’t bring Mr and Mrs F more welcome news at what I can see is a very difficult time for them. But in all the circumstances I don’t find that Aviva has treated Mr and Mrs F unfairly, unreasonably, or contrary to the policy terms and conditions in declining the claim.

I note that Mr F has since had a further consultation with his consultant. Should his health have deteriorated, or they’ve provided some additional comments on his condition, he’d need to raise these with Aviva to consider further.

My final decision

For the reasons I’ve given above, my final decision is that I don’t uphold this complaint.
I don’t require Aviva Life & Pensions UK Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mrs F and Mr F as trustees of the F Trust to accept or reject my decision before 29 October 2025.

Anthony Mullins
Ombudsman