DRN-5859229

The complaint

Mr M is unhappy that Aviva Insurance Limited have declined to cover a claim he made on his private medical insurance policy.

What happened

Mr M made a claim on his private medical insurance policy. He's unhappy that Aviva declined the claim on the basis it fell within the moratorium.

Mr M complained to Aviva but they maintained their decision was fair. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. She thought Aviva had fairly applied the policy terms, based on the available evidence. Mr M didn't agree and asked an ombudsman to review his complaint. In summary, he said his claim was for a new condition and his previous symptoms were unrelated to this. He said Aviva had placed an onus has been on him to self-diagnose.

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.

The relevant rules and industry guidelines say that Aviva has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

Mr M's policy has a moratorium period. This means there are exclusions which apply to claims related to pre-existing conditions. The relevant term says:

> "Moratorium (mori)
>
> We do not cover treatment of any pre-existing condition, or any related condition, if you had:
>
> • symptoms of
>
> • medication for
>
> • diagnostic tests for
>
> • treatment for, or
>
> • advice about that condition in the five years before you joined the policy
>
> However, we will cover that condition if you do not have:
>
> • medication for

• diagnostic tests for

• treatment for, or

• advice about that condition during a continuous two year period after you join the policy.

With mori underwriting the claims process may take a bit longer, as each time you make a claim we'll look at your medical history, and may ask for information from your GP, to understand if your symptom or condition is new or pre-existing."

I'm satisfied it was fair and reasonable for Aviva to decline the claim because:

- Mr M's claim was for dysfunction/obstruction of the eustachian tube. He described this as causing symptoms of fullness in ears, neck pain and tinnitus.

- I think Aviva reasonably concluded that this was related to Mr M's pre-existing condition of sinusitis and tinnitus, for which he received prescription medication. Based on the available medical evidence I think that was a reasonable conclusion.

- Mr M's GP provided a letter saying that Mr M had a history of sinusitis, a deviated nasal septum and tinnitus. The GP said Mr M was experiencing new pressure symptoms which appeared to be unrelated. However, the GP didn't give any explanation about why that was their opinion or explain what clinical evidence supported that assertion. So, I think Aviva reasonably concluded that evidence didn't support the claim being paid.

- Mr M provided a letter from December 2022 from a consultant. This referred to a diagnosis of tinnitus and recurrent sinusitis. It also said Mr M experienced facial pains when his sinuses were causing him difficulties. Given the similarities between the symptoms, I think Aviva fairly concluded the exclusion applied.

- I appreciate that Mr M says he's had confirmation that the symptoms he experienced weren't linked to his pre-existing conditions. However, I don't think that was reflected in the evidence presented to Aviva during the claims process.

- I appreciate that Mr M feels that he was asked to self-diagnose but I think they reasonably asked during the claims process what issues the symptoms were causing. And, based on the answers provided, I think Aviva reasonably concluded the moratorium exclusion applied.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 27 January 2026.

Anna Wilshaw
Ombudsman