DRN-5951612

The complaint

Mrs S is unhappy that Aviva Insurance Limited (Aviva) declined her private medical insurance claim. She's also unhappy with how Aviva handled her claim.

Mrs S is being represented on this complaint. For ease, I will refer only to Mrs S throughout this decision.

What happened

Mrs S took out a private medical insurance policy which started in May 2023 – Aviva is the underwriter. This policy was accepted from a previous provider on a continued medical exclusions basis. The moratorium start date was 27 March 2020.

The policy was set up on a moratorium underwriting basis. This means that no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required. And any pre-existing conditions from the previous five years of starting the plan are excluded which can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

In September 2024, Mrs S started a claim for cataract procedures to be carried out on both her eyes. She sent Aviva some information to assess the claim. Aviva needed further information and requested this from Mrs S.

Mrs S made a complaint to Aviva about the delays in assessing the claim. A decision was made in January 2025 by Aviva to decline the claim.

Mrs S had the procedures carried out in January 2025 and in February 2025 privately. She's requesting a reimbursement of the costs incurred for the consultation and the procedures for both eyes that were carried out.

Mrs S added further complaint points to Aviva. It responded and said the condition Mrs S claimed for was pre-existing, which meant that it wasn't covered under her policy. Aviva apologised and offered £100 compensation for the delays in processing the claim.

Unhappy, Mrs S brought her complaint to this service. Our investigator didn't uphold it. He didn't think Aviva had treated Mrs S unfairly.

Mrs S disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me.

I issued a provisional decision on 22 October 2025. I said the following:

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account,

amongst other relevant considerations, such as industry principles and rules, the policy terms and the available evidence, to decide whether I think Aviva handled Mrs S's claim fairly.

First, it's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mrs S. Rather it reflects the informal nature of our service, its remit and my role in it.

The policy terms and conditions

I've started by looking at the relevant terms and conditions of Mrs S's policy. Page 24 explains the terms of the moratorium underwriting. This states:

> *'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'.*
>
> *A pre-existing condition is defined in the policy on page 37 as:*
>
> *'Pre-existing condition*
>
> *Any disease, illness or injury for which:*
>
> - *You have received medication, advice or treatment, or*
> - *You have experienced symptoms*
>
> *Whether the condition has been diagnosed or not before you joined the policy'.*

Having considered the above policy term, I think it's clearly set out.

The policy also states that with the moratorium underwriting, the claims process may take a bit longer, as each time a claim is made, the medical history is looked at. And Aviva may ask for information from the GP to understand if the symptom or condition is new or pre-existing.

I think this is also clearly set out.

Has the claim been unfairly declined?

Aviva says Mrs S's medical records show that the cataracts were pre-existing - prior to the policy starting in March 2020. So, the claim isn't covered.

Mrs S says she had no symptoms; the optician confirmed that she had no visual impairment and no known ocular history. She also says a suspected possible cataract was mentioned in 2019 but was dismissed later that year in a follow up appointment. And subsequent reports show Mrs S had no visual impairment or symptoms for the five years since lockdown. She didn't get cataract tests but regular prescription check-ups.

The issue in dispute centres around the records provided by the optician. I've reviewed the medical information provided.

In March 2019, notes from the check-up say that cataracts were detected in both eyes. The notes refer to the left eye, but there's reference to the right eye and the cataract being 'mild'.

There's also reference to a discussion with Mrs S at the time, and she confirmed she had private medical insurance and would need a referral or would need to consider NHS referral through the GP. A six-month check-up was arranged.

In September 2019, at the six-month follow-up appointment, nuclear cataracts were noted in both eyes. Notes state that there are occasional floaters and there's been no increase lately. Mrs S said she wasn't having problems with the cataract.

Mrs S had no eye check-up appointments in 2020.

In February 2021, the optometrist recommended 12-month monitoring on the right eye for the cataract.

In March 2022 the optometrist recommended 12-month monitoring on both eyes for cataracts. The same happened in March 2023. In April 2024, Mrs S was referred for cataract surgery on both eyes.

She had the cataract procedures carried out 14 January 2025 and in February 2025.

Based on the evidence available, it's clear that cataracts were detected in both eyes in March 2019. The moratorium underwriting on the policy started in March 2020. Therefore, the claim isn't covered. The notes from the eye appointments show that Mrs S received advice and was being monitored for the cataracts. She experienced symptoms, whilst they were mild to begin with, they were nevertheless there prior to the start of the policy. I think Mrs S had the cataract before March 2020 and, in line with the policy terms and conditions, this is considered a pre-existing condition – whether diagnosed or not.

The information also shows that Mrs S was not symptom-free for a continuous two-year period. For this reason, the claim is also not covered.

Having carefully considered the information, I'm satisfied that Aviva hasn't declined the claim unfairly.

I've also considered Mrs S's comments about whether the specialist who carried out the procedures was covered under the policy and the information she was given about this. I don't think I need to address this because ultimately, I've found that the claim isn't declined unfairly.

<u>Handling of the claim</u>

Mrs S says there wasn't just a delay in the claim being processed but Aviva also asked for information which had already been sent on more than one occasion. And further customer service issues were experienced such as Aviva not clearly informing Mrs S about whether the specialist was covered.

Mrs S says, based on the telephone conversations, while the claim was being considered, they had the consultation with the specialist. She believed the claim would be covered by Aviva at this point.

I understand that Mrs S's son had several telephone conversations and there was also confusion about whether Mrs S's son was able to discuss her details with Aviva. This took a few months to get sorted. I also note that the Aviva adviser realised the claim was ongoing for some time in January 2025 and therefore wanted to ensure that Mrs S had the answer to her claim quickly at this point.

Whilst I'm satisfied the claim itself isn't covered, I do think that Aviva provided inadequate customer service, with poor communication and unnecessary delay. So, the matter at hand is what would be an appropriate level of compensation. I don't doubt that the lack of clarity has caused distress and inconvenience, and I think it's fair to say this has been a frustrating time for Mrs S.

I've also taken into account that Aviva apologised and followed its process in requesting the relevant information from Mrs S so it could assess the claim. But it took longer than it should have even having taken this into account. I appreciate that it's not unusual for insurers to ask for additional information.

In terms of the handling though, I think Aviva could have handled this better. I can't make Aviva responsible for covering the claim and it was Mrs S's choice to go ahead with the procedures knowing that the claim wasn't covered.

But having taken into account everything, I think it's fair and reasonable for Aviva to pay the consultation fee that's been incurred by Mrs S. The consultation took place whilst Mrs S was waiting to hear about her claim decision and at this point, her understanding was that the claim was covered. It's also not in dispute that delays were caused during this time. So, I don't think it's unreasonable for Aviva to reimburse this amount to Mrs S.

And I think it's fair and reasonable for Aviva to pay £200 compensation in total for the distress and inconvenience caused overall. I fully appreciate that Mrs S thinks a more significant amount is fair in the circumstances, but I don't agree.

It's not our role to punish the business. Awards of compensation are primarily to reflect the impact on the consumer. I have a great deal of sympathy for the situation Mrs S found herself in. And I can understand why she believes she should receive a more significant amount for the trouble and upset she has incurred. However, as an alternative dispute resolution service, our awards are lower than she might expect and probably less than a court might award.

Mrs S says based on what happened, the level of premiums she's paid doesn't in any way reflect the standard of service she's received. And she should therefore receive a refund of the premiums. I'm afraid I don't agree. Whilst I understand that the claim wasn't covered on this occasion, she's continued to have the benefit of cover for other potential medical issues on the policy.

Having thought very carefully about what Mrs S has said, my intention is to direct Aviva to reimburse Mrs S for the consultation fee she paid and for Aviva to pay £200 total

compensation for the distress and inconvenience caused to her. I'm currently satisfied this is fair and reasonable.

Putting things right

I intend to direct Aviva to do the following:

> *• Reimburse Mrs S the consultation fee she paid to the specialist.*
> *• Pay total compensation of £200 (including the £100 already paid) for the distress and inconvenience caused.*

Both parties responded to the provisional decision. I've considered carefully the further comments to which I'll respond to below.

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.

Mrs S said in summary:

- Whilst she is pleased with the compensation recommended and the refund of the initial diagnostics tests that were carried out, this is not commensurate with Aviva's actions, and this service has continued to act favourably towards Aviva.
- Her policy started in May 2023, not March 2020.
- She complained about the delays and poor service *before* the claim was declined and this that hasn't been reflected in the provisional decision.
- Aviva says it will check the specialist in the policy but none of its staff members checked that the referral was covered – it had all the information from the start. This issue hasn't been addressed.
- This service should impose fairer, more significant compensation to consumers and should tell the insurance companies to improve its performance. The incompetence and indifference will continue without sufficient incentive to take responsibility and do better.

Aviva said:

- Mrs S's policy is an Expert Select and has a policy excess of £500. Even if the claim was accepted, this invoice would not have been paid as the excess would have applied, and Mrs S is liable for this amount.
- The underwriting on the policy continued from March 2020 and the policy started in May 2023.

Having considered the additional comments from both parties, I'll partially upholding the complaint. I'll explain why.

The crux of the issue is that the claim for the cataract procedures has been declined by Aviva. This is because there was a note of bilateral nuclear cataracts in September 2019. The policy was taken out in March 2020 on a continued moratorium underwriting basis from a previous provider and started with Aviva in May 2023. Therefore, the cataracts were considered to be pre-existing. Mrs S had annual eye tests since 2021, and notes were made of cataracts showing there were symptoms and advice was given. So, the claim also doesn't meet the two years of being symptom-free. I understand it's difficult to recall something that's happened from five years ago, but the notes show the cataracts were present. I'm therefore satisfied the claim isn't covered and Aviva hasn't treated Mrs S unfairly in declining the

claim.

Mrs S comments that the policy only started in May 2023. Aviva has shown the policy started at this point, but the moratorium underwriting continued from a policy that started in March 2020. I don't agree that the policy terms and conditions apply from May 2023 and that the earlier date of March 2020 ought not to be taken into account. The membership certificate for 28 May 2023 confirms that the moratorium start date was 27 March 2020.

I understand that Mrs S was unhappy about the delays and service before she was unhappy with the claim decision. I appreciate her comments, and it wasn't my intention to put more weight over the other. I've considered both aspects of the complaint and I do understand the complaint about the claim decline was made after and added onto the initial complaint about the delays and service.

Mrs S also says that Aviva didn't at any time inform her that the specialist wasn't covered – even though it had all the information from the start. The claim was declined for two reasons.

Firstly, because Mrs S's condition was considered to be pre-existing. Based on the evidence provided, I'm satisfied the claim is not covered under her policy.

Secondly, Aviva said, the specialist that carried out the consultation and the procedures, wasn't covered on its cataract network which is a requirement of the policy. So, for this reason, the claim also wasn't covered. So, the invoice for the consultation wasn't settled. Aviva also said in response to my provisional decision that a policy excess of £500 would have applied and therefore it wouldn't have settled the consultation invoice as Mrs S would have been liable for this.

Whilst I understand that Mrs S would like me to address the issue of the specialist not being covered, I don't need to necessarily to do this. The test in the first instance was whether the condition was pre-existing. I'm satisfied, having looked at everything that it was pre-existing – I provided my reasons for this in my provisional decision. So, even if I were to address the issue about the specialist, I think the claim is fairly declined. I realise that Mrs S sent Aviva the information about the specialist, but until it fully reviewed the information, it wasn't able to validate the claim. By this time, Mrs S had her consultation with the invoice being sent to Aviva for settlement. I note emails from Mrs S's son confirming that treatment wouldn't be put off. However, it's not unusual for an insurer to have all the information before it's validated a claim and a decision is made on whether it's covered or not. Mrs S went ahead with the knowledge that the claim had been declined, and I can't make Aviva responsible for this. I do think though that delays were caused and several call for updates had to be made.

This service is not the regulator but a dispute resolution service. Our role is to look at the individual merits of a complaint. So, the level of compensation reflects this. I fully appreciate the strength of feeling Mrs S has on this matter, but it's not for this service to pay significant levels of compensation with the aim of improving the overall performance of a business.

I'm satisfied that Aviva has declined the claim fairly and in line with the terms and condition of the policy.

I understand Aviva's comments that the consultation invoice would not have been paid had it accepted the full claim for the cataract procedures. This is because there is a £500 excess on the policy. I agree that this invoice would not have been payable. However, I think Aviva should pay compensation equivalent to the cost of the invoice to Mrs S. This is because delays were caused whilst Mrs S was trying to get her claim authorised from the period November 2024 to January 2025. She was waiting for a claim decision, and it took longer

than it should have done. She was under the impression that this invoice would be paid. Aviva could have updated Mrs S better by providing more meaningful updates. So, I think Aviva should pay £312 as compensation to Mrs S. I'm satisfied the claim for the procedures is not covered.

And for the overall service provided to Mrs S, having reviewed everything, I'm satisfied that a total of £200 compensation for the distress and inconvenience caused is fair and reasonable.

Putting things right

I direct Aviva Insurance Limited to pay Mrs S:

- £312 compensation equivalent to the cost of the consultation invoice for the lack of communication and the lack of meaningful updates to Mrs S whilst she awaited an answer to the claim.
- £200 (including the £100 already offered) compensation for the distress and inconvenience caused for the overall delays and poor communication caused.

Aviva must do this within 28 days of the date on which we tell it Mrs S accepts my final decision. If it takes longer, Aviva must give Mrs S a meaningful update setting out the timeframe when it pay this.

My final decision

For the reasons give, I partially uphold Mrs S's complaint about Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S to accept or reject my decision before 12 December 2025.

Nimisha Radia
Ombudsman