DRN-5991309

The complaint

Mr A complains about the value of the insurance settlement he received from Aviva Life & Pensions UK Limited, following a claim made under his life and critical illness cover.

What happened

The background to this complaint is well known to the parties, so I won't repeat all the details here. In brief summary, in 1993, Mr A took out a flexible protection plan, which provided life and critical illness cover.

Most unfortunately, in January 2025, Mr A was diagnosed with cancer. He made a claim for critical illness benefit which was accepted by Aviva. But Mr A was unhappy with the payment he received. He said that as well as the critical illness benefit, he should also have received the fund value of the investment element of his plan.

Aviva disagreed, saying that the benefit payable was the greater of the sum assured and the fund value of the investment element.

Mr A complained, but Aviva maintained its stance, so Mr A came to the Financial Ombudsman Service. But our investigator didn't uphold his complaint, so Mr A asked for an ombudsman to review everything and issue 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.

Having done so, I'm not upholding this complaint. I appreciate this will be disappointing news for Mr A and I'm sorry about that. I'll explain my decision, focusing on the points and evidence I consider material to the outcome. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focused on what I think are the key issues. The rules that govern the Financial Ombudsman Service - an informal dispute resolution service - allow me to do this. So, if I don't refer to a specific point or piece of evidence, it's not because I haven't thought about it. Rather, I don't think it changes things. 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.

Mr A's plan allowed him to withdraw funds from the investment element. But withdrawal would trigger a review to assess whether the premiums paid were still sufficient to maintain the level of cover. If they were not, Mr A would be offered the option of increasing the premium or reducing the sum assured. But Mr A feels he's lost out because Aviva has confirmed he could've withdrawn funds from the investment element of his plan and then made a critical illness claim.

As part of my review of this complaint I requested the calls between Mr A and Aviva. I've listened to all of them. The calls confirm Mr A's account of events and are consistent with his evidence to us. In summary, Mr A:

- called to enquire about making a CIC and during that call also asked for a fund valuation
- did not make any request to withdraw funds from the investment element of his plan
- enquired about what payout he would receive after he'd been told his claim was accepted
- challenged the meaning of the benefit payment terms after he'd received his payment.

I've reviewed the plan terms. In my view, the key issue in this complaint relates to the interpretation of the terms dealing with payment of benefits. Under section 13, the critical illness benefit is paid in accordance with the terms relating to payment of a death benefit, cited in section 11. These state the benefit shall:

- *'… equal the greater of the Sum Assured and the value of the Units cancelled at the Bid Prices established at those Valuations.'*

Mr A says the wording of this term means he's entitled to the value of the critical illness benefit and the fund valuation. Aviva says it means Mr A's payout would be whichever is the greater of those two things. Mr A also feels that as the term is, at best, ambiguous, it should be construed in his favour. But I'm afraid I don't agree with Mr A's interpretation of the term, or that it is ambiguous.

To my mind, the meaning of section 11 is clear and is consistent with Aviva's interpretation. It says it is the greater of these two things – the sum assured and the value of the units - not both of them. Moreover, if Mr A's interpretation were correct, the words 'the greater of' would be unnecessary. Mr A's interpretation would be right without those words, that is, if the plan term just said, '*the benefit shall equal…the Sum Assured and the value of the Units.'*

Mr A says Aviva has treated him unfairly and should've advised him of his options. But the primary reason Mr A contacted Aviva was to make a critical illness claim. Aviva dealt with the scenario Mr A presented to them. I acknowledge that Mr A also requested and was provided with a fund valuation. But on the basis of that enquiry, I don't think it's reasonable to say Aviva should have given Mr A information about the way his plan worked.

At this stage, there was no indication that Mr A might've misunderstood the benefit payment terms. And Aviva's call handlers – not themselves qualified to give advice – were primarily responding to his enquiries about making a claim. It was always open to Mr A to ask for clarification about how his plan worked or take independent advice. But from what Mr A has said to us, I don't think he would've thought about this, or about withdrawing part of the investment element of his plan – something he was aware he could do – because he had a clear view about how his plan worked.

Mr A has also indicated that Aviva failed in its duty towards him, both as a vulnerable customer and in terms of avoiding foreseeable harm. Mr A has disclosed a neurodevelopmental condition to our service. Aviva has said it was not aware of this and that no specific vulnerabilities were disclosed, although it's acknowledged Mr A would've been vulnerable, due to his recent diagnosis.

From what I've seen, Aviva responded appropriately and as I'd expect a business to, where a customer makes contact regarding a claim about a recent cancer diagnosis. Taking this into account, as well as the clarity of Aviva's plan term, I don't see that Aviva's actions have disadvantaged Mr A.

I say this because, fundamentally, the plan has operated as it should have and this complaint centres on a misunderstanding about how it worked. Mr A asked for a fund valuation. He didn't enquire about the plan payment terms until after his claim was accepted. I think this is likely because he didn't think he needed to, firmly believing he would receive both the critical illness benefit and the fund value. Unfortunately, this was incorrect.

I can only ask a business to do something different if I think it's done something wrong in the first place. That's not the case here. I can fully appreciate Mr A's frustration with the situation. But I don't think Aviva has acted unreasonably or failed in its regulatory obligations towards him, as it has settled his critical illness claim according to the terms of his plan. It follows I'm not going to ask Aviva to do anything more in respect of this complaint. Once again, I'm sorry to send unwelcome news to Mr A.

My final decision

For the reasons given above, my final decision is that I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 25 February 2026.

Jo Chilvers
Ombudsman