DRN-6040053

The complaint

Mr and Mrs J are unhappy with the service they received from Aviva Insurance Limited when Mr J needed to claim on his travel insurance policy.

What happened

Mr and Mrs J held a travel insurance policy, linked to a package bank account. Mr and Mrs J took out the 'travel pack' in 2022 and disclosed information about Mr J's health. The policy has remained in place since then with exclusions for claims arising from an irregular heartbeat and heart failure.

Mr and Mrs J were on holiday when Mr J became unwell with cardiac symptoms. He was taken from the island he was visiting to another island for treatment and then returned home. Aviva hadn't agreed to cover the claim but did so under a 'duty of care' arrangement meaning that Aviva hadn't accepted it would be responsible for the costs.

Ultimately Mr J's claim was declined as Aviva said there were exclusions for cardiac problems. Mr J didn't think this was fair and also said that the options relating to the treatment options weren't made clear and he might have made different decisions about his treatment if he'd been better informed.

Our investigator looked into what happened. He didn't think Aviva had fairly relied on the Consumer Insurance (Disclosure and Representations) Act 2012(CIDRA) when declining the claim as he didn't think Mr J had made a qualifying misrepresentation. However, he thought Aviva had fairly relied on exclusions in the policy relating to Mr J's cardiac issues. Overall, he thought Aviva had offered reasonable assistance and explained to his family that the costs may not be covered when providing assistance. He did note that there were some customer service issues and Aviva offered to pay £400 compensation for those issues. Our investigator concluded that was fair and reasonable.

Mr and Mrs J asked an ombudsman to review their complaint. In summary, they highlighted that there could have been other cheaper alternatives to moving Mr J to the island he was treated on and that they'd been denied the opportunity to make their own arrangements. They also questioned how the compensation figure of £400 had been arrived at. So, the complaint was referred to me to decide.

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.

I'm sorry to read of the circumstances which led to Mr and Mrs J making a claim. I understand it was a difficult time and that they have incurred significant medical costs which need to be repaid. I have a lot of empathy with their circumstances.

Aviva has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably. The policy terms explain the policy doesn't offer cover for claims arising

directly or indirectly from a pre-existing medical condition. The policy terms also contained specific exclusions for claims arising from an irregular heartbeat and heart failure.

I'm not upholding this complaint because:

- I'm satisfied the information about the exclusions was provided to Mr J and it was made sufficiently clear to him when he put the policy in place in 2022. The exclusion was set out on the policy schedule and was discussed with Mr J during a call. It was for Mr and Mrs J to ensure that the policy in place continued to meet their needs and arrange alternative cover if they wanted cover for those conditions.

- Mr J's claim arose because he experienced cardiac symptoms and required urgent surgery to correct an arrythmia caused by his defibrillator (which had previously been surgically implanted). I don't think it was unreasonable for Aviva to decline the claim in line with the policy terms. I think Aviva reasonably concluded the condition was directly or indirectly linked to the excluded medical conditions.

- As I think it was reasonable for Aviva to decline the claim based on the exclusion alone I don't think whether Mr and Mrs J made a misrepresentation is central to the outcome of this complaint. So, I don't need to reach a conclusion on this point.

- Aviva were entitled to validate the claim and consider Mr J's previous medical history, the available medical evidence about his current condition and whether the exclusion applied. That's standard industry practice and is also reflected in the terms of the policy. However, I think some of the communication around these issues could have been clearer as the impact of the exclusion could have been explained more promptly and clearly to Mr and Mrs J's daughter (who was assisting them).

- Overall, I'm persuaded Aviva acted fairly and reasonably when handling the claim and assisting Mr and Mrs J under a 'duty of care' arrangement. Mr J required urgent medical treatment and was able to access it, with assistance from Aviva. I'm satisfied Aviva made it sufficiently clear that they were not guaranteeing they would cover the costs incurred as they hadn't accepted the claim was valid.

- Mr and Mrs J feel that they should have been given a breakdown of costs and alternative treatment options so they could have made a more informed choice about the treatment options based on cost. However, in the circumstances I don't think that would have been reasonable. It would have involved sourcing information about costs and treatment from other facilities and providers during a time sensitive and urgent medical assistance claim. So, I think that would have most likely further complicated matters and also may have placed Mr J at risk.

- I think Aviva reasonably relied on the information available to them about accommodation options for Mr J's daughter. They were told by the hospital that there wasn't an option for her to stay there and so I think it was reasonable for Aviva to arrange a hotel for her instead.

- I've also thought about Mr and Mrs J's argument that they'd have acted differently. In the circumstances of this case and bearing in mind the seriousness of Mr J's condition, I'm not persuaded it is most likely they would have done so. I accept it's possible they may have been able to access alternative treatment via different means or sourced alternative providers at a lower cost. But, having weighed up the available evidence, I think it's most likely Mr and Mrs J would have followed the treating team's recommendation to move Mr J to a facility where he could access treatment as

quickly as possible and in a hospital which had the facilities to treat him. Considering the urgency of the situation, Mr J's location and the available options I think it's most likely they would have opted for the quickest way to get Mr J treatment with the minimum inconvenience.

- Aviva has offered a total of £400 compensation for the customer service issues that I've outlined above. I think that fairly reflects the impact of the distress and inconvenience caused to Mr and Mrs J by their expectations not being appropriately managed and unclear communication at some points during the claims process. It was understandably frustrating and worrying for them to learn later in the claims process that there was an exclusion which was relevant to the claim. So, I accept that they were caused considerable distress, upset and worry when they were later made aware of this.

Putting things right

Aviva needs to put things right by paying Mr and Mrs J a total of £400 compensation. This amount is not to be deducted from the outstanding claim balance and should be paid to Mr and Mrs J directly.

My final decision

I'm partly upholding Mr and Mrs J's complaint and direct Aviva Insurance Limited to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs J and Mr J to accept or reject my decision before 18 February 2026.

Anna Wilshaw
Ombudsman