

The complaint

Mrs P is unhappy with Aviva Life & Pensions UK Limited's decision to alter the terms upon which it offered her an income protection policy.

What happened

Mrs P applied for an income protection policy, through a financial adviser, in December 2024. She said Aviva originally offered her a policy with a four-week deferred period, however, later changed it to 26-weeks and added an exclusion to the policy. Mrs P also said it took Aviva around five months to incept the policy and when it eventually did, it didn't tell her about the changes made to the policy terms. Mrs P said when she questioned Aviva about this, its underwriter responded using arbitrary and speculative reasoning, which she said wasn't supported by her medical evidence.

Mrs P said Aviva added a strict income requirement to the policy and said that she'd have to maintain an income of at least £170,000 in order to claim.

Aviva said Mrs P was under investigation for a lump on her left knee at the time she applied for the policy in December 2024. It said this affected the terms upon which it offered cover. It decided to increase the deferred period to cover the associated risks and add an exclusion for any disease or disability arising from the condition and its treatment, including any complications. It accepted the application process took longer than usual but said there were no unnecessary delays. Aviva said it told Mrs P's financial adviser about the changes before the policy was incepted.

Our investigator didn't uphold this complaint. She said Aviva based its decision on the available medical evidence which highlighted Mrs P's intended surgery had a high risk of further complications. She explained Aviva was entitled to determine factors which helped it decide the risk of insuring Mrs P, including the likelihood of a future claim and any associated conditions linked to her intended treatment. She also noted Aviva told Mrs P's financial adviser about the changes to the terms and so didn't think it'd done anything wrong.

Mrs P, unhappy with this, asked for an ombudsman to review her complaint. She said, in summary, Aviva didn't tell her about the changes before it took payment for the policy; that the 26-week deferred period is disproportionate as it related to all illnesses; that underwriting decisions should not be based on hypothetical assumptions; that the delays meant she was disadvantaged as more details about her condition emerged during that time which influenced Aviva's position; and that she's paying for a level of cover that she's unlikely to receive unless she maintains a high level of income. And so, it's now for 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.

Having done so, I've decided not to uphold it and for similar reasons reached by our

investigator. Aviva, like all insurers, is entitled to consider relevant factors to determine the risk of insuring Mrs P. It's not for the ombudsman to tell Aviva the terms upon which it should offer a policy, or the price of cover. That relates exclusively to Aviva's commercial discretion. Having said that, I can consider whether it's treated Mrs P fairly when considering her individual circumstances and whether she's been treated the same as other consumers in similar situations. The evidence I've seen persuades me Aviva did that and I'll explain why.

I wanted to reassure Mrs P that I've considered everything she's raised throughout this complaint and although I may not refer to each point, that's not to say I've not thought carefully about what she's said. Rather, I've focused on what I consider to be the crux of her complaint and the issues I consider central to the outcome.

Mrs P has referred to Consumer Duty throughout her complaint and said Aviva hasn't complied with it. In particular, she said Aviva hasn't, acted in good faith, avoided foreseeable harm, enabled informed decision making or delivered fair value. I've thought carefully about that, but I'm not persuaded that's the case here. I say that because although Aviva changed the original terms it offered the policy on, there were relevant factors that informed that decision.

Mrs P is self-employed and she sourced this policy through her financial adviser. As this complaint is against the insurer, I'm unable to consider the actions of the adviser in this case – which includes any activity related to the sale of the policy.

Before the policy was incepted, Aviva wrote to Mrs P's financial adviser to explain the changes to the policy. This happened on 14 May 2025. Aviva said the deferred period would need to be increased from four-weeks to 26-weeks, and that an exclusion would need to be added to the policy. Mrs P said she didn't know about this until a month later when she was checking her documents, but that's not Aviva's fault. Aviva did what I'd expect it to, which was to notify the adviser and so although there appears to have been a breakdown in communication, the error wasn't Aviva's.

Aviva explained the reason it decided to increase the deferred period was because Mrs P was under investigation for a lump on her left knee. Having reviewed the medical evidence, I'm persuaded that was the case. Mrs P saw her GP about the lump in January 2024, and it was initially thought to be a baker's cyst or tendon ganglion. She was referred to radiology for further tests and it was determined it may be a nerve sheath tumour. Further appointments took place with specialists on 24 October 2024 and on 11 December 2024 to discuss the results of an ultrasound and MRI scan and that diagnosis was confirmed.

I should note Mrs P also applied for the policy in December 2024 whilst these investigations were ongoing. And so, because Mrs P was under investigation at that time, Aviva referred to its underwriters for guidance. I should say that's what I'd expect it to do in these circumstances. The underwriters wanted more medical evidence to better understand Mrs P's condition and so it asked for her medical records.

In March 2025, a letter was provided from Mrs P's treating consultant surgeon which highlighted there was '*frequent major complications*' with the surgery Mrs P was intending to have. It also said there was a risk of infection, nerve damage and recurrence amongst other issues. I think it's important to mention this because these are issues that would affect the likelihood of Mrs P bringing a claim later. And that's why Aviva said Mrs P presented a greater risk to insure than it first thought.

Aviva's underwriters considered not offering Mrs P a policy, because of the increased risk, but then decided it would on the amended terms. I've also seen that Aviva amended the original cost of the policy to reflect the restricted cover it was offering. The premium was

initially going to cost £589 per month, but was reduced to £260, which I'm persuaded shows Aviva considered the price and value of the policy. In addition, Aviva said it would look to offer Mrs P cover on her original terms, only after the surgery had been completed and provided there were no further issues related to the condition or the treatment. I also thought that was fair too.

And so, whilst I accept Aviva made changes that were less favourable to the cover it initially offered Mrs P, I'm satisfied this was because she had complex surgery outstanding and not because it had treated her unfairly.

Mrs P argued Aviva should not allow hypothetical complications to affect the terms upon which it offers a policy, but I think that's an unreasonable expectation. The nature of insurance is to determine the risk a consumer presents and then decide the terms upon which the insurer can offer cover. Aviva, like all insurers, will assess factors that impact a consumer's risk profile. So, the associated risks with Mrs P's surgery were a relevant factor to consider because there's a greater chance, she may need to take time off work connected to complications with the surgery itself, or potentially other illnesses linked to her condition. Aviva's able to use its commercial awareness to help it decide that.

I've seen Aviva's comments about associated difficulties with mental health and the type of treatment Mrs P intended to have. Mrs P said this was unjustified given she'd never suffered with mental health issues previously. I agree her medical records show she doesn't have a history of mental health related issues. But given what I've just explained about Aviva's commercial right to determine risk, the insurer's awareness is that there is a link between the condition, the risks involved with the intended treatment and the potential impact on her mental health should there be continued complications.

Mrs P said Aviva took around five months to incept the policy and that because of this, she was negatively impacted. I understand the argument she's making, but I'm not persuaded Aviva delayed things unnecessarily. The application was received from the financial adviser on 19 December 2024. Because this was a high-value policy, Aviva needed Mrs P to undergo a series of medical tests, including blood, urine and other tests. This would also be the case for all other consumers that opt for this type of policy and so I'm satisfied Mrs P wasn't treated unfairly by having to meet that criteria.

Aviva didn't receive the results until 5 February 2025. After which, Aviva decided to put the application on hold, pending the results of Mrs P's hospital appointment with the specialist, which took place in March 2025. It wasn't until 29 April 2025 that Aviva had the necessary information to progress the application further. Two weeks later, the underwriter confirmed it could offer cover, albeit on different terms. I see why Mrs P said it took a long time, but that's because her case wasn't straight forward as she was actively under investigation for her condition when she applied for the policy. I'm persuaded that's the reason for the delays, none of which were unnecessary, and so I disagree Mrs P lost out because of that in the way she's described.

Mrs P said that in order to make a claim on the policy, she needed to maintain an annual income of £170,000. She explained this is unrealistic as her income fluctuates. I've not seen any evidence that Aviva said that, and I should say that's not how the policy works. The policy will cover her up to that amount (although I note she has an RPI linked policy so that is subject to change as the years progress). But there's not an income restriction on the policy in the way she's described, the £170,000 is the policy limit. So, should her income be less than £170,000, that's doesn't mean Aviva won't pay her claim. The income indemnified isn't a predetermined figure, it's based on the pre-tax income from her business, in the 12 months immediately before incapacity, less any allowable expenses against income tax.

The terms also encourage Mrs P to regularly review her policy to ensure it continues to meet her needs. It says that if she has a reduction of earnings, then she can potentially reduce her cover, which would mean she pays a lower premium. I should also say it's not for Aviva to recommend policies for Mrs P. Aviva is simply a policy provider and therefore it would be inappropriate for it to make recommendations about suitability.

My final decision

For the reasons I've explained, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs P to accept or reject my decision before 4 March 2026.

Scott Slade
Ombudsman