

The complaint

Ms M and Mr W complain that Aviva Life and Pensions UK Limited didn't give them enough information about a life and critical illness policy when they bought it.

What happened

Ms M and Mr W are unhappy because there's no cover under their policy for tumours of the pituitary gland. In summary, they say this information wasn't made clear to them when they took out cover. Ms M was later diagnosed with a benign tumour of the pituitary gland.

Aviva said they provided Ms M and Mr W with enough information about the policy and the handbook made clear that only certain types of benign tumours were covered. Ms M and Mr W didn't agree and made a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. She thought information provided during and after the sales process made it sufficiently clear there were limitations on cover. And, in any event, she thought it was unlikely they'd have acted differently even if they'd been given more information about the relevant exclusion.

Ms M and Mr W didn't agree and asked an ombudsman to review the complaint. They said their decision to purchase was made on incomplete and misleading information, so they hadn't been able to make an informed decision. The complaint was therefore referred to me to make a 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.

The relevant rules and industry guidelines say that Aviva had a responsibility to ensure that the policy they recommended was suitable for Ms M and Mr W's demands and needs. And they also needed to provide them with clear, fair and non-misleading information.

The policy summary says there is cover for:

Benign brain tumour - resulting in permanent symptoms.

It also says:

Further details of how we will consider your claim including the full definitions we will use and the evidence we will need are given in the illnesses and operations covered in the membership handbook.

The membership handbook defines benign brain tumour. It says:

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

The following are not covered:

- tumours in the pituitary gland
- angiomas.

I'm not upholding this complaint because:

- I'm satisfied that the policy recommended was suitable for Ms M and Mr W's needs. Based on the information captured during the application process there was no suggestion that cover for pituitary tumours was something they specifically wanted or needed cover for. And, overall, the policy offered a reasonable level of cover for the demands and needs identified.
- I'm satisfied Ms M and Mr W were given enough information to decide if the policy was right for them. The summary of cover made it sufficiently clear that there were further limitations to the policy definitions and that the list of covered conditions was further explained in the more detailed handbook.
- Ms M and Mr W say they weren't given a copy of the handbook. Usually that information is provided, and I can see various documentation was sent to Ms M and Mr W around the time that the policy was taken out. That included a letter saying that Ms M and Mr W should check they'd received all the information they wanted to understand the policy and that the policy was suitable for their demands and needs. If Ms M and Mr W hadn't received the handbook I think it would have been reasonable for them to contact Aviva to ask for another copy.
- Even if I accepted that Ms M and Mr W weren't given a copy of the handbook I still wouldn't uphold this complaint. That's because, even if Aviva failed to provide this, I'd need to be satisfied Ms M and Mr W would have acted differently had the handbook been provided. I'm not persuaded they would have done.
- On balance, I think that if Ms M and Mr W had been made aware of the more detailed definition, they'd have still taken out this policy. As I've outlined above it met their overall demands and needs. And, there's no suggestion that element of cover was particularly important to them at the point of application. I appreciate that following Ms M's diagnosis they were disappointed to discover there was no cover. But, I don't think that's most likely to have been such an important feature of cover when they applied for the policy.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms M and Mr W to accept or reject my decision before 11 March 2026.

Anna Wilshaw
Ombudsman