DRN-6257218

Financial Ombudsman Service

The complaint

Mr P complains that Aviva Life & Pensions UK Limited turned down a claim he made on a group critical illness insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I consider to be the main events.

In June 2024, Mr P became insured under his employer's group critical illness insurance policy.

Unfortunately, in February 2025, Mr P suffered a heart attack. So he made a critical illness claim on the policy.

Aviva obtained Mr P's medical records so it could assess the claim. It noted that Mr P had had raised blood pressure readings since at least mid-May 2024 and that the GP had recorded Mr P as having hypertension in April 2024.

The terms of the group policy excluded cover for heart attack claims where an insured person had an 'associated condition' before their insurance began. Hypertension was listed as an associated condition in cases of claims for heart attack. As Mr P's medical records showed he'd been suffering from hypertension before he became covered under the policy on 1 June 2024, Aviva concluded that his claim was specifically excluded by the contract terms. And it turned down his claim.

Mr P was unhappy with Aviva's decision and he asked us to look into his complaint.

Our investigator didn't think Aviva had treated Mr P unfairly. In brief, she thought it had been reasonable for Aviva to rely on the medical evidence to conclude that Mr P's claim wasn't covered by the terms of the group contract.

Mr P disagreed and so the complaint's been passed 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.

Having done so, whilst I'm very sorry to disappoint Mr P, I don't think it was unfair for Aviva to turn down his claim and I'll explain why.

First, I'd like to say how sorry I was to hear about Mr P's ill-health and it's clear this was a very worrying time for him. I do hope he's made a good recovery. I'd also like to reassure Mr P that while I've summarised the background to this complaint and his submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been raised and our rules don't require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly; that they mustn't turn down claims unreasonably and that they must provide information which is clear, fair and not misleading. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think Aviva treated Mr P fairly.

It's important I make it clear that the contract of insurance in this case is between Mr P's employer and Aviva. Mr P is a beneficiary of the insurance policy – he doesn't hold a personal critical illness insurance policy with Aviva. This means that Aviva didn't individually underwrite Mr P's cover, so it didn't ask him questions about his health and circumstances in order to decide whether or not to offer him cover – and on what terms. Instead, it set out the policy cover and relevant exclusions in the terms of the group contract. In my experience, this isn't unusual in group policies of this nature.

I've carefully considered the terms of the group contract. It's clear that Aviva considers a heart attack to be a covered critical illness in specific, defined circumstances. However, that doesn't mean all claims will be paid. Section nine of the policy sets out specific things Aviva has chosen not to cover. This includes 'associated conditions'. The contract says:

'We will not pay a lump sum benefit for a member or a child who has a critical illness or operation if they had an associated condition at any time prior to:

- *the date their cover commenced under the scheme and;*
- *the most recent date (prior to the current claim) that they met the conditions for a valid claim for a critical illness or operation under the scheme….*

The exclusion will no longer apply if the member or child does not have a valid claim for that critical illness or operation within the first two years of the date they joined your scheme.'

An associated condition is defined as:

' Any symptom, condition, illness, injury, disease or treatment which is either;

• *recognised by reasonable specialist medical opinion to be related to the occurrence of a critical illness or operation, or*
• *is listed in the associated conditions column of the critical illness/operation table which begins on page 4.'*

The heart attack definition set out in the contract lists the following medical conditions as associated conditions:

'Any disease or disorder of the heart, diabetes mellitus, hypertension or any obstructive/occlusive arterial disease.'

In my view, Aviva has set out the exclusion and what it means by an associated condition in a clear, fair and not misleading way. And if Mr P thinks his employer didn't do enough to make him aware of the relevant terms before he decided to join the group scheme, that would be something he'd need to raise directly with his employer. That's because Aviva isn't responsible for his employer's actions.

Aviva considers that Mr P had an associated condition and therefore, that his claim is excluded by the policy terms. So I've looked very carefully at the available medical evidence to decide whether I think that was a fair conclusion for it to draw.

Mr P's GP provided Aviva with a medical certificate. The GP was asked whether Mr P had

ever suffered from, or been diagnosed with, amongst other things, hypertension. The GP answered: ‘*Hypertension diagnosed 16/4/2024’.* This accords with the diagnosis and date set out in Mr P’s medical records. I also note that in December 2023, the GP surgery produced a ‘High Blood Pressure/Hypertension Care Plan’ for Mr P, which states: ‘*You have been diagnosed with high blood pressure, also known as hypertension.’*

The evidence indicates then that Mr P was diagnosed with hypertension, at the latest, in mid-April 2024. This was only a few weeks before his cover under the critical illness policy began. This means I think it was reasonable for Aviva to conclude that Mr P had an associated condition in line with the policy terms. And as Mr P suffered a heart attack around 10 months after becoming insured by the policy, I think it was fair for Aviva to find that he’d made a claim within the first two years of cover starting. As such, I don’t think the exception I’ve set out above applied to his situation.

So, I don’t find that Aviva acted unfairly or unreasonably when it concluded that Mr P’s claim was specifically excluded by the contract terms and therefore turned down his claim.

I do appreciate that Mr P says he wasn’t made aware that he had hypertension – and that his blood pressure had been referred to as high or elevated. However, I don’t think that makes a difference to the outcome here – because, as I’ve said, Aviva didn’t ask Mr P any questions when he applied for the policy. The policy simply excludes cover for heart attack claims if an insured member had an associated condition – including hypertension- when cover began. As I’ve said, given Mr P did have a hypertension diagnosis when his cover started, I’m satisfied Aviva was reasonably entitled to rely on the exclusion to decline his claim.

My final decision

For the reasons I’ve given above, my final decision is that I don’t uphold this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr P to accept or reject my decision before 15 May 2026.

Lisa Barham
Ombudsman