complaint

Ms S complains that Aviva Insurance Limited ('Aviva') has unfairly declined her disability claim under a payment protection insurance ('PPI') policy. She is also unhappy about the time taken by Aviva to investigate her claim and the service she received during this process.

background

In August 2006 Ms S took out the PPI policy to cover her mortgage repayments in case she became unable to work due to accident, sickness or unemployment – subject to the terms of the policy.

In November 2014 Mrs S made a claim for disability due to total knee replacement (left side). Aviva declined the claim on the basis that Ms S's medical condition was pre-existing. Ms S believes that Aviva's decision on her claim is unfair. She considers that because of her condition and circumstances it was not at all clear that her condition ought properly to be regarded as pre-existing.

Our adjudicator who considered Ms S's complaint did not recommend that it should succeed. He concluded that Ms S's claim form and the medical records were consistent with Aviva's position that the condition which led to the claim was an escalation of a medical condition that was first diagnosed in 2000. He also thought that Aviva had dealt with Ms S's claim in a satisfactory manner and that it had investigated and processed Ms S's claim within a reasonable time frame.

Ms S did not accept this assessment and asked for her complaint to be passed to an ombudsman for a final decision.

my findings

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

In declining Ms S's disability claim I need to decide whether or not Aviva applied the terms of the PPI policy fairly and reasonably. In declining the claim, Aviva relied on the following policy definitions and terms:

What is not covered (in addition to General Exclusions)
"We will not pay any accident or sickness claims due to or arising from:
- Any pre-existing medical condition unless you have been symptom free, have not received treatment or consulted a doctor about the condition in the 12 months before the start of your accident or sickness claim"
Pre-existing medical condition is defined in the policy as follows:

"A pre-existing medical condition is any condition, injury, illness, disease, sickness or related condition and/or associated symptoms, whether diagnosed or not:
- Which you knew about, or should reasonably have known about, at the start date or,
- Which you had seen or arranged to see a doctor about, during the 12 months immediately before the start date."

In the claim form sent by Ms S to Aviva her GP responded 'yes' to the question *"has the patient previously consulted you or any other doctor for any condition or symptoms that could be related to their present condition?"* The GP also noted *"pain in both knee, got worse gradually".*

In the 12 months before the policy start date, on September 2005, Ms S told her consultant that she was still getting a lot of problems with her left knee. In the 12 months before the claim date Ms S was on the waiting list for a total knee replacement operation. And a short time after she took out the policy, in September 2006, Ms S's consultant noted that she was still complaining about both knees (*"with regard to her knee, she is still complaining of discomfort in both knees slightly worse on the right than the left. X-rays of both knees reveal quite marked osteoarthritis especially at the patella femoral joint").* So on the face of it, it seems to me that Ms S's disability claim in November 2014 does fall within the exclusion above: she had consulted her doctor about her condition during the 12 months before the policy start date, and she should reasonably have known about her condition at the time of taking the policy out.

In addition, during the course of our investigation of Ms S's complaint we have been provided with some of Ms S's medical records. Correspondence sent to the consultant orthopaedic surgeon in September 2013 and April 2014 records that Ms S had suffered from osteoarthritis of the knee as early as 2000. Overall I am satisfied that the condition Ms S was claiming for was excluded under the policy terms and conditions and I can understand why Aviva declined the claim on this basis.

I appreciate that Ms S has referred to there being a "grey area" about whether or not her condition was really pre-existing. When validating a claim Aviva is entitled to rely upon the evidence provided by medical professionals. Although Ms S disputes the pre-existing nature of her knee condition, having carefully considered all the evidence in this complaint, the weight of the evidence indicates that in declining the claim on the basis that the condition claimed for was pre-existing, and within the exclusion above, Aviva did not act unfairly or unreasonably. It follows that I do not uphold Ms S's complaint

A further aspect of Ms S's complaint is about the time taken by Aviva to look at and make a decision on her claim and the service she received. She has said that she feels she should have not needed to chase her employer and doctor's surgery for information, and that she was left waiting for communication from Aviva. Ms S made her claim in November 2014 and there were various communications that month and in December. Then in January 2015 Aviva wrote to Ms S advising her of the status of her claim, and explaining that it was waiting for information from her GP. Although there were some delays in obtaining the requested information, Aviva contacted Ms S's GP within a reasonable timeframe and Aviva cannot be held responsible for the delay in obtaining a response from her GP. Overall I do not think the service Ms S received from Aviva was such that she ought to have her claim paid or to receive compensation.

my final decision

My decision is that I do not uphold Ms S's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms S to accept or reject my decision before 5 November 2015.

Claire O’Connor
ombudsman