DRN-4533185

The complaint

Mr G complains about Aviva Insurance Limited declining his personal accident claim.

What happened

Mr G had a personal accident policy with Aviva. It was designed to provide a benefit if Mr G had an accident that directly resulted in a permanent injury. In 2023 Mr G made a claim for the loss of use in his right arm and said he'd injured it in an accident in 2016, but Aviva declined it.

Aviva said the loss of use needed to occur within 24 months of the accident, and there was no record of an accident in 2016 or any injuries to Mr G's arm during that timeframe in the medical evidence it had received.

Mr G acknowledged he hadn't sought medical intervention at the time. He explained he'd sought 18 months' worth of treatment with a sports masseuse he was already seeing instead because he thought he'd pulled a muscle and that would help. He also explained his pain got worse in 2020, an ultrasound in 2021 showed that he'd snapped a tendon, and he was offered a shoulder operation in 2023. But Aviva maintained its decision to decline the claim, so Mr G approached this service.

Mr G told us that Aviva was being unreasonable and trying to avoid payment. He said he actually had two policies with Aviva, but was only aware of the need to claim as soon as reasonably possible which is what he'd done. He reiterated why he'd sought massage at the time of the accident and said wider circumstances such as the UK lockdown hadn't helped the 24 month timescale either.

Our investigator looked at what had happened but didn't recommend Mr G's complaint be upheld. They confirmed that the personal accident policy did require the loss of use to occur within 24 months of the date of the accident. And they agreed that the medical evidence provided to Aviva hadn't demonstrated that either. Our investigator also explained that the other policy Mr G was referring to was an accidental death policy, which was subject to its own separate terms and conditions.

Mr G disagreed with that opinion and asked for his complaint be referred to an ombudsman. He said he'd since reviewed his policy and could now see the 24 month time limit. But he said that timescale should have been set out elsewhere, and it could be conceived that Aviva was trying to hide it. Mr G also asked this service to make recommendations about where that timescale be shown in future, and he said that although he accepted his claim was lost it was unfair because his injury was still being treated.

In addition to the above Mr G also explained that he'd since cancelled both of his policies because he was insured for an accident and had received nothing. He also raised concerns about Aviva not previously cancelling a policy when he had added his wife to his cover and said he wanted a refund in premiums because of that.

So, as no agreement was reached the matter was 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.

Aviva had a responsibility to handle Mr G's claim both promptly and fairly, and to not reject it unreasonably. The cover available to Mr G was set out in his policy's terms and conditions. I know Mr G has confirmed he's now reviewed these and accepts his policy included a 24 month timescale, but I'm aware he thinks this should have been located in a different section of the document and wants us to recommend where it be shown in future.

I respect Mr G's opinion on where the timescale should be located, but making such a recommendation is not the role of this service and I don't think the 24 month timescale was unclear.

Page seven of the terms and conditions set out the specific cover available through the policy. It was titled "*Your cover*" and explained:

"***Section A – Permanent bodily injury***

What is covered

1. …

2. Loss of us of arms and/or legs

*If an **insured person** suffers an **accident** which directly results in some degree of permanent loss of use of arms and/or legs, **we** will pay a percentage of the benefit shown in the table of benefits depending on the extent of loss of use that a **doctor** confirms **you** have suffered.*

- *…*
- *…*

*For multiple injuries sustained during the same **accident we** will calculate the percentage of benefit payable, for partial loss of use for each arm of leg, separately.*

*In all cases the loss of use must occur within 24 months of the date of the **accident**.*"

So I can't agree that timescale was hidden, and I think it was reasonable of Aviva to rely on it when assessing this claim given it did form part of Mr G's policy.

I know Mr G says he now accepts his claim is lost because of the 24 month timescale, but for the avoidance of any doubt I think it'd be helpful of me to explain why I don't think it was unreasonable of Aviva to decline his claim either.

It isn't unusual for an insurer to want medical evidence to assist it in assessing and validating a claim. It's not disputed that Mr G didn't seek medical intervention at the time of his accident, and he's already explained the absence of any evidence from the time was because he thought he'd pulled a muscle so pursued massage instead. Whilst I fully appreciate the course of action Mr G chose to take here, I must bear in mind that the onus was him to demonstrate he had a valid claim.

Mr G was able to provide Aviva with some medical evidence, following the more recent medical intervention he'd sought, but I don't think it was unreasonable of Aviva to find this didn't demonstrate that he had a valid claim either. This evidence included letters from his Consultant Orthopaedic Surgeon, but they all post-dated the date of the accident and the 24 months that followed it. Some were from 2023 for example, which was some seven years

after Mr G said the accident had taken place, and while they discussed his injury and the planned treatment for it, they provided a retrospective review of Mr G's testimony about what had originally happened.

Mr G may still be having treatment but his policy wasn't designed to provide benefit for this. It was designed to pay benefit for a specific injury as a direct result of an accident, and so although I wish Mr G well in any ongoing treatment it would be unfair of me to direct Aviva to pay benefit for something there is was provision for.

For all of the reasons given above I don't think it was unreasonable of Aviva to decline this claim.

Separate to the above Mr G raised complaint points in his response to our investigator's opinion that don't appear to have formed part of his original complaint to Aviva. These relate to concerns about Aviva's actions when adding his wife to his policy and for which he is now seeking a premium refund. It would be inappropriate of me to give a determination on this particular issue first, so if Mr G still wants this matter considered he'll need to consider approaching Aviva about it in the first instance.

My final decision

My final decision is that I do not uphold this complaint against Aviva Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr G to accept or reject my decision before 8 March 2024.

Jade Alexander
Ombudsman