DRN-4582711

The complaint

Ms P complains about how Aviva Insurance Limited handled her claim against her private medical insurance policy.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here in full. In summary, Ms P has had private medical insurance for many years. In September 2022 she arranged to take out a private medical insurance policy underwritten by Aviva. The policy start date was 1 October 2022 and it was on a continued medical exclusions basis, which means that Aviva agreed to continue Ms P's cover without the need for fresh underwriting.

The medical report Ms P's NHS GP completed for Aviva says that on 3 October 2022, Ms P saw her NHS GP about fatigue. Ms P's GP suspected a gynaecological cause and referred her to a gynaecologist. The report from Ms P's NHS gynaecology team following her appointment on 19 October 2022 says that Ms P was referred by her GP for post-menopausal bleeding.

Ms P had diagnostic tests in the NHS, including a biopsy on 7 November 2022. Unfortunately, on 16 November 2022, Ms P was diagnosed with endometrial cancer. She contacted Aviva on the same day. Ms P says that Aviva wasn't helpful. I'll refer to that phone call in more detail below. Ms P continued in the care of the NHS and had surgery on 6 December 2022.

On 6 December 2022, Mrs P – or someone on her behalf, given that it was the same day as her surgery - submitted a claim form to Aviva. On 14 December 2022, Aviva asked Ms P's NHS GP for her medical records from birth. On 12 January 2023, Aviva asked Ms P for her authority to contact her private doctor. On 13 January 2023, Aviva asked both Ms P's NHS and private doctor for certain medical records for five years before the policy start date on 1 October 2022.

On 23 January 2023, Aviva told Ms P that it had received the information it had requested. One of Aviva's clinicians looked at the records and requested clinical letters. On 26 January 2023, Ms P explained that there were no missing clinical letters.

On 27 January 2023, Aviva made a new request for clinical letters about Ms P's cancer care to date. On the same date, it told Ms P that her medical records showed that she had symptoms and appointments in the relevant period but didn't disclose them. On 30 January 2023, Aviva made a further request to Ms P's GP. Aviva received the information it asked for on 1 February 2023.

On 17 February 2023, Aviva told Ms P that it would cover her current claim but exclude from future cover any recognised complication or treatment arising from diverticular disease or irregular bleeding. On 8 March 2023, Aviva amended the exclusion to endometrial cancer and any spread of that cancer to other parts of the body. It

subsequently said that was an error. On 9 May 2023, Aviva wrote to Ms P about the terms of her policy generally, including information about NHS cancer cash benefit.

Ms P complained about Aviva's handling of her claim. Aviva apologised for its poor handling of its request for medical information, including its request for Ms P's medical records from birth. It also apologised for the level of questioning and lack of empathy by one of its advisors and the mistakes it made in relation to applying exclusions.

Aviva refunded Ms P's payments of the premium from 1 October 2022 to 31 March 2023, with interest. It also paid Ms P the NHS cancer cash benefit of £200. Aviva offered Ms P compensation of £750 in relation to her distress and inconvenience. Ms P didn't think that was sufficient. She accepted that amount and reserved her right to pursue her complaint.

Ms P says that Aviva didn't treat her respectfully and treated her claim with suspicion from the outset. She says that she didn't receive the professional, sensitive and helpful approach she expected. Ms P complains that Aviva asked her GP for her medical records from birth. She says that dealing with Aviva was more stressful than her diagnosis. Ms P says that she should have had the benefit of private health care in a private hospital setting and that she had a poor experience whilst admitted to the NHS hospital for surgery.

Ms P doesn't think that Aviva's offer of compensation of £750 in relation to her distress and inconvenience is sufficient. She wants a sum equivalent to the amount Aviva would have paid if she had private treatment, rather than treatment in the NHS. Ms P says that anything less than £10,000 is unfair.

One of our investigators looked at what had happened. He said that Aviva fell short of the standard we'd expect to see but he thought that the steps it had taken to resolve Ms P's complaint were fair and reasonable. The investigator said that Aviva was entitled to ask for necessary medical information in order to validate Ms P's claim. He said that it appeared that Ms P's treatment in the NHS started quickly and that she'd received the treatment she needed on time.

Ms P didn't agree with the investigator. She said that he'd overlooked several very important points, for example, Aviva's request for all her medical history. Ms P said that the investigator's description of what happened doesn't capture the whole story from her perspective and that he'd drawn some conclusions that are incorrect. She said that Aviva had asked for an unusual and enormous amount of her medical records, which delayed her claim. Ms P said that Aviva made an error in excluding certain things from her cover then realised it had made a mistake.

Ms P said that Aviva put an extra and unnecessary burden on her and caused her much stress at what was already an incredibly stressful time. She said that Aviva's unacceptable demands and delays left her with no choice but to seek help elsewhere. Ms P says that Aviva refused to discuss with her what assistance it could provide if her claim was accepted. She says that it took six months for Aviva to process her claim. Ms P says that she didn't receive the treatment she needed and deserved and that she had a poor experience in the NHS hospital and no after-care service.

Ms P says that Aviva implied that she wasn't eligible for cover at all but continued to collect premiums. She says that Aviva paid her £750 for one night's stay in an NHS hospital when she should have been in hospital for at least two or three nights. Ms P says that she stayed only one night in the NHS hospital as she had poor care there. She

says that Aviva put her to the trouble of challenging the exclusion, which it later admitted was an error.

Ms P says that Aviva let her down and didn't take care of her in her time of need. She says that she wants compensation in excess of £10,000, which she considers modest in terms of what Aviva would have had to pay if it had dealt with her claim correctly.

Miss C asked that an ombudsman consider her complaint, so it 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.

It's clear and quite understandable that Ms P has very strong feelings about this matter. She has provided detailed submissions to support her complaint, which I have read and considered. I'm conscious that I've condensed what I don't doubt was a very worrying time into a short narrative. That reflects our service that, wherever possible, aims to be informal. I'm satisfied that I've captured the essence of what happened. I trust that Ms P will not take as a discourtesy the fact that I focus on what I consider to be the central issues: whether Aviva acted fairly and reasonably in its handling of her claim and in its resolution of her complaint.

I'm aware that Ms P has asked to speak to the ombudsman reviewing her case. I've considered all that's been said and provided. I have a good understanding of Ms P's complaint. I don't need any more information from her in order to decide this complaint.

The relevant rules and industry guidance say that Aviva has a responsibility to handle claims promptly and fairly.

<u>The relevant terms and conditions</u>

The terms and conditions of Ms P's policy include the following:

'***How to claim***
[…]
Whenever possible we'll assess your claim over the telephone. Our experienced claims consultants will talk you through the claims process and advise you what to do next.
If we require the completion of a claim form, we'll need five days to assess it. […]

We may ask for more information to assess your claim, such as:
- *Medical reports relating to your treatment*
- *Previous medical records*
- *A doctor's report if we need one […]*'

<u>Did Aviva act unfairly or unreasonably?</u>

Aviva is entitled to ask Ms P for certain information in order to assess her claim. An insurer is likely to ask for medical information when, as here, the events leading to the claim are soon after the start date of the policy.

It's common ground that Aviva made errors in dealing with Ms P's claim. Aviva acknowledges that it made an error in asking for Ms P's medical records from birth and that

there were delays in it obtaining further medical information. It has also apologised for the level of questioning and lack of empathy in one of its phone calls with Ms P.

Aviva's assessment of Ms P's claim took much longer than we'd expect. Ms P first contacted Aviva about this matter in November 2022 and submitted a claim form in December 2022. In February 2023 Aviva told Ms P that it would cover her current claim. But it wasn't until May 2023 that Aviva resolved the issue of erroneous exclusions and gave Ms P an explanation of her cover.

I've listened to the recording of the phone call between Ms P and Aviva on 16 November 2022. I think that Aviva dealt with Ms P appropriately and respectfully in that call. It explained that it required a claim form and some medical information. Ms P wanted to speak with an oncologist for guidance but Aviva said that it doesn't offer that service. Ms P told Aviva that her CT scan was already arranged with the NHS for the following day and, during the call, she received confirmation from the NHS that her MRI would take place then too. So, Ms P's treatment in the NHS was proceeding at pace.

Ms P proceeded with treatment in the NHS and had surgery on 6 December 2022, the day her claim form was sent to Aviva. Aviva's delay in dealing with Ms P's claim and its erroneous request for Ms P's medical records from birth occurred after Ms P had treatment in the NHS. So, I don't think that Aviva's errors were pivotal in Ms P's decision to have treatment in the NHS, rather than private treatment.

I have noted what Ms P has said about the poor experience she had in the NHS but Aviva isn't responsible for that. As I've said, I think that Ms P chose to continue treatment in the NHS before Aviva made errors in its handling of her claim.

Ms P says that her claim is for the full amount Aviva would have paid for her treatment if it had assessed her claim correctly. I don't think it's fair or reasonable to direct Aviva to pay compensation on that basis. That's because Ms P chose NHS treatment before Aviva made errors. In any event, this service has no power to award punitive compensation. There are no grounds on which I can fairly direct Aviva to pay Ms P what it would have paid to third party health care providers if she had chosen private treatment.

When mistakes like this happen, we consider the effect of the errors on the individual concerned. In this case, I accept what Ms P says about Aviva's handling of her claim causing her additional distress at an already very stressful time. I think that Aviva's errors in relation to applying exclusions to Ms P's cover meant that the uncertainty about her cover continued for some months.

Aviva apologised for its errors and the questioning and lack of empathy in one of the phone calls. It has refunded the payments of premium Ms P made from 1 October 2022 to 31 March 2023, with interest. It also paid Ms P the NHS cancer cash benefit of £200 and compensation of £750 in relation to her distress and inconvenience. Ms P has referred to the £750 as payment for one night's stay in an NHS hospital but it's for her overall distress and inconvenience arising out of this matter.

I've given this matter careful thought. Considering everything, I think that the steps Aviva has already taken to put matters right are fair and reasonable. In reaching that view, I've taken into account the nature, extent and duration of Ms P's distress and inconvenience arising out of Aviva's errors in this case.

My final decision

My final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms P to accept or reject my decision before 13 March 2024.
Louise Povey
Ombudsman