DRN-5076581

The complaint

Mrs H has complained that Aviva Life & Pensions UK Limited declined a claim made under her employer's group critical illness policy.

What happened

Mrs H had a routine breast mammogram on 1 December 2023. On 1 January 2024, Mrs H joined her employer's group critical illness scheme. This was the first available opportunity for her to join. On 9 February 2024, Mrs H received a letter explaining that her breast x-rays had been examined and were unclear. She was therefore asked to attend a new appointment on 4 March 2024. Mrs H underwent an ultrasound and biopsy and was later diagnosed with a grade 2 lobular cancer. She submitted a claim under the policy.

Aviva initially declined the claim on 29 May 2024 referring to the following policy exclusion:

9.3 Associated conditions

We will not pay a lump sum benefit for any member or a child if they had an ***associated condition*** *at any time prior to the date their cover commenced under the scheme.*

An associated condition is defined in the policy 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.

Aviva said that Mrs H didn't have an associated listed condition. But it concluded that as the mammogram had detected an abnormality prior to the policy start date, this would fall under the associated condition exclusion. Aviva declined Mrs H's claim.

Unhappy, Mrs H referred her complaint here. Our investigator recommended that it be upheld. He didn't think that Aviva had shown that Mrs H had an associated condition and recommended that it paid her £250 for the distress caused by unreasonably declining her claim.

Aviva didn't agree. It said that, simply put, Mrs H did have the disease before the cover started and this is what was detected on the routine breast screening. It also made the point that Mrs H had not been disadvantaged by the fact that there was no medical underwriting under this group policy. It said that had she applied for individual critical illness cover she would have been obliged to declare that she was awaiting the results of a test. And that it is likely cover would not have been offered until the results of the test were known – when they were and cancer had been identified, cover would have been declined.

As no agreement has been reached the case has been passed to me to determine.

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.

I'm aware I've summarised the background to this complaint - no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. Having done so I agree with the conclusion reached by the investigator for the following reasons:

- The relevant regulator's rules say that insurers mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the critical illness policy, relevant regulatory rules and guidance, and the available medical evidence, to decide whether I think Aviva has handled Mrs H's claim fairly.

- Sadly Mrs H was diagnosed with cancer. However the policy doesn't automatically offer cover, rather it sets out '*What is not covered?*' in chapter 9. Pre-existing and related conditions are excluded from cover. Aviva has confirmed that neither apply here so I won't detail those exclusions here.

- In declining the claim Aviva has relied on the first limb of the 'Associated Conditions' exclusion set out above. In short, Aviva needs to show that prior to the policy start date, Mrs H had a symptom, condition, illness or treatment which is recognised by reasonable specialist medical opinion to be related to the occurrence of a critical illness. Prior to the policy start date Mrs H had no symptom, condition, illness or treatment – she had merely attended for a routine mammogram. She was only recalled some weeks after the policy started and cancer detected some weeks after that.

- Following our investigator's view Aviva sought the opinion of its Consulting Medical Advisor. To summarise, given the timeline of events, they didn't think it was pathologically possible for the cancer to have spontaneously developed after the cover started. So it seems that Aviva's position is that the cancer was there before the policy commenced. This doesn't seem unreasonable – but it would mean that the condition was pre-existing. Aviva has conceded that the pre-existing definition doesn't apply here, as Mrs H hadn't experienced symptoms or received medication, advice, treatment or diagnostic tests prior to the policy start date.

- Aviva has therefore attempted to rely on the associated condition clause to decline the claim. But I can't conclude it has shown that prior to the start date Mrs H had *symptom, condition, illness, injury, disease or treatment which recognised by reasonable specialist medical opinion to be* ***related*** *to the occurrence of a critical illness.*

- The policy gives clear examples of what an associated condition may be. The examples are of someone experiencing a numb hand before the policy commenced and being diagnosed with Multiple Sclerosis within two years of joining the scheme. Or experiencing reduced hearing or vision before an increase to the lump sum benefit then being diagnosed with a brain tumour. In both examples the earlier symptoms would be deemed as associated conditions. But by Aviva's own logic this wasn't an associated condition, it was the same condition. This may be semantics, but I don't find it is fair and reasonable for Aviva to attempt to rely on the associated condition exclusion in these circumstances.

- I appreciate it may not have been Aviva's intention to offer cover in situations such as this, but I don't find it has shown the application of the related condition exclusion leads to this claim being excluded. It follows that I don't find that Aviva has treated Mrs H fairly in the assessment of her claim. I accept that she has been caused distress and inconvenience by this for which I find compensation in the sum of £250 is merited.

- Finally I note Aviva's representation that Mrs H hasn't been disadvantaged by its position – as had she applied for individual critical illness cover it would have been medically underwritten. I don't find there is any analogy here though. She joined her employer's group scheme at the first opportunity open to her and Aviva hasn't shown that a policy exclusion applies to her claim.

My final decision

My final decision is that I uphold this complaint. I require Aviva Life & Pensions UK Limited to:

- Reassess Mrs H's claim in line with the remaining policy terms

- Pay Mrs H £250 in compensation

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H to accept or reject my decision before 12 December 2024.

Lindsey Woloski
Ombudsman