DRN-4223714

The complaint

Mr R has complained that Aviva Insurance Limited declined a sickness claim that he made on his mortgage payment protection insurance policy.

What happened

Mr R had a stroke in August 2015. He made a backdated claim on the policy and so Aviva started assessing it in 2022. The claim was declined on the basis that Mr R hadn't been working for 30 continuous days during the period immediately prior to the stroke.

Our adjudicator thought that Aviva had acted fairly, in line with the policy terms, to decline the claim. Mr R disagrees with the adjudicator's opinion and so the complaint has been passed to me for a decision.

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.

Mr R had unfortunately suffered a heart attack in 2014. His claim for that was declined on the basis that he had a pre-existing heart condition. He returned to work in July 2015 and suffered the stroke the following month.

The policy terms state:

'You can make a completely new accident or sickness claim as long as you have returned to work for at least 90 days in a row. Two claims (that arise from a related medical condition) separated by less than 90 days continuous work are treated as the same period of claim. You will only be entitled to receive monthly benefit entitlement that is left over from the previous period of claim. This period is reduced to 30 days continuous work for any claim that arises from a medical condition that is not related to the accident or sickness that brought about the previous claim.'

Evidence from Mr R's GP shows that the stroke was unrelated to the previous heart attack. Therefore, he didn't need to have returned to work for 90 days to be able to make a successful claim, but he did need to have returned to work for 30 days.

Aviva asked Mr R for evidence that he'd been back in work for 30 days, such as bank statements showing income from his employment. Mr R hasn't been able to provide much documentation, which isn't surprising given that he was trying to find information from 2015. But aside from that, Mr R has actually said that he was only back at work for two weeks when he had his stroke. As he hadn't returned to work for a minimum of 30 days, he does not meet the qualifying conditions under the terms of the policy.

Mr R thinks that Aviva should pay the claim as he has been paying for the policy for a number of years and the reason he hadn't been working for long enough at that time was due to his previous heart attack. I have a great deal of sympathy for Mr R's situation. It is

unusual and unfortunate that he should have suffered a second serious medical condition so soon after recovering from the first one.

However, when looking at whether or not Aviva has acted fairly and reasonably, I need to look at whether it has assessed the claim in line with the policy terms and conditions. In this case, I am satisfied that Aviva has applied the terms correctly and that it was therefore reasonable for it to decline the claim.

I've thought very carefully about what Mr R has said. But whilst I know it will be disappointing for him, I am not able to uphold his complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R to accept or reject my decision before 9 August 2023.
Carole Clark
Ombudsman