DRN-4216784

The complaint

Ms B is unhappy that Aviva Insurance Limited declined a claim she made on her private medical insurance policy and with the service she received.

What happened

Ms B has a private medical insurance policy with Aviva. She switched from another insurer, who I'll refer to as 'Insurer B', in October 2021. Her Aviva policy was underwritten on a moratorium basis, with continued underwriting from Insurer B. Ms B had previously had a diagnosis of, and treatment for, ovarian cancer.

Around eight months after she took out the policy her consultant identified a mass in her pelvis. Ms B underwent private cancer treatment at a cost of approximately £49 000. Aviva has declined to cover the cost of the treatment as they say that the moratorium applies because:

- Ms B had symptoms of, medication or treatment for, or advice about such a disease, illness or injury within five years before the start date of the policy

- There had not been a clear two year period after the start date of the moratorium during which she'd been free of medication or treatment for, and advice about such a disease, illness or injury or related condition.

They also didn't think Ms B had completed the 'switch declaration' correctly. So, they declined the claim. Ms B complained but Aviva maintained their decision to decline the claim.

Ms B complained to the Financial Ombudsman Service. Our investigator looked into what had happened and didn't uphold the complaint. She didn't think it was unreasonable for Aviva to decline the claim. And, she didn't think Ms B had accurately answered the medical questions when she switched from Insurer B. She also thought that the medical evidence suggested it was most likely Ms B's current cancer diagnosis was connected to the previous diagnosis.

Ms B didn't agree and asked an ombudsman to review her complaint. In summary, she said she'd had blood tests, but they shouldn't be considered as cancer diagnostic tests. She also said she'd not received advice from a GP or consultant during the relevant time. Finally, she said that Aviva couldn't have known with certainty that her more recent cancer was a recurrence of her previous cancer.

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 have a great deal of empathy with Ms B's circumstances. I understand that she's been left with a significant bill to pay for her treatment at an already difficult and worrying time. However, based on the available evidence, I'm not upholding this complaint.

The 'switch declaration'

Aviva says Ms B answered medical questions incorrectly when she switched her policy. This means the law set out in the Consumer Insurance (Disclosures and Representations) Act 2012 ("CIDRA") is relevant and I think it's fair and reasonable to apply these principles to the circumstances of this case.

CIDRA is designed to make sure consumers and insurers get an appropriate remedy if a policyholder makes what is called a 'qualifying misrepresentation' under the Act.

A qualifying misrepresentation is when a consumer fails to take reasonable care not to misrepresent facts which an insurer has asked about. The standard of care required is that of a reasonable consumer. One of the factors to be considered when deciding whether a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

When Ms B switched her policy from Insurer B she had to complete a switch declaration. It said:

> Have you or any person to be covered by this policy experienced symptoms, or had any consultations, tests or treatment in the last 12 months or do you currently have any appointments planned with a GP, Specialist or a hospital in the future?
>
> Have you or any person to be covered by this policy had any consultations, tests, medication or treatment in the last 5 years relating to any:
>
> a) Type of cancer or suspected cancer (if the consultations or tests are part of routine NHS screening programmes and resulted in no further action then you do not need to tick yes to this question)…

Ms B answered 'no' to both questions.

The relevant moratorium date is 6 October 2017 although Ms B joined the Aviva policy in October 2021. She was discharged from her consultant oncologist's care in October 2019. She had a 'CA125' check in September 2020. A CA125 check is a blood test which checks for a particular protein which is commonly associated with detection of ovarian cancer. In September 2021 she had a general health check and a further CA125 check.

I think it was reasonable for Aviva to conclude Ms B ought to have answered 'yes' to the switching questions. Ms B was asked in October 2021 if she had any consultations, tests, medication or treatment in the last 5 years relating to any type of cancer or suspected cancer. She'd had a consultation with her consultant, attended her GP and had tests which related to cancer. All of this took place within five years of October 2021 which was when she joined the policy.

Based on the evidence available to me I don't think it's reasonable to conclude these were consultations or tests which were part of a routine NHS screening programme. I think it's more likely these were follow-up tests to monitor Ms B for ovarian cancer and keep an eye out for recurrences of it.

Aviva hasn't confirmed what action they would have taken had they been aware of Ms B's

medical history. But, for the reasons I'll go on to explain I think there are other reasons why Ms B's complaint shouldn't be upheld.

The moratorium

Aviva has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

The policy terms and conditions say:

> We do not cover treatment of any pre-existing condition, or any pre-existing condition, or any related condition, if you had:
>
> - Symptoms of
> - Medication for
> - Diagnostic test for
> - Treatment for, or
> - Advice about
>
> That condition in the five years before you joined the policy.
>
> However, we will cover a pre-existing condition if you do not have:
>
> - Medication for
> - Diagnostic tests for
> - Treatment for, or
> - Advice about
>
> That condition during a continuous two-year period after you join the policy.

'Advice' is defined as:

> 'Any consultation, advice or prescription from a GP or specialist'.

The moratorium period started in October 2017. Ms B's diagnosis was in October 2013 and she had treatment followed by consultations until 2019, as well as blood tests after that date. Ms B continued to visit her GP for tests, and I think it's reasonable to conclude that amounted to her receiving advice about her condition. So, I think it's most likely this was a condition that met the criteria set out in the moratorium terms I've set out above.

Ms B's position is that she was cancer free between 2019 and 2021 and so she should be covered by the policy. But, I don't think Ms B had a continuous two-year period without 'advice' as she's suggested. For example, as I've outlined above, she had an appointment for a CA125 blood test in September 2020. She also had a further appointment for the same test in September 2021. I think it's most likely they fall within the period Ms B says she didn't receive any advice about her condition. I also think Aviva fairly concluded a GP appointment for a blood test which checks for cancer can reasonably considered to fall within the relevant policy definition of 'advice'.

I've taken Ms B's representations into account, but they haven't changed my thoughts about the outcome of this complaint. I'm not persuaded that the blood tests were routine in the way Ms B has suggested. As I've outlined above, I think Ms B was most likely being monitored for a recurrence of cancer. So, even if the tests weren't being used as diagnostic tests, I still think they can reasonably be considered as her seeking advice about her condition.

I appreciate Ms B feels that she didn't get 'advice' in relation to any form of cancer in the two years before her claim. She said that any form of GP appointment would then be 'advice'. I don't agree. And, in any event, Ms B was attending her GP in order to complete the CA125 check. So, she was attending her GP for a specific purpose, linked to her previous diagnosis of cancer.

I also think Aviva reasonably relied on the medical evidence provided by Ms B which suggested that there had been a reoccurrence of the cancer. That was reflected in the medical evidence that was available to Aviva at the time. I appreciate that Ms B received more information at a later date. But that information wasn't available to Aviva and they could only act on the basis of the information available to them. I don't think it would have been reasonable to expect Aviva to pay for the claim until a more detailed analysis had taken place, particularly bearing in mind the overarching evidence relating to the moratorium period.

I've taken into account what Ms B has said about Aviva's handling of the claim. I appreciate that this took place at a worrying and difficult time for her. However, I've not seen evidence that Aviva caused unreasonable delays when handling the claim. The circumstances surrounding the claim were complex and I think this meant that Aviva had to ask for more information to ensure that the claim was assessed fairly. Whilst I appreciate that it was frustrating for Ms B, I don't think Aviva acted unreasonably in the circumstances of this case.

The sale of the policy

If Ms B has concerns about the sale of the policy, including any advice or information given by her broker, she'll need to make a complaint to the broker first.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms B to accept or reject my decision before 8 August 2023.

Anna Wilshaw
Ombudsman