DRN-4052134

The complaint

Miss M complains that Aviva Insurance Limited has unfairly declined her private medical insurance claim and cancelled her policy.

What happened

In December 2021 Miss M took out a private medical insurance policy through Aviva. The policy was underwritten on a moratorium basis.

In March 2022, Miss M made an online claim to Aviva to obtain authorisation to see a consultant in relation to painful periods. Miss M told Aviva the symptoms had started in January 2022 and that she hadn't suffered from any gynaecological problems previously. The claim was accepted.

Later in 2022, Aviva says her claim came up as part of a routine audit. It requested additional information about her previous medical history. As part of this information, Aviva received a letter relating to a consultation Miss M had in January 2021. In this letter it referred to Miss M suffering from painful periods. Based on this information, Aviva declined the claim as it said that the symptoms were in existence prior to her claim in early 2022. It also said that, as Miss M had made a false statement about her previous medical history, it would cancel her policy from March 2022 and Miss M would be required to pay for all the treatment she had received.

Unhappy with this, Miss M made a complaint to Aviva and brought the complaint to our service. Our investigator looked into the matter but found that it was fair and reasonable for Aviva to rely on the medical information it had been provided to decline her claim and cancel the cover. Miss M disagreed with this outcome. She said that the comments on the letter from January 2021 related to historical symptoms she had suffered in 2016, not at the time of the consultation. As no agreement could be reached, the matter has been 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 is important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Miss M. Rather it reflects the informal nature of our service, its remit and my role in it.

The relevant rules and industry guidelines say that insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when deciding what I think is fair and reasonable in the circumstances of Miss M's complaint.

The policy terms and conditions

Miss M's policy is underwritten on a moratorium basis. The policy states the following:

> *We do not cover treatment of any pre-existing condition, or any related condition, if you had:*
>
> *• symptoms of*
> *• medication for*
> *• diagnostic tests for*
> *• treatment for, or*
> *• advice about*
> *that condition in the five years before you joined the policy.*
>
> *However, we will cover that 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.*

I think the above makes it clear that Aviva won't cover any medical conditions, which a policyholder has experienced symptoms of in the five years before the policy began. In this case, the relevant moratorium period began in December 2021.

The policy also includes a section relating to the cancellation of the policy – Section 7 – and within this section it states:

> *7. Cancelling the policy*
> *If a claim made by, or on behalf of, the policyholder or a member is in any way fraudulent or fraudulently exaggerated or supported by a false statement or fraudulent evidence, we may:*
>
> - *refuse to pay the claim, and*
> - *recover any sums paid by us in respect of the claim.*
>
> *In addition:*
>
> - *where the claim is made by, or on behalf of, the policyholder, we may cancel the policy back to the date of the fraudulent act and keep all premiums. This will end the cover of the policyholder and all members listed on the policy schedule…*

Has the claim been declined fairly?

Aviva said that when Miss M made contact in March 2022, she indicated that the symptoms had started in January 2022. Aviva asked Miss M if she had suffered from gynaecological problems previously – Miss M said she hadn't. She also provided a GP form with details of the consultations she had with her GP – these show the last time she had consulted the GP about period pain had been in 2016. On this basis, Aviva agreed the claim.

Towards the end of 2022, during a routine audit, Aviva reviewed the claim and asked for additional medical information. Within this was a consultant's letter, dated January 2021, which referred to Miss M suffering from dysmenorrhea (painful periods). As this consultation

took place within the five years prior to the policy being taken out, Aviva said her symptoms of painful periods were pre-existing and therefore the claim being made wasn't covered.

Having looked at this letter I can see that the consultant refers to Miss M's periods being "*regular with some dysmenorrhea during the first couple of days*". Based on what has been written, I think it is reasonable to consider that Miss M was suffering from these symptoms in January 2021. As this was less than a year before the insurance policy was taken out, it follows that these symptoms occurred within the five years prior to the policy inception. And the policy terms and conditions are clear that medical conditions where symptoms are suffered in the five years prior to taking the policy are not covered. I'm satisfied that Aviva's decision to decline the claim is fair and reasonable.

Miss M has stated that she believes the letter from the consultant refers to her previous history of painful periods in 2016, which is outside the moratorium period of the policy, and not any current symptoms. I've noted her comments and considered this point carefully. The letter refers to Miss M's periods being regular with some dysmenorrhea – I'm of the opinion that this has been written in the present tense. I therefore don't think it is unreasonable for Aviva to consider that the consultant was referring to current symptoms at the point the letter was written.

I'm aware that Miss M feels that Aviva has ignored the medical evidence supplied by her GP which she says shows she hadn't seen her GP for painful periods since 2016. I've looked at the information sent to Aviva, and I note that there doesn't appear to be any consultation with her GP regarding painful periods after 2016 until the time of the claim. But the policy states it won't provide cover if there have been symptoms of the condition in the last five years, regardless of whether she had seen her GP or not. Based on what is written on the letter from January 2021, such symptoms were present at that time - this is within the five-year period prior to the policy inception. So, this doesn't change my outcome.

Miss M is also unhappy that Aviva agreed to cover the claim initially and it wasn't until nearly six months later that the claim decision was overturned, cover was refused, and the policy was cancelled. Miss M has incurred treatment which she is now required to fund herself - she doesn't think this is fair. Aviva has said that the claim was subject to a routine audit, and it was only when it requested further medical evidence that the consultant's letter was provided. I don't think it is unreasonable for Aviva to conduct audits on claims periodically. And based on the new information made available, which appears to contradict what was provided previously, I'm satisfied that Aviva has acted in accordance with the policy terms and conditions when cancelling the cover and requesting the refund. I don't require it to do anything more.

My final decision

For the reasons mentioned above, I don't uphold this complaint.

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

Jenny Giles
Ombudsman