DRN-4184441

The complaint

Mr T complains about Aviva Life & Pensions UK Limited's decision to decline his application to increase the cover available under his personal income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main issues.

In 2020, Mr T took out a personal income protection insurance policy with Aviva. Shortly afterwards, he had to make a claim for benefit after he became unfit for work due to tinnitus. Initially, Aviva cancelled Mr T's policy, as it considered he hadn't fully disclosed his medical history at the time he applied for the policy. However, it later agreed to reinstate the policy, which included an exclusion for stress and anxiety and other conditions it considered to be associated with stress and anxiety. It accepted Mr T's claim and settled it, without requiring Mr T's full medical records or financial information – which meant it settled the claim on an ex-gratia basis.

Subsequently, in June 2021, Mr T applied to increase his cover level. Mr T says he was told that this would need to be treated as a new policy application and that any increased cover would run as a new policy alongside the existing one.

Aviva turned down Mr T's application. It said that given Mr T's noted medical conditions of stress and anxiety; back pain for which he was awaiting the results of an MRI and tinnitus; it would have needed to apply three exclusions to the policy. This was above its risk threshold and so it wasn't prepared to offer increased cover.

Mr T was unhappy with Aviva's decision and he complained. He didn't think the policy terms included underwriting criteria and he felt the exclusions Aviva would've applied to his contract were at odds with the wider exclusion applied to his existing policy. In addition, he considered that the exclusion added to his existing policy was unclear and ambiguous.

Aviva didn't uphold Mr T's complaint and so he asked us to look into his concerns.

Our investigator concluded that Mr T had brought some of his complaint to our service too late. She noted that Aviva had issued a final response to Mr T's complaint about the way his claim had been handled in February 2021. This letter had also dealt with the terms on which that policy had been set-up. Aviva had given Mr T referral rights to raise those issues with our service within six months of that letter. And Mr T had made a new complaint about the way that applications were dealt with by Aviva. A final response was issued to that complaint in March 2022 – again providing referral rights to our service, within six months of that letter. But Mr T hadn't complained to us until February 2023 – more than six months after the date of both letters. And so the investigator felt that we couldn't look into those particular complaint points under our rules.

The investigator thought we *could* consider Mr T's complaint about Aviva's decision not to increase his cover level and the omission of underwriting criteria from the policy terms. She

didn’t think Aviva was required to set out its underwriting guidelines in the policy booklet. And she explained why she was satisfied that Aviva had provided enough evidence to show why Mr T exceeded its risk threshold. She didn’t think there was evidence to suggest that Mr T had been singled out unfairly. And she concluded it had been reasonable for Aviva not to increase Mr T’s cover.

Mr T disagreed and I’ve summarised his responses. He considered that the exclusions Aviva would have applied to any new policy were ambiguous and discriminatory under the Equality Act 2010. He didn’t think it had provided evidence to show that information it had relied upon was relevant, reliable or reasonable. He considered that the exclusion which had been applied to his original policy was medically incorrect. He didn’t agree that we couldn’t look into the terms of the original policy. That’s because he said the issue with the original exclusion being unfair and discriminatory had only arisen after the application for an increase in Mr T’s cover level had been declined. He also didn’t think it was fair for Aviva to treat tinnitus separately, as he said it was widely considered to be linked to mental health conditions and so it should fall under the original policy exclusion.

Additionally, Mr T considered that exceptional circumstances applied which meant we should look into his time-barred complaints. He said that the complaints had been made against the background of a pandemic. And he also noted that Aviva had continued to correspond with him after it had issued its final responses to his complaints. He said all he wanted was the opportunity to have his salary covered in the same way a person without a disability could.

The complaint’s been passed to me to decide. I’ll firstly consider the issue of our jurisdiction. And secondly, I’ll consider whether I think it was fair for Aviva to decline to increase Mr T’s cover level.

My findings on jurisdiction

The rules about complaining to the ombudsman set out when we can – and can’t – look into complaints. In this part of my decision, I’ve explained what this means for Mr T's complaint.

Our service isn't free to consider every complaint that's brought to us. We're governed by rules set by the industry regulator, the Financial Conduct Authority (FCA). They're called the DISP rules and can be found in the FCA's handbook. The rules set out the complaints that we can (and can't) look into.

DISP rule 2.8.2 states that the Financial Ombudsman Service cannot consider a complaint if it’s referred to us more than six months after the date of the financial business’ final response letter unless that business consents to us looking into it. In this case, Aviva hasn’t consented to us considering the complaint points that its final response letters of February 2021 and March 2022 addressed. The issues covered by the February 2021 final response letter were the handling of Mr T’s claim and the terms on which the income protection policy had been set-up. And the second final response addressed the way that Aviva handled policy applications.

Both of Aviva’s final response letters told Mr T that he had six months from the date of each letter to refer his complaint to this service. That meant that Mr T had until August 2021 to complain to us about the claims handling and the terms on which the policy was set-up. And he had until September 2022 to refer a complaint to us about the way Aviva dealt with policy applications. But Mr T didn’t complain to us about these specific issues until February 2023, which was more than six months after the date of each final response. On that basis, I find that Mr T brought these particular complaint points out of time.

The rules say I can set the time limit aside if I’m satisfied a consumer’s failure to comply with

them was as a result of exceptional circumstances. There is no definitive list of what would be considered to be exceptional circumstances but the rules gives an example of where a consumer might have been incapacitated.

Mr T says that these complaint points weren't referred in time because correspondence had continued between him and Aviva after the final responses had been issued. He said he thought he had to exhaust the complaints process fully before approaching our service. He also said that dealing with the issues caused by the Covid-19 pandemic had taken up a lot of his time and focus. He also said the complaint point about the exclusion hadn't arisen until he tried to apply for the new policy.

I've thought about Mr T's comments carefully. But I don't think I could fairly find that these were exceptional circumstances. I think Aviva made it very clear that if Mr T wished to pursue the complaints, he'd need to refer them to us. And it remains the case that both he, and a representative, were able to contact Aviva during the relevant timeframe. So I think it follows that Mr T likely could have sent us a brief email or made a quick call to register his complaints within the applicable six month periods.

On that basis, I don't think exceptional circumstances apply and my decision is that Mr T's complaint points about the terms on which his 2020 policy were set-up and how Aviva handles applications were made too late. While I appreciate this will come as a disappointment to Mr T, I find that I don't have the power to consider those particular issues. As such, I won't be looking into whether the 2020 policy exclusion was fairly applied or whether it's ambiguous and medically wrong. Mr T appeared to accept Aviva's underwriting terms, which included the exclusion and the final response letter made clear the terms on which cover would apply following the assessment of the claim. So if he'd felt the exclusion had been unfairly applied, he had six months following the final response of February 2021 to complain to us about that issue.

If Mr T wishes to send the medical evidence he's gathered regarding the conditions set out within the exclusion to Aviva for its consideration, it's open to him to do so. I say that because it isn't at all clear that Aviva has had an opportunity to review or comment on all of the NHS 111 evidence Mr T has sent us.

I'll now proceed to consider the complaint point I *do* have the power to look into. That's whether or not it was fair for Aviva to decline to increase Mr T's cover limit.

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.

Having done so, whilst I'm very sorry to disappoint Mr T, I don't think Aviva has treated him unfairly and I'll explain why.

It's clear that increasing the level of cover available under income protection was very important to Mr T. I don't doubt how upsetting it was for him when Aviva didn't agree to offer him a new policy to sit alongside his existing income protection insurance cover.

But it's important that I make it clear that we're not the industry regulator. This means we don't have the power to tell a financial business how it should operate; what products it should offer or what prices it should charge. And we can't tell insurers what policies they can offer or which risks they should and shouldn't accept. In Mr T's case, it means that I can't simply direct Aviva to amend Mr T's existing policy to increase the benefit level. Nor that I can tell it to set-up a new policy for Mr T when it's demonstrated that it wouldn't otherwise

have done so. I also can't require Aviva to set-up a new policy on exactly the same basis, or to apply the same exclusion to a new policy which apply to the existing one, given it's entitled to underwrite each new policy application based on its underwriting terms.

I'd add too that insurers aren't required or obliged to set out their underwriting criteria within their contract terms. That's because underwriting information is generally commercially sensitive to an insurer's business. This isn't unusual – in my experience, it would be very unlikely that any insurer would include underwriting guidance within their contract documents. And I wouldn't reasonably expect Aviva to set out how it rates risk when it assesses income protection applications.

What I can do though is to look at the underwriting guidance Aviva has relied upon when deciding whether or not to offer Mr T a new policy and whether it's done so fairly. This is so that I can be satisfied that Mr T has been treated in the same way as any other Aviva customer in similar circumstances and hasn't been singled out in any way.

Aviva has provided me with detailed, underwriting evidence which shows the reasons why it declined to offer Mr T a new policy to increase his cover level. This information is commercially sensitive and so I'm afraid it's confidential. Therefore, I'm unable to share the evidence with Mr T. What I can tell Mr T is that Aviva has demonstrated that based on the information it holds about his existing medical conditions and medical history, it would have applied three exclusions to any new policy. And its underwriting guidance clearly shows that Aviva is unable to offer income protection cover to any customer for this type of policy if more than two exclusions would apply. On that basis, I find that Aviva declined to offer Mr T increased cover in line with its own underwriting guidance. I'm satisfied too that it would've declined to increase cover for any other customer in Mr T's circumstances and so I don't think Aviva singled Mr T out or treated him unfairly.

I appreciate Mr T disagrees with the number of exclusions that Aviva calculated would apply, given the one exclusion it applied to the original policy. I'm not a medical expert and so it wouldn't be appropriate for me to tell Aviva how it should categorise medical risks. But from Mr T's application form, it seems that he was taking painkillers for back pain, had undergone an MRI to investigate the cause and was waiting for the scan results. Accordingly, Mr T's back pain appears to have remained an undiagnosed condition at the point of application. So I think it was reasonable for Aviva to treat back pain under investigation as a separate and specific exclusion. Mr T had disclosed anxiety and depression when he took out the 2020 policy and so I find it was reasonable for Aviva to accordingly exclude these conditions when considering any new application. And there's no dispute that Aviva had already settled a claim (whether on an ex-gratia basis or not) for Mr T's tinnitus, which appeared to develop between the start of the 2020 policy and the date of the application to increase cover. As such then, again, I don't think it was unfair for Aviva to conclude that this too would be excluded on any new policy.

It isn't unusual for income protection insurers to exclude some conditions from cover which exist at the time an application is made. That's because the insurer thinks there's a higher risk of claim from a condition which has already been diagnosed and which a policyholder already suffers from.

Mr T says he feels that Aviva has treated him unfairly to the point of discrimination. I can understand why Mr T feels this way, but, having looked at all the evidence, I don't think Aviva has done so. And taking into account my findings above, nor do I think Aviva has acted unfairly or unreasonably. I do hope that it helps Mr T to know that someone impartial and independent has looked into his concerns.

Overall, despite my natural sympathy with Mr T's position, I don't think it was unfair for Aviva to conclude that it wasn't prepared to increase his cover. In any event, I wouldn't expect Aviva to pay the full amount of Mr T's salary in the event of a claim. I say that because income protection insurance generally pays out a set proportion of an insured person's earnings while a claim is in payment.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 28 August 2023.

Lisa Barham
Ombudsman