DRN-4465173

The complaint

Mr and Mrs V complain about the way that Vitality Health Limited has handled claims they made on a personal private medical 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 key events.

In January 2023, Mr and Mrs V took out a personal private medical insurance policy. In late January 2023, Mrs V made a claim for investigation into a breast lump. And in February 2023, she made a claim for varicose veins.

Vitality looked into Mrs V's claims and it asked for further information from third-party medical professionals. Mrs V chased Vitality at regular intervals for updates on her claims but was told that the claims remained under review.

Unhappy with the delays she'd experienced, Mrs V made a complaint to Vitality about its claims handling. Vitality didn't respond to Mrs V's complaint within the eight-week timeframe set out by the industry regulator and nor did it provide her with an outcome to either of her claims. So she asked us to look into her complaint.

After the complaint had been brought to us, Vitality issued its final response letter on 16 June 2023. Briefly, Vitality explained that it had needed further information in order to assess both claims. It stated that it had decided that Mrs V's breast claim could be accepted in March 2023, but that it was still in the process of reviewing the varicose vein claim. It acknowledged that it hadn't handled Mrs V's claims as well as it should have done and so it paid her £75 compensation.

Our investigator didn't think Vitality had handled Mrs V's claim fairly. She noted that on 4 June 2023 – prior to Vitality sending its final response letter – Mrs V had provided it with consent to access her medical records. However, nine months after the claim had been made, Vitality still hadn't made a decision in respect of Mrs V's claim for varicose veins. This was despite it being aware that Mrs V had booked a procedure for the end of August 2023, which she had undergone and self-funded. So she didn't think Vitality had paid Mrs V fair compensation to reflect the trouble and upset its handling of the claim had caused her. She therefore recommended that Vitality should pay total compensation of £250 and that it should make a claims decision within four weeks of her assessment.

Vitality disagreed with the investigator's findings. It sent us a copy of a letter, dated 4 October 2023, which it had sent to Mr and Mrs V. The letter, in brief, stated that it considered that Mr and Mrs V had made a misrepresentation about Mrs V's health when they'd taken out the policy and that depending on Mr and Mrs V's comments, it intended to apply an exclusion on cover. The letter also stated that once an exclusion had been applied, the claim would be reassessed in line with the new cover terms.

So Vitality considered that many of the delays in assessing the claim had been driven by

misrepresentation and that this therefore ought to have been taken into account. It also thought that we should consider the claims handling and ultimate claims decision as one complaint. It told us that it had agreed to pay Mr and Mrs V £100 compensation, but given the misrepresentation, it didn't think it was fair to ask it to increase the award.

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, I agree with our investigator that the fair outcome to this complaint is for Vitality to pay Mr and Mrs V a total of £250 compensation and I'll explain why.

First, I must make the parameters of this decision clear. Since the investigator issued her findings on Mr and Mrs V's complaint, Vitality has contacted Mr and Mrs V to let them know that it thinks they answered some of its medical screening questions wrongly when they applied for the policy and that therefore, it intends to add a retrospective exclusion to the contract.

However, I note that this letter asked for Mr and Mrs V's comments and indicated that the claim would be reassessed if and when an exclusion was applied to the policy. It seems to me then that no claims decision had been made at the point the complaint was referred for an ombudsman's decision. Nor have Mr and Mrs V asked us to consider a complaint about this particular issue. Their complaint – and the complaint Vitality addressed in its final response letter – was about the delays in Vitality handling their claim and the poor service they'd received. Therefore, my decision is limited to considering the delays in reaching claims decisions and the service Mr and Mrs V received. If Mr and Mrs V are unhappy with Vitality's proposal to add an exclusion to their policy or with any claims decision it consequently goes on to make, they may be able to make a new complaint to us about that issue alone.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. Vitality accepts that it didn't handle Mr and Mrs V's claims as well as it should have done and so it now says it is prepared to pay £100 compensation to reflect this. So I've gone on to decide whether I think this is a fair and reasonable award.

And I don't think it was. Having looked at Vitality's claims notes, I accept that much of the delay in assessing both claims was caused by it needing to ask for further medical and other information. However, it's clear that Mrs V wasn't called back at times when I think she should have been. She was put to unnecessary time and trouble in chasing things up. I also think there were periods when the breast claim in particular appeared to be largely inactive. I say that because I can see that Vitality had agreed to accept this claim on 16 March 2023. But the notes don't suggest that this decision was communicated to Mrs V at this point, or that the invoice was actioned until early June 2023. The notes also indicate that two excesses had been applied to invoices in error, which I think is also likely to have caused some additional worry to Mrs V.

I'm mindful too that Vitality was aware that Mrs V had booked surgery to treat varicose veins which was due to take place at the end of August 2023. I appreciate it needed more information before making a cover decision. But I can't see that Vitality provided Mrs V with meaningful or regular updates about the progress of her claim after she submitted her consent to access her medical records on 4 June 2023. It seems Mrs V continued to get in touch with Vitality to chase things up but didn't receive a substantive update until the letter of 4 October 2023. In my view, while Vitality may not have been in a position to provide a claims decision at the point it issued its final response and in the months afterwards, I do

think it could have kept Mrs V better updated throughout a broadly nine-month period.

Overall then, I agree with our investigator that a total award of £250 compensation (less any amount already paid) is a fair and reasonable award to recognise the trouble and upset I think Vitality's delays in handling Mrs V's claim and the poor service it provided caused her. So I'm now directing Vitality to pay Mr and Mrs V total compensation of £250.

My final decision

For the reasons I've given above, my final decision is that I uphold this complaint.

I direct Vitality Health Limited to pay Mr and Mrs V total compensation of £250 (less any amount it's already paid).

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr V and Mrs V to accept or reject my decision before 3 January 2024.

Lisa Barham
Ombudsman