DRN-4290282

The complaint

Mrs M complains about how AWP P&C SA ('AWP') handled a claim under her private medical insurance policy. Mrs M also complains because AWP refused to renew her policy, at a time when she was undergoing medical investigations.

All references to AWP include the agents appointed to administer claims on its behalf.

What happened

Mrs M took out a private medical insurance policy, provided by AWP, which started on 1 March 2022.

In November 2022, Mrs M made a claim under the policy and sent AWP a private referral letter from her GP. AWP replied to Mrs M on the same day and said it appeared from the information provided that Mrs M's claim related to a pre-existing medical condition and, so, wouldn't be covered under her policy. AWP said it would reassess the claim if Mrs M had any other medical evidence.

The following day, Mrs M sent AWP another private referral letter from her GP. She asked AWP to remove the previous referral letter from her claim, as it contained incorrect information. A few days later, Mrs M also sent AWP an extract from her medical records dating from February 2020, which she said showed that the condition she was claiming for wasn't pre-existing. In response, AWP said it would need further information from Mrs M's GP and sent Mrs M a consent form to complete. AWP subsequently sent Mrs M a copy of a medical report for her GP to complete if she wished to arrange for this to be done herself.

In December 2022, Mrs M sent AWP a letter from her GP in support of her request for a private referral. On the same day, AWP told Mrs M that the available information indicated her medical condition was pre-existing, and that it wouldn't reassess her claim unless Mrs M either arranged for her GP to complete the medical report or returned a signed consent form to allow AWP to contact her GP directly

A few days later, Mrs M sent AWP another private referral letter from her GP. Mrs M said her previous GP wouldn't complete the required medical report and she was waiting for her current GP to do so. AWP reiterated that it would need a completed medical report in order to review the claim and, if there was an issue with Mrs M's medical records, she'd need to speak to her current GP about updating these. AWP sent Mrs M another medical consent form to complete if she wished for AWP to contact her GP directly.

In early January 2023, Mrs M sent AWP a medical report completed by her GP but AWP said there was information missing. Mrs M subsequently sent AWP an email from her GP surgery about incorrect information which had been provided previously, as well as information about previous A&E attendances. After reviewing this evidence, AWP said it would need to contact Mrs M's GP directly about her medical history and it sent Mrs M a new consent form to complete. Around the same time, AWP told Mrs M it would only communicate with her via email because of what it said were her rude and disrespectful interactions with its staff over the telephone.

On 31 January 2023, after receiving and reviewing further information received from Mrs M's GP, AWP said it would pay for Mrs M's initial consultant's appointment but that her claim for the costs of a scan wouldn't be covered as the scan was related to a pre-existing medical condition.

AWP wrote to Mrs M on 1 February 2023 to say it wouldn't be renewing her policy.

On 6 February 2023, AWP authorised payment for further tests, including a follow-up consultation with a specialist to discuss the test results.

Having complained to AWP at various points throughout the claims process, Mrs M brought the matter to the attention of our service.

One of our investigators looked into what had happened and said she didn't think AWP had acted unfairly or unreasonably in the circumstances. Mrs M didn't agree with our investigator's opinion, so the complaint has been referred to me as the final stage in our process.

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.

Rules set out by the industry regulator (the Financial Conduct Authority) say that insurers must handle claims promptly and fairly and shouldn't unreasonably reject a claim. The rules also say insurers should provide reasonable guidance to help a policyholder make a claim, as well as appropriate information on the claims progress. I've taken these rules into account when making my final decision about Mrs M's complaint.

A policyholder has a duty to provide sufficient evidence to demonstrate that they have a valid claim under their insurance policy, and an insurer is entitled to make reasonable enquiries and request reasonable information to satisfy itself that a claim satisfies the criteria for payment under the policy terms and conditions before accepting cover. I'd expect a policyholder to cooperate with an insurer's reasonable requests for information. In my experience of dealing with complaints like this one, it's not unusual for an insurer to require the completion of a GP's medical report when assessing a claim and I don't think it was unreasonable for AWP to do so here.

It's not up to Mrs M – or her GP, her insurance broker or her solicitor - to decide what evidence AWP reasonably needs to assess whether there is a valid claim under her policy, or to seek to interpret what the pre-existing medical condition exclusion and/or the moratorium provisions mean – that's for AWP's medical team to do under the terms of AWP's contract with Mrs M.

I accept that Mrs M says the first private referral letter which she provided from her GP contained incorrect information. But, if that was the case, then that was something which Mrs M needed to take up with her GP directly so her GP could confirm to AWP what the errors were. AWP had no way of knowing at the outset how long Mrs M had been with her GP and AWP was reasonably entitled to rely on the contemporaneous medical evidence which Mrs M submitted in support of her claim. Based on the content of this first referral letter, I don't think it was unreasonable for AWP to conclude that Mrs M's claim likely related to a pre-existing medical condition. And AWP offered to reassess Mrs M's claim if she provided new medical information, which I think was fair and reasonable in the circumstances.

I wouldn't have expected AWP to entirely disregard the content of the first referral letter

based purely on Mrs M's testimony, without specific clarification from the doctor who'd written the letter about what the inaccuracies or errors were. The second private referral letter didn't confirm this. While the second letter removed reference to Mrs M having significant chest issues *'over the last year or so'*, it inserted a reference to Mrs M having a persistent cough. I don't think this second letter, even when taken with the time-limited extracts of medical records which Mrs M sent to AWP, means that AWP was unreasonable in again concluding that Mrs M's claim likely related to a pre-existing medical condition.

I don't think the letter from Mrs M's GP surgery dated 6 December 2022 is persuasive medical evidence that the position which AWP had taken was unfair. And I'm not satisfied that the third private referral letter from Mrs M's GP dated 9 December 2022 was satisfactory evidence upon which it would have been reasonable for AWP to accept this claim without the completion of a medical report either. The brief email from Mrs M's GP surgery dated 9 January 2023 and the evidence relating to A&E attendance also don't change my findings on this point.

In summary therefore, I'm satisfied that AWP wasn't unreasonable in turning down Mrs M's claim based on what I think was the somewhat contradictory and unclear information available to it up until this point. And I'm also satisfied that AWP was fairly entitled to request the medical report it was asking for from Mrs M's GP. I think AWP did its best to explain to Mrs M, on more than one occasion, why this information was needed. While AWP did end up accepting Mrs M's claim in part once it received the completed medical report from her GP, this doesn't mean its previous actions were unreasonable. And I'm satisfied that AWP gave Mrs M the option of AWP contacting her GP directly from as early as 29 November 2022, so Mrs M didn't necessarily have to do this herself first.

Overall, I don't think AWP caused any excessive or unreasonable delays when handling Mrs M's claim. Based on the content of some of the calls I've listened to, I think Mrs M had somewhat unrealistic expectations regarding AWP's claims process. Any delays by or difficulties Mrs M experienced with her GPs were outside of AWP's control and were for Mrs M to resolve with her GPs directly.

As AWP has repeatedly explained to Mrs M, the moratorium provision applies regardless of when a pre-existing condition was diagnosed if the policyholder has had any <u>medication, advice, treatment or symptoms</u> [my emphasis added] for that condition or for related conditions in the five years before the policy start date. Mrs M's medical records show she was taking medication related to a pulmonary embolism in March 2017, which means the moratorium applies to this condition. A letter from Mrs M's consultant dated 15 December 2022 says the scan which AWP refused to pay for was arranged in connection with investigating effects from previous pulmonary emboli, so, based on the evidence available to AWP at the time, I'm satisfied that AWP wasn't unfair or unreasonable in refusing to pay for the scan – regardless of what the scan subsequently found as any secondary medical issues.

Mrs M's policy renews annually, as is clearly set out on her policy certificate, regardless of the length of time her premiums were fixed for. If Mrs M feels that the annual renewal provisions of her policy weren't properly explained to her when she bought the policy then she'd need to raise this with the business who sold her the policy in the first instance. The business who sold this policy is a separate and distinct business from AWP who is regulated in its own right, and AWP isn't responsible for the seller's actions.

AWP was under no obligation to offer Mrs M cover on an ongoing basis. The terms of Mrs M's policy say that AWP will tell Mrs M (or the broker) at least 21 days before the end of the period of insurance if the policy isn't being renewed. I'm satisfied that AWP did this, and that Mrs M received a letter from AWP dated 1 February 2023 confirming that her cover would

not renew, as this letter formed part of Mrs M's original complaint submissions to our service.

I've seen internal emails regarding AWP's decision not to renew Mrs M's policy and I'm satisfied this was because of Mrs M's conduct and comments during telephone calls with its staff. Having listened to some of the calls between AWP and Mrs M, I think AWP was entitled to take this position in the circumstances, regardless of whether swearing or threats were involved. I've seen no indication that Mrs M's complaint, the speed at which Mrs M provided the information requested and/or the cost of any future claims played any part in AWP's decision in this regard. I think AWP was entitled to refuse to renew Mrs M's policy, irrespective of whether or not she was awaiting any further investigations or treatment. And the fact that Mrs M had previously agreed to communicate only by email didn't prevent AWP from refusing to renew her policy at a later date if it no longer wished to have her as a customer.

Mrs M's policy only covers treatment which takes place during the period of cover, regardless of when pre-authorisation was given. The pre-authorisation code email which AWP sent to Mrs M in February 2023 confirmed that treatment would only be covered where a policy remained in force. So, the treatment which AWP pre-authorised for Mrs M would have been covered under the original policy, but not after that annual policy ended.

In summary therefore, I don't think AWP acted unfairly or unreasonably by refusing to renew Mrs M's policy and I won't be directing AWP to do anything further.

My final decision

My final decision is that I don't uphold Mrs M's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 17 November 2023.

Leah Nagle
Ombudsman