DRN-4258228

The complaint

A, a limited company, complains about the way Vitality administered its group private medical insurance policy.

Mr L represents A.

What happened

In November 2021, A took out a group private medical insurance policy through a broker, which was underwritten by Vitality. The policy beneficiaries were all covered under Vitality's 'Countrywide' list.

Subsequently, in September 2022, Mr L contacted Vitality as he wished to add a new beneficially, who I'll call Mr K, to A's group scheme. During the call, Mr L asked about cover options and he was told that the rest of the beneficiaries were set-up on the Countrywide list and that therefore, Mr K's policy should be set-up on the same basis. Mr L asked what would happen if Mr K was undergoing treatment with a medical professional who wasn't on the Countrywide list and he was told that this would be referred to the underwriting team.

A ultimately applied for Mr K to take out cover on a medical history disregarded basis, with the Countrywide list. The application form made no reference to any treatment Mr K was undergoing, or with which practitioner.

After Mr K had been added to A's policy in late September 2022, A made a claim on his behalf. However, the claim was for treatment at a hospital which wasn't on the Countrywide list. The terms of A's policy stated that Vitality's liability would be limited to 60% of the costs of treatment at a hospital which wasn't on the Countrywide list.

Mr L therefore asked Vitality whether Mr K's list could be changed. But Vitality told Mr L that the list could only be amended at renewal, which was due at the end of November 2022. In October 2022, Mr L enquired whether the hospital list could be amended for all of A's policy beneficiaries at renewal. However, Vitality ultimately told him that this wouldn't be possible as one of its members already had a claim in progress.

Unhappy with Vitality's position, Mr L complained on A's behalf. He felt Vitality hadn't asked him to check with Mr K where he was undergoing treatment and the importance of ensuring that Mr K's application was for the appropriate hospital list. He also felt it had provided him with misleading information about whether or not the policy could be upgraded at renewal and had delayed giving him a clear negative answer until the policy had already renewed. He asked us to look into A's complaint.

Our investigator thought A's complaint should be upheld. He considered that Vitality had advised A to add Mr K to the policy and that therefore it should have ensured the policy was suitable for him. As Mr K had been at an off-list hospital, the investigator didn't think the policy had been right for him. He felt Vitality ought to have stressed the importance of checking the hospital list when Mr L had called regarding the new application. He recommended that Vitality should agree to cover Mr K on the upgraded hospital list, backdated from the date he was added to the policy; that it should deal with any claims that

had been made as if Mr K had had the upgraded list cover from the start and that it should pay £200 for A's inconvenience.

I issued a provisional decision on 26 June 2023, which explained the reasons why I didn't intend to uphold A's complaint. I said:

'The addition of Mr K to the policy

Vitality didn't sell this policy to A – it was sold, in November 2021, by a broker. So Vitality wasn't responsible for any advice given about the policy when the contract was sold. The investigator has considered this complaint as if Mr K's application for addition to the group scheme was a new, advised sale by Vitality and assessed it in line with the regulatory obligations which apply to the advised sale of insurance policies. However, this wasn't a new sale – A wished to add Mr K to its existing group scheme. So I don't agree that Vitality recommended Mr K should join the existing policy, or that it needed to check the cover level was suitable for him.

However, Vitality did still need to give A clear, fair and not misleading information about the policy when it was dealing with Mr L's enquiries. And, on balance, while I think it could have been clearer in some regards, overall, I think it gave Mr L enough clear information about the way the policy worked.

I've listened carefully to a call between Mr L and Vitality in September 2022. Mr L asked a direct question about the level of cover Mr K would need. The call handler correctly told Mr L that the scheme was set-up with Countrywide list cover. They indicated that Mr K's application should be completed with the same hospital list. In my view, the call handler could have been a little more proactive in explaining that while A's existing policy beneficiaries all had Countrywide cover; this didn't mean it couldn't offer upgraded lists to new beneficiaries who were being added to the policy.

With that said, Mr L went on to ask what would happen if Mr K needed treatment which wasn't on the Countrywide list. The call handler told Mr L that the underwriter would look at the application form and would be in contact if this was the case to discuss a way forward. In my view, this didn't amount to indicating that Mr K's claims would be covered as if they were on an upgraded list.

And Mr L has consistently told us that he knew Mr K was undergoing treatment under his old employer's group scheme at the time he looked into adding Mr K to the policy. He's also stressed how important it was to Mr K and to A to ensure that Mr K was fully covered before switching from his old employer's scheme to the Vitality policy. It seems to me then, based on Mr L's question to the call handler, that he was reasonably aware of the possibility that Mr K's treatment might not be covered by the Countrywide list. So before going ahead and completing the application form, I think it might have been reasonable for Mr L to check with Mr K what treatment he'd undergone and where, to allow him to ensure that he applied for the correct hospital list.

Initially, A completed a continued personal medical exclusions 'switch' application form to add Mr K to the policy. It had ticked to say that it wanted Mr K to be added to the Countrywide list. I think the hospital list option was set out clearly and prominently. This form also included a table for an applicant to complete with details of any existing medical conditions, any treatment, investigations or surgery they'd undergone and when. This table was left blank and there was no indication as to the previous claims Mr K had made or where he'd undergone treatment. When this form was sent to Vitality, it appears Mr K's old group scheme policy certificate was sent with it. Mr K had previously held medical health disregarded cover. So Vitality's underwriters got in touch with Mr K to ask him to complete

the relevant medical health disregarded form instead. It seems to me then that had Mr K or A included details of his previous treatment on the application form, Vitality would've been in a position to notice, prior to his addition to the policy, that Mr K actually likely required a different hospital list.

When the second form was received, this too stated that A wished to add Mr K to the policy on the basis of the Countrywide list. Again, there was nothing on the form which I think ought to have put Vitality on notice that the Countrywide cover wouldn't provide full cover for Mr K and to accordingly give A the opportunity to amend the application. On that basis, I think it was fair and reasonable for Vitality to set-up Mr K's cover with the Countrywide list hospital option. And, in the round, I don't think it provided unclear or misleading information.

Did Vitality cause unreasonable delays in letting A know that the policy couldn't be upgraded?

The evidence I've seen indicates that Mr L was told, within a matter of days of his addition to the policy, that the full cost of Mr K's treatment wouldn't be covered, because the hospital wasn't on the Countrywide list. Understandably, Mr L looked into the possibility of upgrading Mr K's cover immediately; but was told this would only be possible at renewal. It's clear Mr L was told on a number of occasions that hospital lists (including for all scheme beneficiaries) could be upgraded at renewal. The policy terms and conditions make it clear that policies can only be changed at renewal, so I don't think Vitality gave Mr L misleading information on this point.

However, the policy was due to renew on 30 November 2022. And Vitality's notes indicate on 24 October 2022, over a month before renewal, that its call handler checked with the underwriters and told Mr L that Vitality wouldn't be able to upgrade the hospital lists for the group beneficiaries because Mr K already had a claim open. This was reiterated to Mr L on 7 November 2022 – again, a few weeks prior to the renewal date. And it was restated again in Vitality's final response to A's complaint on 16 November 2022.

I asked Vitality to provide me with evidence to show that it won't upgrade a group scheme hospital list at renewal in these circumstances. It's provided me with a statement from an underwriter, which I accept demonstrates that it won't upgrade hospital lists in these circumstances. I'm afraid I'm unable to share this with A, as it's confidential.

Overall, I don't think I could fairly or reasonably conclude that Vitality unreasonably delayed in telling A that the hospital lists couldn't be upgraded until after the policy had already renewed. In my view, A had been made aware of Vitality's position and this had been restated more than once ahead of renewal. Therefore, I think A was given an opportunity to look elsewhere for alternative cover - which included cover for the hospital lists it was seeking - if it wished to do so.

On balance, I don't think Vitality gave A unclear or misleading information and I think it fairly declined to upgrade A's policy's hospital list at renewal in line with its underwriting criteria. So I don't find it's treated A unfairly and it follows that I'm not planning to tell it to take any action.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

Vitality didn't respond by the deadline I gave.

Mr L, on behalf of A, disagreed with my provisional findings and I've summarised his responses:

- A hadn't taken out the policy through a broker in 2021 – it had been taken out directly with Vitality;
- There'd never been any intention on A, Mr L or Mr K's part not to get the application right. Mr L was happy for A to pay higher premiums for the right level of cover;
- Mr L felt it was Vitality's job to ensure a customer got the right cover, as the expert in the situation. He'd tried to draw out the relevant information through numerous conversations with Vitality;
- Mr L had clearly told Vitality that Mr K needed to join the policy to ensure his treatment was covered – and it hadn't done this. Mr L provided a copy of an email he'd sent Vitality attaching Mr K's application form and policy certificate, which stated that if it needed more information, it should contact Mr K directly;
- Mr K hadn't needed to fill in the table on the application form which I'd referred to in my provisional decision. That's because due to the size of A's business, those particular questions weren't applicable;
- Vitality had repeatedly told Mr L that the policy could be upgraded, but this hadn't been the case;
- Mr L felt I'd asked for more information late in the day which had impacted how I'd decided the complaint – he didn't think whether A had been adversely affected or not should affect the outcome;
- When Mr L had previously answered my questions about what A would've done differently, he hadn't answered this from Mr K's perspective – as Mr K had been the affected employee;
- Mr L found it hard to understand why I hadn't agreed with our investigator and felt I was setting a precedent which would allow an insurer to repeatedly provide incorrect information and then backtrack on it;
- A was only asking for Mr K to be moved to an upgraded list – the cost would be microscopic to such a large company;
- Mr L felt that if Vitality spent more money on its documentation and staff training than on advertising, A would not be in this position.

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 sorry to disappoint Mr L (acting on behalf of A), I've decided not to uphold this complaint and I'll explain why.

First, I'd like to reassure Mr L that while I've carefully considered all of the submissions he's made on A's behalf. But I haven't commented on each individual point he's made within this decision and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

It's clear that Mr L is very disappointed that I have reached a different conclusion to our investigator. In line with our process, our investigator issued his opinion and both parties had an opportunity to respond. Either party had the right to request an ombudsman's decision if they didn't agree with our investigator's view. Vitality didn't agree with the investigator's recommendations and so, the complaint was referred to me. As my opinion of the complaint differed from the investigator's, in accordance with our rules, I wrote to both parties to explain my reasoning and to give both parties an opportunity to provide new evidence or comments ahead of making a final decision. I'm satisfied that both A and Vitality have had the chance to send me any evidence they wished me to consider to allow me to make an independent and impartial decision on the merits of the complaint. It's also important I make

it clear that our decisions don't set precedent. Each individual case is assessed on its own specific facts and evidence.

Mr L says that the 2021 policy wasn't taken out through a broker. On the other hand, Vitality has told us that A's policy *was* sold through a broker. I don't think this is material to the complaint though. I say that because at the point A applied to add Mr K to the policy; the contract was already in place. Vitality didn't advise A to add Mr K to the existing contract and therefore, it remains the case that it didn't need to carry out an assessment of his demands and needs, or ensure it was suitable for him.

But Vitality did still need to give A clear, fair and not misleading information about the policy and the way it worked. As I explained, I've listened to the calls between Mr L and Vitality. It's clear that Mr L did want to try and ensure that Mr K would have the cover he needed and there was nothing to suggest that A was trying to cut costs. I've also looked at the application form again and I agree that given the financial and other characteristics of A's business, it does appear that Mr K wasn't required to complete the table I referred to previously.

However, I still think that, overall, Vitality did give A clear information about the hospital lists and how they worked. As I've said, given Mr L asked Vitality a direct question about what would happen if Mr K needed off-list treatment, it still appears that he was aware of the possibility that Countrywide cover might not be right for Mr K. I still don't think the call handler led Mr L to believe that Mr K would be covered regardless – I think they made it clear enough that this would be for the underwriter to decide.

Given the importance to A of ensuring Mr K's existing condition was covered by the new policy; I still think it would've been reasonable for Mr L/A to check with Mr K what treatment he was undergoing and where ahead of submitting the application forms. Had Mr L done so, I think he'd likely have realised that Mr K's treatment wouldn't be covered by the Countrywide list. And on balance, I think it's most likely that if Mr L or Mr K had given Vitality details of Mr K's ongoing treatment at the point of application, it would have been put on notice, ahead of policy set-up, that Mr L needed a different hospital list.

As I set out above, I found that the application forms are clear as to the hospital list options. Mr L selected Countrywide cover for Mr K. And I still think that overall, Vitality gave A clear information about the way the policy worked. So I'm satisfied that it was fair for it to set-up Mr K's policy on the Countrywide list basis.

Next, I've thought again about A's concern that Vitality repeatedly wrongly told it that the hospital list could be upgraded at renewal. I still don't think that this did represent misinformation. It's still the case that the policy terms allow for upgrades at renewal. And it would be for the underwriters to decide whether or not to approve an upgrade. I appreciate Mr L would like to see the underwriting evidence which shows that Vitality won't upgrade a policy in these specific circumstances. However, this is business sensitive information and that's why it's confidential. As such, I'm afraid I'm unable to share this information with him. Again, I'd like to reassure Mr L that Vitality did act in line with its own underwriting criteria when it declined to upgrade A's policy at renewal.

Prior to issuing my provisional decision, I asked A to comment on what it would've done differently had it known ahead of time that the policy couldn't be upgraded at renewal if a claim was in progress. It appears Mr L feels I asked for this information late in the day to reach a decision. I asked for this information in order to allow me to assess, what, if any, impact this matter had on A, as it necessarily formed part of my overall consideration of the complaint. It's also important that I stress that I need to consider any loss to A – as the policyholder. A is the complainant in this case. If Mr K feels that he's lost out because Vitality

potentially handled a claim on the policy unfairly, then he'd need to complain separately about that issue, as a beneficiary of the contract.

Based on all of the evidence, I'm still satisfied that Mr L was told that the policy couldn't be upgraded over a month before the policy renewal date. In my view, this gave him some weeks to explore other policy options and to decide whether to take out a new policy with a different insurer. It follows then that I remain persuaded that Vitality didn't unreasonably delay in telling Mr L that the policy couldn't be upgraded until the policy had already renewed.

Overall, despite my natural sympathy with A's position, I don't think that Vitality made any error here for which I could fairly or reasonably could direct it to pay compensation. Therefore, I'm not upholding this complaint.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask A to accept or reject my decision before 24 August 2023.

Lisa Barham
Ombudsman