DRN-4346367

The complaint

Mrs S complains about her private medical insurance policy with BUPA Insurance Limited.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here in full. In summary, in mid-January 2023, Mrs S applied to BUPA for a private medical insurance policy and completed a medical history form. In mid-February 2023, BUPA asked Mrs S to complete a medical history form. Mrs S was confused by BUPA's request, as she knew that she'd completed the form previously. She queried the matter with BUPA and provided it with a copy of the medical history form she'd already completed. BUPA said that it had sent Mrs S a text message in January 2023, asking her to call. Mrs S says that she didn't receive that text message and complained to BUPA.

Mrs S was frustrated by BUPA's progress in dealing with her complaint. In March 2023, Mrs S stopped her direct debit payments. The policy subsequently lapsed.

Mrs S says that she suspended her direct debit payments because she believed that she was paying for a policy that wasn't yet underwritten, so wasn't valid. Mrs S wants a refund of the two payments she made and to resolve the issue about the outstanding information.

In response to Mrs S' complaint, BUPA agreed that its service hadn't been good enough. It said that it couldn't find evidence that it had sent Mrs S a text message in January 2023 asking Mrs S to contact it. BUPA said that it hadn't responded adequately when Mrs S raised the matter. It said that it would have dealt with any claim made at the relevant time. BUPA paid Mrs S compensation of £100. Mrs S didn't think that was sufficient and pursued her complaint.

One of our investigators looked at what had happened. He thought that the compensation of £100 BUPA had already paid in relation to service issues was fair. The investigator didn't think that BUPA was at fault in cancelling the policy after Mrs S stopped her direct debit payments.

Mrs S didn't agree with the investigator. She said that he'd concentrated on the cancellation of the policy whereas her key point was that she was paying for a policy that wasn't valid or underwritten. Mrs S says that BUPA didn't make reasonable efforts to contact her for the information it required. She says that she had no alternative but to stop paying her subscriptions. Mrs S says that if she'd made a claim during the first two months of the policy, BUPA would have declined it as the policy wasn't underwritten, so two months' payments were wasted.

The investigator considered what Mrs S said but didn't change his view. Mrs S asked that an ombudsman consider her complaint, so it was passed to me to decide.

Mrs S has expressed concern about how BUPA handled her complaint. Our service can only consider complaints about financial services. So, I can't consider the additional points that Mrs S has raised about the handling of her complaint because it isn't a regulated activity.

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.

the relevant terms and conditions

The relevant parts of the membership terms say as follows:

'*1.* ***Cover for you and your dependants***
[…]
1.1.7 You must pay subscriptions […] in advance throughout your membership. […]
[…]
1.6.2 Your cover […] will automatically end if

- *you do not pay your subscriptions, or any other payment you have to make in respect of cover, on or before the date they are due. […]'*

has BUPA acted unfairly or unreasonably?

It's common ground that BUPA made errors in this case. It didn't send Mrs S a text asking her to contact it in relation to the additional medical information it required. Then it replaced her completed medical information form with a blank form on its system and asked her to complete it without explaining what additional information it required. I can see why that was confusing for Mrs S.

When Mrs S queried the matter, BUPA gave an incorrect response. Mrs S didn't find out what had gone wrong until BUPA's final response letter in April 2023. I appreciate that was frustrating. What should have been an easy process – setting up a policy – became a confusing and protracted matter.

I think that BUPA's payment of compensation of £100 is fair and reasonable in relation to the service issues Mrs S encountered. In reaching that view, I've taken into account the nature, extent and duration of the distress and inconvenience caused by BUPA's errors in this case.

BUPA wasn't at fault in relation to the lapsing of the policy. As I've set out above, the terms and conditions require payment of the subscriptions. Mrs S wants a refund of the payments she made as she says that she was paying for a policy that wasn't yet underwritten, so wasn't valid.

Mrs S is right that the underwriting process hadn't been completed but BUPA says, and I accept, that if Mrs S had made a claim it would have completed the underwriting process and dealt with the claim accordingly. That's what we would expect it to do. So, Mrs S had the benefit of cover even though BUPA made errors in its setting up of her policy. There are no grounds on which I can fairly direct BUPA to refund the payments Mrs S made.

I'm sorry to disappoint Mrs S but, for the reasons I've explained, I don't uphold this complaint.

My final 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 Mrs S to accept or reject my decision before 22 November 2023.

Louise Povey
Ombudsman