DRN-4734679

## The complaint

Ms T is unhappy that Vitality Health Limited (Vitality) declined her private medical insurance claim.

## What happened

Ms T took out a private medical insurance policy with Vitality which started on 5 August 2023.

Ms T had two policies set up at the same but one of these has now been cancelled and the premium has been refunded.

The policy is underwritten by Vitality and was taken on a moratorium basis. This means no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and, any medical practitioner, if required at the time of the claim. Any pre-existing medical conditions from the previous five years of starting the plan, are excluded. And pre-existing medical conditions can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

On 9 August 2023, Ms T sustained a knee injury. She contacted Vitality on 10 August 2023 to submit a claim. She had an online consultation, and a Condition Information Request (CIR) form was sent to Ms T. This was returned to Vitality on 14 August 2023.

Vitality assessed the claim and declined it due to pre-existing conditions. The CIR form was completed by Ms T's NHS GP and confirmed that she was diagnosed with a meniscal tear in her knee and had surgery to repair this in 2017. This fell outside of the moratorium period.

The GP also said that a consultation had taken place on 23 November 2018 for occasional left knee pain, following the surgery in the knee in 2017. This falls within the moratorium period. Vitality informed Ms T that her claim was declined. She said she would discuss this with her GP and dispute the information they had provided.

Ms T provided a further information from the consultant notes in November 2018 which confirmed she saw her GP regarding a road traffic incident and that she had no new injury to her knee. The notes also said she hadn't actively sought advice about her knee. Vitality's claims team approved Ms T's claim, but this was in error.

After a further review, it said as the GP notes say she was experiencing ongoing symptoms to her knee, the claim should have been declined. Vitality says Ms T was aware she had ongoing symptoms relating to her knee.

Treatment was authorised in error for Ms T to have a consultation, a diagnostics test, an MRI and up to six physiotherapy sessions. Vitality paid the fees, less an excess of £250.

Vitality says it informed Ms T not to go ahead with the surgery until it had been approved and if she did go ahead with it, it would be at her own risk. Vitality informed her that if she had to

cancel the surgery, it would reimburse her for the cost of cancellation.

There was ongoing communication between Ms T and Vitality and surgery was scheduled for 12 October 2023. Ms T says until the day of the surgery, she didn't know whether it had been authorised. But on the day of the surgery, she received a text to say it had been authorised, so she went ahead with it.

The text that was sent to Ms T on 12 October 2023, advised her to check her member zone for an authorisation letter, no further details were given. Vitality says the text was sent in error and no letter was generated for Ms T. Vitality says Ms T should have contacted it to check whether the surgery was approved before going ahead with the surgery and get clarification of this.

Following surgery, because the claim was declined, Ms T was being chased to pay the invoice for the surgery costs.

Ms T sent Vitality a further letter from her GP dated 21 December 2023. This letter clarified what the GP meant when the CIR form was completed on 11 August 2023. Vitality reviewed this and maintained its decision to decline the claim.

Ms T made a complaint to Vitality, and it maintained its decision to decline her claim due to the condition being pre-existing.

Unhappy with this, Ms T brought her complaint to this service. She's unhappy with the way her claim has been handled, the lack of communication and the ongoing issues she's had with the claim. She says she's now left with paying for the cost of the surgery and is facing financial difficulty.

Our investigator looked into the complaint. He said, he didn't think, on balance, it was fair for Vitality to decline the claim based on pre-existing conditions as the GP had provided clarification on what she'd meant when she completed the CIR form.

The investigator said, however, based on the rest of the policy wording, the claim still wasn't covered. This was because Ms T went ahead with the surgery knowing there was a risk the claim wouldn't be approved and knowing the cost would fall on her to pay. While the decision to go ahead was based on the text message Ms T had received, there wasn't evidence to say that the message confirmed treatment was authorised. And Ms T didn't contact Vitality to get this confirmed before she went ahead with the surgery. Our investigator said he didn't think the claim was declined unfairly on this basis.

He didn't think the service provided by Vitality was to the standard Ms T should expect. He therefore recommended that Vitality increase the compensation to a total of £275 for the failings.

Vitality accepted the investigator's findings.

Ms T disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

Ms T says she doesn't agree with the compensation amount of £275 as she'd paid premiums which total around £600. If Vitality had declined her claim in August 2023, she would have cancelled the policy and sought treatment through the NHS. Instead, she followed Vitality's treatment path, and she cannot afford to pay for the cost of the surgery. She also sent a further letter from the GP's practice manager for us to consider providing clarification of the notes made by the GP in the CIR form.

**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 insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly. I've taken these rules into account when making my decision about Ms T's complaint.

At the outset, I acknowledge that I've summarised this complaint in far less detail than Ms T has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern our service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to fulfil my statutory function.

*Has the claim been declined fairly?*

*Moratorium*

I've started by looking at the terms and conditions of Ms T's policy. On page 30 of the policy document, it states:

> *"Moratorium*
> *Before starting your cover, you did not have to answer any health questions on your application form or undergo a medical examination. Instead, each claim is assessed on the information provided by you and, if necessary, a GP (or other medical practitioner) when you claim. We apply a straightforward criteria when assessing your claim.*
> *The Moratorium Clause*
> *We don't pay claims for the treatment of any medical condition or related condition which, in the five years before your cover started:*
> *• you have received medical treatment for, or*
> *• had symptoms of, or*
> *• asked advice on, or*
> *• to the best of your knowledge and belief, were aware existed. This is called a 'pre-existing' medical condition."*

On page 48, it states:

> *"The moratorium clause excludes all conditions that you were aware of during the five years before your cover began, even if you have not needed to see a GP about them or taken prescribed medicine. The condition will become eligible for cover, subject to the terms and conditions of your plan, if you have not received any medical advice or treatment or taken any medication for that condition, or any related condition, for a continuous period of two years after your cover starts."*

Based on the notes from the CIR form, the GP said Ms T had occasional knee pain in November 2018, following the surgery in 2017. Vitality says this shows that Ms T had symptoms related to her knee and so falls within the moratorium clause.

I've carefully considered the additional information provided by the GP and the further letter Ms T has sent to us, dated 5 April 2024, from the GP practice manager. I acknowledge that these did further clarify that Ms T had a full body check and no new injury to the knee was found. They also confirmed that Ms T hadn't actively sought advice in relation to her knee.

Based on the conflicting information provided by the GP and bearing in mind that Ms T had no other recorded medical notes between December 2017 and August 2023 relating to her knee, I can't fairly find there's enough evidence to suggest the medical condition was pre-existing as per the moratorium clause.

On balance, therefore, I don't think Vitality has declined the claim fairly on this aspect of the policy terms and conditions.

*Authorisation of treatment*

On page 32 of the policy document, it states:

> *"We will not pay for treatment we have not authorised in advance."*

In terms of the treatment that had been authorised, a letter was sent to Ms T dated 18 August 2023. This states that the authorised treatment was for a consultation and diagnostics test, an MRI/scan and up to six sessions of physiotherapy only. I can't see that authorisation for the surgery was approved at this stage.

Following a further review process, Vitality says the claim for the consultation and MRI should not have been approved and further medical information was required to complete an assessment of further treatment.

Because it made an error in approving this treatment, Vitality paid for the cost of the treatment Ms T had up until this point. It paid £200 for the consultation, £150 for the MRI (and an excess of £250 was deducted), and a follow-up consultation fee of £160.

I can see Vitality informed Ms T that should she decide to go ahead with the surgery this would be at her own risk. It also advised her that if the surgery was booked and there was a cancellation fee she incurred, Vitality would reimburse her for this.

I note Ms T's comments that had she not received a text from Vitality to confirm the surgery had been authorised, she would not have gone ahead. I've considered this. The text message advised Ms T to check her member zone for an authorisation letter and no further information was given. The text message was an error due on Vitality's part. Also, there was no letter on the member zone and Ms T has confirmed this in an email to Vitality on 13 October 2023.

I would have expected Ms T to contact Vitality, at the very least, to confirm authorisation bearing in mind that Vitality had said to her that the surgery hadn't been approved and there was a risk that she would have to otherwise finance this herself.

Based on the evidence available, I don't think Ms T's claim has been declined unfairly considering Vitality hadn't provided authorisation to Ms T for the surgery. I note also that Vitality offered to pay for any cancellation fees for the surgery while Ms T was waiting to find out if the surgery had been approved.

*Customer service*

Having looked at everything that's happened, I agree Vitality's customer service and

communication hasn't been to the standard expected. I agree that Vitality hasn't helped Ms T in ensuring the claim process was dealt with in an efficient way. It made errors along the way – it could have been clearer in its communication and avoided any confusion with regards to the claim. However, Vitality has accepted its failings and apologised. It's also accepted our investigator's recommendation that £275 total compensation is fair.

I've considered this and I'm satisfied that £275 is fair and reasonable in the circumstances of this complaint. I have every sympathy for the situation Ms T found herself in. And I can understand why she believes she should receive a more significant amount for the distress and inconvenience she has incurred. However, as an alternative dispute resolution service, our awards are lower than she might expect and probably less than a court might award.

I note Ms T's comments that had she gone ahead with the surgery in August 2023, Vitality would have had to settle the claim at the time. I appreciate this but this didn't happen and I'm afraid I can't comment on a situation that may or may not have happened.

In terms of the excess that was deducted of £250. This was the standard policy excess amount, and I don't think it was unfair for Vitality to deduct this as this in line with the policy terms and conditions.

*Conclusion*

Having taken everything into account, I'm satisfied that Vitality has declined Ms T's claim in line with the terms and conditions of the policy and I think that is fair and reasonable.

I also think £275 total compensation is fair and reasonable for the errors it made and for the distress and inconvenience caused to Ms T.

## Putting things right

Vitality needs to put things right by:

- Paying Ms T £275 compensation for the distress and inconvenience caused by its poor service and communication.

It must do this within 28 days of the date on which we tell it Ms T accepts my final decision.

## My final decision

For the reasons given above, I uphold in part Ms T's complaint about Vitality Health Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms T to accept or reject my decision before 12 June 2024.

Nimisha Radia
**Ombudsman**