DRN-3375991

The complaint

Mr C complains that BUPA Insurance Limited (Bupa) turned down his private medical insurance claim.

What happened

Mr C was covered under his former employer's private medical insurance group scheme with Bupa. When he changed jobs, he took out an individual policy with Bupa on a continued personal medical exclusions basis. The individual policy started on 27 February 2021.

Mr C then made a claim under the policy for investigations he required. Bupa turned down the claim. It thought Mr C had misrepresented relevant information when he took out the policy. Bupa said if it had known that information, it would've charged Mr C a higher premium. Unhappy with this, Mr C brought a complaint to this service. Meanwhile, he cancelled his Bupa cover.

Our investigator recommended the complaint be upheld. She thought Bupa should've paid a proportion of the claim rather than turn down the claim. Our investigator recommended that Bupa settle the claim in this way, and add interest.

Bupa didn't accept our investigator's recommendations, and so the matter has been passed to me for a decision.

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.

As this complaint concerns misrepresentation, I need to consider the case in accordance with the principles set out under the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract.

Mr C took out the policy through a broker. I haven't seen evidence of the medical questions initially asked of the broker. However, Bupa emailed the broker and said its records showed that Mr C had made recent claims (under the group scheme). It asked the broker to confirm with Mr C that he had answered no to the below medical question correctly.

"Does the person to be covered have ANY planned or pending investigations, treatment, surgery, for any condition or symptom? (This applies whether the treatment is planned privately or under the NHS)"

I'm satisfied this was a clear question. The broker responded and confirmed that Mr C had nothing planned or pending, so could answer no to this question.

I see that Mr C had a consultation with a specialist in January 2021 after experiencing respiratory symptoms since December 2020. He then had investigations in January and February 2021 and was given treatment.

Mr C accepts that he needed further check-ups after receiving treatment in January and February 2021. He says he made an appointment with his specialist and visited him on 5 March 2021.

I don't know when Mr C made the appointment with his specialist. However, given that Mr C doesn't dispute that he knew he required those further check-ups when he took out the policy, I think he should've answered yes to the question. I therefore agree with Bupa that Mr C didn't take reasonable care when answering the question, and so there was misrepresentation.

Mr C says that Bupa was aware of his treatment, as it had all the details on file. However, as Bupa has explained, it asks medical questions when someone transfers from a group scheme to an individual policy in order to assess the risk they present (and therefore the premium to charge). I therefore wouldn't have expected Bupa to have known the answer to the question should've been yes. Bupa did notice that Mr C had made recent claims for treatment, and did double check that his answer to the relevant question was no. This was confirmed by Mr C's broker on his behalf.

Having said that, I accept that Mr C wasn't trying to deliberately mislead Bupa and that the misrepresentation was careless. I note that Bupa also accepts this.

Bupa has confirmed that if Mr C had answered yes to the question, then it would've charged him a higher premium. That means the misrepresentation was qualifying, under CIDRA.

CIDRA explains that in such circumstances, an insurer may reduce proportionately the amount to be paid on a claim. I agree with our investigator that Bupa should settle the claim in this way. Therefore, the claim payment Mr C receives from Bupa will depend on the proportion of the premium that he actually paid, compared to the premium he should have paid.

Bupa says that because Mr C paid the lower premium, his claim isn't covered because this is against its rules. However, I'm satisfied that CIDRA (as the relevant law on misrepresentation) takes priority over Bupa's internal rules.

Bupa says that an alternative option could be for it to offer Mr C to change his answer retrospectively to the question, and then pay the correct premium from the date his cover started. He would then be eligible to claim in full for any treatment. Though I note Bupa says this offer would be subject to Mr C reinstating his cover, and so he would need to pay the backdated premiums due since his cancellation.

CIDRA doesn't give an insurer the right to charge a higher premium. However, where an insurer wishes to make this offer and a consumer wants to accept it, then that will be up to the two parties. Therefore, if Mr C doesn't wish to accept my decision and would instead prefer to accept Bupa's offer, he can contact Bupa directly about this.

My final decision

My final decision is that I uphold this complaint. I require BUPA Insurance Limited to settle Mr C's claim in line with the remaining policy terms, but reduce proportionately the claim amount. *Interest at the rate of 8% simple should be added from the date of claim to the date of settlement.

*If Bupa considers that it's required by HM Revenue & Customs to take off income tax from that interest, it should tell Mr C how much it's taken off. It should also give Mr C a certificate showing this if he asks for one, so he can reclaim the tax from HM Revenue & Customs if appropriate.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 27 April 2022.

Chantelle Hurn-Ryan
Ombudsman