DRN-3665631

The complaint

Mr B has complained about the way Vitality Health Limited ('Vitality') dealt with his claim.

What happened

Mr and Mrs B have a private medical insurance policy underwritten by Vitality on a moratorium basis, which started on 1 May 2021. On 2 May 2021 Mr B twisted his knee and subsequently saw his GP who referred him to a specialist for treatment.

- Mr B contacted Vitality to make a claim – and it asked for a form to be completed by his GP. This was completed and sent back to Vitality on 9 June 2021.

- On 18 June 2021, Vitality requested further information from the GP which was returned on 30 June 2021.

- By 6 July 2021, Vitality reviewed the information but said it needed further information from the GP including Mr B's full medical records and notes about his condition.

- On 5 and 6 August 2021 Vitality received the additional information and records from the hospital it had contacted and the GP.

- Vitality then said it needed to ask the GP for confirmation that Mr B hadn't had any treatment, advice or medication for his knee between May 2019 and May 2021. The GP confirmed that Mr B hadn't.

- The claim was approved on 1 September 2021.

Throughout July, Mr B called and spoke to Vitality – he said he was in pain and needed the treatment authorised. He wasn't happy with the number of times Vitality had contacted his GP for information.

Mr B complained to Vitality. It offered Mr B £100 compensation and apologised for delays. Unhappy with this as a resolution, Mr B referred his complaint to this Service.

Our investigator looked into the complaint and found that Vitality unnecessarily delayed the assessment of the claim. And recommended that Vitality pay £300 compensation for the delays which she said could have been avoided had it asked for all the information it needed at the outset.

Vitality disagreed with the level of compensation and said it asked for further information at the appropriate stages and wouldn't ask for everything at the outset as this often caused delays. It also didn't think this Service should determine when Vitality should ask for medical information.

As an agreement couldn't be reached, the case has been passed to me for a final 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.

Having done so, I think this complaint should be upheld. I'll explain why.

The relevant rules and industry guidelines say an insurer should handle claims promptly and fairly, and shouldn't unreasonably reject a claim.

Vitality accepts that it didn't handle the claim as well as it could have done for which it has offered £100 compensation. But I agree that £300 is more appropriate in all the circumstances of this case based on the impact on Mr B. I'll explain why.

I accept that Vitality is entitled to request and review Mr B's medical information. And that part of its process is to request an initial report and then request further information at a later stage, if necessary. But I would expect Vitality to consider the claim promptly and fairly, and request information at the earliest possible opportunity to minimise delays without repeat requests.

I also accept that Vitality can't be held responsible for all of the delays caused by third parties such as GPs and hospitals. And that it won't ask for full medical information at the outset as this can often cause delays.

Having considered the nature of the requests Vitality sent to the GP, I've seen that in its last request to the GP, it simply needed confirmation that Mr B hadn't had any advice, treatment or medication for knee problems between 2019 and 2021. As Mr B claimed for knee problems and had a moratorium policy, I think this question could have been asked earlier.

I've noted what Vitality has said about the role of this Service – and that it is not to determine when Vitality should ask for medical information. The role of this Service is to determine whether Vitality has treated Mr B fairly and whether it has dealt with his claim promptly. And that includes determining whether Vitality acted reasonably, taking into account all the circumstances of the case. If there was a delay, I have to consider whether Vitality was responsible for the delay and whether it could reasonably have done anything differently.

Having considered everything as a whole, I don't think Vitality dealt with the claim promptly as it failed to ask the simple question about advice, treatment or medication for knee problems until August 2021, especially when it was aware that the GP wasn't responding to requests quickly. So it could have done more to move things along and think about how to minimise the number of times it would have to request information from the GP – based on what it knew about the claim.

Mr B says he wouldn't have had to call Vitality so many times had it requested information at an earlier stage and this caused him distress and inconvenience. I've seen Mr B called 17 times and told Vitality he had to wait for a long time each time he called which added to his frustration. I'm satisfied that the impact on Mr B was more than just minimal and so a higher level of compensation is appropriate in this case.

In addition, Mr B told Vitality he was in pain and how he was affected by his knee problem. Even a short amount of unreasonable and avoidable delay meant Mr B was suffering with knee pain and chasing for updates at the same time which caused him distress and inconvenience.

Taking everything into account, I think £300 compensation is fair and reasonable in all the circumstances of this case.

My final decision

For the reasons set out above, I uphold this complaint and direct Vitality Health Limited to pay Mr B £300 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B and Mr B to accept or reject my decision before 7 December 2022.

Shamaila Hussain
Ombudsman