

## **The complaint**

Miss W complains about Vitality Health Limited's handling of her private medical insurance claim.

Miss W is represented in this complaint by Ms S.

## **What happened**

On 27 August 2021 Miss W made a claim under the policy for a gynaecological condition. A few weeks later Vitality turned down the claim, as it did not think there was an acute medical condition. After Ms S disagreed with Vitality's decision on Miss W's behalf, Vitality asked that Miss W's GP provide more information.

After Vitality received the additional information from the GP, it thought Miss W may have misrepresented information about her health when joining the plan.

Whilst Vitality was still considering the matter, Miss W attended an appointment with the NHS in November 2021. After examination, Miss W was admitted to the hospital for emergency surgery. She remained there for two nights before being discharged.

Unfortunately, Miss W needed to be admitted to an NHS hospital again soon after, where she remained for a further two nights.

In February 2022, Vitality said that whilst the issue had been present before Miss W had joined the plan, it thought she may not have considered the matter to be a medical condition, particularly given her age at the time. It therefore decided to accept the claim. However, as no further treatment was needed, Vitality offered Miss W £100 compensation for the delay, as well as a hamper. Unhappy with Vitality's handling of the matter, Miss W brought a complaint to this service.

Our investigator mediated with Vitality about the matter, as he thought Vitality ought to have made a decision on the claim sooner than it did. Vitality offered Miss W compensation of £2,500. It said £2,000 was the estimated cost of the procedure if it had been performed privately, plus £500 compensation for any distress and inconvenience. Our investigator thought Vitality's offer was reasonable in the circumstances.

Miss W didn't accept Vitality's offer, 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.

The information Vitality received from Miss W's GP in September 2021 said that Miss W had had the issue for at least the last four to five years. Given that Miss W only joined the plan in 2019, it would seem that the issue predated her joining the plan.

The policy was taken out on a fully underwritten basis. That meant that Miss W disclosed information about her health in response to questions asked. I haven't seen the application form, but Vitality says that Miss W did not mention the issue in response to questions asked.

When an insurer suspects that someone has misrepresented information when taking out an insurance policy, it has a duty to investigate this. I therefore see nothing wrong with Vitality doing so.

Having said that, I do agree with our investigator that Vitality took too long to consider the matter. I say that because it took Vitality around five months to decide that it would not pursue the misrepresentation (for the reasons I've outlined above).

Vitality now accepts that it should have covered the procedure privately. To put matters right, it has offered Miss W the equivalent private cost of an initial consultation, day-case procedure, and a follow-up consultation. It has estimated this to be around £2,000. In addition to this, Vitality has offered £500 compensation for the distress and inconvenience caused to Miss W.

As our investigator has said, in circumstances such as this, we would not expect an insurer to pay an amount equal to the cost of private treatment that a member could have had. Instead, where someone has NHS treatment instead of private treatment, we would usually require an insurer to recognise they had been denied the comfort of private accommodation. To put things right, we would usually ask the insurer to pay compensation based on the cost to it of a private bed multiplied by the number of nights the member stayed in an NHS hospital.

Miss W stayed in an NHS hospital for two nights for her initial procedure. In my experience, the cost of a private bed to an insurer for two nights would have been much less than £2,000.

I appreciate Miss W had to go back to an NHS hospital after her procedure. I haven't seen any medical information relating to that hospital admission. Though given that it took place after the initial procedure was carried out, Miss W may well have still needed that hospital admission even if the procedure had been carried out privately rather than on the NHS. I therefore haven't taken this into account (though even if I had, it's likely that the cost of a private bed to an insurer for four nights would have still been less than £2,000).

I do recognise that Miss W had a very upsetting experience, and the emergency hospital admission was distressing for her. However, taking into account that Vitality's offer of £2,000 is higher than I would have required it to pay, and it has offered an additional £500 for the distress caused to Miss W, I find that this total offer was reasonable in all the circumstances.

To be clear, Ms S is not an eligible complainant for the purposes of this claim, and so I have not been able to consider any costs or impact to her.

### **My final decision**

Vitality Health Limited has already made an offer to pay £2,500 to settle the complaint and I think this offer is fair in all the circumstances.

So my decision is that Vitality Health Limited should pay £2,500.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss W to accept or reject my decision before 22 February 2023.

Chantelle Hurn-Ryan  
**Ombudsman**