DRN-3878078

The complaint

Mr C complains about how Vitality Health Limited dealt with a claim against his private medical insurance plan.

Ms J is assisting Mr C in bringing his complaint. Mrs L has provided comments. For ease of reference, I'll mostly refer to Mr C and will ascribe Ms J and Mrs L's comments to him.

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, Mr C had private medical insurance with Vitality and its predecessor for many years. His plan renews in February each year.

In June 2021, Mr C was admitted to hospital and subsequently suffered a dural arteriovenous fistulas - an abnormal connection between an artery and a vein in the brain - which required emergency surgery. In the complaint form, Mr C said that his wife, Mrs C, contacted Vitality after he was taken ill and was told that a claim adjuster would contact her but no one from Vitality contacted her.

On 21 July 2021 and 20 September 2021, Mr C's son contacted Vitality on Mr C's behalf. What was said in those phone calls is in dispute. I'll refer to that in more detail below.

Mr C was discharged from hospital on 17 September 2021 and required neuro rehabilitation.

In October and November 2021, Vitality wrote to Mr C about unpaid premiums. Vitality received an enduring power of attorney for Mr C. In processing that, it mistakenly recorded that Mr C had died and cancelled Mr C's plan in error. I understand that it sent Mr C's family a letter of condolence.

In January 2022, Vitality declined Mr C's claim for rehabilitation. It said that the plan didn't cover what happened here as it was more than two months after Mr C's diagnosis.

Vitality apologised for its error in cancelling the plan and sending a letter of condolence. It offered to write off some of the unpaid premiums and send flowers by way of an apology. Vitality maintained its position about Mr C's claim for rehabilitation expenses. Mr C pursued his complaint. The outstanding premiums weren't paid, and Mr C's plan remains cancelled.

One of our investigators looked at what had happened. He didn't think that Vitality had refused to register Mr C's claim. The investigator said that Vitality declined Mr C's claim in accordance with the terms and conditions of the plan. He said that Vitality cancelled Mr C's plan and sent his family a letter of condolence in error. The investigator noted that Vitality apologised for that and sent flowers to Mr C's family. He also noted that Vitality offered to write off outstanding premiums but that wasn't acceptable to Mr C. The investigator thought that Vitality should pay Mr C compensation of £250 in relation to recording, incorrectly, that he had passed away and for cancelling his plan.

Initially, Vitality didn't agree with the investigator. It said that it had offered to write off some of the unpaid premiums and that the flowers were the most appropriate form of compensation in this case. It transpired that Vitality had not in fact sent Mr C's family the flowers. Vitality agreed to pay the compensation recommended by the investigator.

Mr C didn't agree with the investigator and said, in summary:

- Vitality's notes don't accurately record the relevant conversations. It's surprising that recordings of the phone calls aren't available. When his son phoned Vitality on 21 July 2021, he didn't say that he didn't want to log a claim.

- His son contacted Vitality again on 20 September 2021, when Mr C was ready for rehabilitation, and it's not accepted that Vitality's records of that phone call are accurate. His son didn't say he would call back when he had more information but did ask Vitality if there were any other services available for him.

- The criteria for rehabilitation cover is conflicting as the patient has to be stable and treatment has to begin within two months. Vitality misled his son during the phone call on 21 July 2021, as it didn't draw his attention to the fact that if it took Mr C longer than two months to become stable, he couldn't claim.

- They didn't stop paying the premium. There was a lengthy process with the bank to register an enduring power of attorney which meant that the premium payment wasn't made.

- Vitality acted unreasonably in declining the claim. Vitality didn't tell his relatives the extent of the plan and its limitations. It's questionable whether the strict requirements of the plan frustrate a claim, as a patient with a brain injury may not be stable in two months.

- Vitality's error led to cancellation of the plan.

- The compensation recommended by the investigator isn't sufficient.

- His family didn't receive flowers or a letter of apology.

- Vitality could put things right by paying his claim for 21 days rehabilitation and paying compensation for distress and upset caused to Mrs C.

The investigator considered what had been said but didn't change his view. As there was no agreement between the parties, the complaint was passed to me to decide.

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 starting point is the terms and conditions of the plan, the relevant parts of which say as follows:

"***CORE COVER – REHABILITATION***
WHAT'S COVERED
This benefit provides you with up to 21 days of ***rehabilitation treatment*** *following a stroke or serious brain injury.*
The ***treatment*** *must:*

- *immediately follow a period of* ***in-patient treatment***
- *start no more than two months after initial diagnosis or date of injury*

WHAT'S NOT COVERED

- ***treatment*** *not undertaken in a rehabilitation unit at a recognised rehabilitation facility*
- ***treatment*** *given or arranged by a consultant not recognised by us."*

"GENERAL CONDITIONS
[…]
4.1 WHAT WE EXPECT FROM YOU
It is your responsibility to:

- *ensure that all premiums are paid when due […]"*

has the claim been handled unfairly?

The relevant rules and industry guidance say that Vitality has a responsibility to handle claims promptly and fairly and it shouldn't reject a claim unreasonably. I'm upholding Mr C's claim in part. I'll explain why:

the date of the claim

- There's a dispute about when Mr C first made a claim against his plan for rehabilitation. In the complaint form, Mr C said that Mrs C first contacted Vitality and wasn't contacted by a claim adjuster, as promised. Vitality say that the first contact it had was on 21 July 2021 from Mr C's son who said that he wasn't aware of Mr C's medical condition and didn't want to log a claim. Mr C disputes that. Vitality says that the next contact was from Mr C's son on 20 September 2021, when he said that he'd call back when he had more information. Mr C disputes that and says that his son asked Vitality if there were any other services available for him.

- Where the evidence is incomplete or contradictory, as some of it is here, I need to consider what's most likely to have happened in light of the available evidence and the wider circumstances.

- Vitality hasn't retained recordings of the relevant phone calls. That's not unusual. It isn't obliged to record phone calls or retain indefinitely any recordings it made. Vitality has produced its contemporaneous notes of the phone calls.

- Vitality has no record of a call by Mrs C. I don't think I can safely conclude that Mrs C contacted Vitality about Mr C's claim in June or July 2021. I think it would be unusual for Vitality to say that it would arrange for a claim adjuster to contact Mrs C. The more unusual an event, the more evidence is required to support the recollection.

- On balance, I accept Vitality's notes as an accurate record of Mr C's son's calls on 21 July 2021 and 20 September 2021. The notes were contemporaneous. I think that

they are likely to be more reliable than Mr C's relatives recollections some considerable time later. I think that Mr C first made a claim for rehabilitation on 20 September 2021. In reaching that view, I've noted that Vitality sent out a form for NHS to private transfers after the conversation with Mr C's son on 20 September 2021.

Vitality's decision to decline Mr C's claim

- Insurance policies aren't designed to cover every eventuality or situation. An insurer will decide what risks it's willing to cover and set these out in the terms and conditions of the plan document. The onus is on the consumer to show that the claim falls under one of the agreed areas of cover within the plan.

- Based on what I've seen, I think that Vitality didn't act unfairly or unreasonably in declining Mr C's claim. The terms of the plan provide that the rehabilitation treatment claimed for must start no more than two months after initial diagnosis. Mr C received a diagnosis in June 2021. I've found above that he first made a claim on 20 September 2021, more than two months after the diagnosis. So, the rehabilitation treatment couldn't start within two months of the diagnosis, as required by the plan.

- Mr C says that Vitality misled his son during the phone call on 21 July 2021, as it didn't draw his attention to the fact that if it took Mr C longer than two months to become stable, he couldn't claim. In the particular circumstances here, I don't think that Vitality was obliged to explain the limitations of the cover for rehabilitation treatment at that stage. Vitality's notes of the phone call of 21 July 2021 show that Mr C's son wasn't aware of Mr C's medical condition. Vitality explained that Mr C's medical condition would need to be stable. Mr C's son said he'd discuss the matter with family and revert to Vitality if he wished to pursue a claim. I don't think that Vitality needed to do any more at that stage.

- I think that Vitality was entitled to rely on the terms of the plan and decline Mr C's claim. There's no basis on which I can fairly direct Vitality to accept Mr C's claim for rehabilitation costs.

the cancellation of Mr C's plan

- It's common ground that Vitality made errors in recording that Mr C had died, cancelling the plan, and sending a letter of condolence to Mr C's family. That caused Mr C distress and inconvenience. Vitality has explained how that happened and offered to write off some unpaid premiums. It's since agreed to pay Mr C compensation of £250. I think that's fair and reasonable.

- In reaching that view, I've taken into account that I can only award compensation for distress and inconvenience to Mr C, as he's the plan member. And whilst Vitality's cancellation of the plan caused some initial distress and inconvenience, it coincided with non-payment of the premium due to issues Mr C's attorney had with Mr C's bank. Under the terms of the plan, it's for Mr C to ensure that all premiums are paid when due. I think Vitality was entitled to ask for missed premiums. There's no basis on which I could fairly direct Vitality to reinstate Mr C's plan.

Putting things right

In order to put things right, Vitality should now pay Mr C compensation of £250 in relation to his distress and inconvenience.

My final decision

My final decision is that I uphold Mr C's complaint in part. Vitality Health Limited should now pay the compensation I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 20 March 2023.

Louise Povey
Ombudsman