DRN-3997676

The complaint

Ms C complains about the way Vitality Health Limited has handled claims she made under her private medical insurance policy.

What happened

In July 2020, Ms C took out a private medical insurance policy through Vitality. The policy was underwritten on a moratorium basis. It also provided a cash benefit paid for treatment covered under the policy that is taken through the NHS.

During February and March 2021, Ms C registered three claims with Vitality for shoulder pain, abdominal pain and a gynaecological condition – for the last one Ms C had received treatment via the NHS. On all three claims, Vitality requested that Ms C and her GP complete claim information request forms (CIR).

In relation to the claim for the shoulder, the CIR form was received but Vitality said it needed further medical information and so it requested Ms C's consent to access her medical records (MR) about this condition.

Ms C contacted Vitality to say that her GP was refusing to complete the CIR for the abdominal pain claim. Vitality reviewed previous claims history that it held for Ms C and found that she had received treatment for abdominal pain before. It therefore declined the claim, saying this was a pre-existing condition.

The CIR form was received for the gynaecological condition and the claim was accepted. A private consultation was agreed which Ms C attended. Ms C said the private consultant suggested having a procedure completed in six months' time. Vitality advised that it needed additional information in order to provide the NHS cash benefit for the treatment she had already received.

Vitality said it didn't receive the consent for the MR regarding the claim for the shoulder. So, in October 2021, it asked for consent to access her MR for all of the conditions that were being claimed. This meant that Ms C's claims were all put on hold while this was being obtained.

When consent was received in November 2021, Vitality requested the MR, which were received in December 2021. At this point Vitality agreed it would pay the NHS cash benefit for the gynaecological claim while it continued to assess her remaining claims.

By April 2022, as her claims hadn't been settled, Ms C decided to stop her premium payments. As a result, the policy was cancelled. Vitality continued to investigate the claims and decided to void the policy – which meant it would no longer consider any claims. Vitality said that some of the claims related to pre-existing conditions and that Ms C had misrepresented her history. It referred to The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA) and said it was entitled to void the policy as a result of this Act.

Ms C made a complaint and brought the matter to this service. She said she was unhappy:

- with the way her gynaecological claim had been handled as it meant she had to see three different consultants. And that Vitality had referred her to the oncology team when her condition wasn't cancerous.
- that Vitality had declined her claim for abdominal pain when this wasn't related to a pre-existing condition.
- with Vitality's customer service and that it had referred to her being in the medical profession in its correspondence which she found threatening.

Our investigator looked into the matter but didn't uphold the complaint. He didn't think that Vitality was being reasonable when voiding the policy as a result of CIDRA, but he did say that it was reasonable for it to void the policy under other terms within the policy relating to providing correct information when making a claim.

He also found that there was evidence Ms C had previously had treatment for the shoulder pain and also abdominal pain which meant that these claims wouldn't be covered. And in relation to the delays in handling the claim for the gynaecological issue he found that it was reasonable for Vitality to ask for medical information to enable it to consider the claims and that the majority of delays related to the requests for information. He noted comments which said Ms C had decided to receive NHS treatment rather than continuing with private care. So, he didn't think it was Vitality's fault she had seen different specialists for this condition.

Our investigator found that Ms C had been incorrectly referred to the oncology team regarding her gynaecological problem. Vitality had noted the error, but it had decided to continue having a care consultant from the team to oversee the claim. As this was a condition which could lead to cancer, he didn't think this was unreasonable.

In relation to Vitality referring to her profession, he said that it was mentioned as a reminder that Ms C was a medical professional and therefore should have been aware of what to declare as pre-existing conditions. So, he didn't think it was unfair for Vitality to have put this in the letter.

Ms C disagreed with the investigator's opinion. She said she only returned to using NHS treatment due to the poor handling of the gynaecological claim by Vitality. And she maintained that the mention of her medical knowledge by Vitality related to her gynaecological claim, not any pre-existing conditions. So, she still didn't think it was fair.

As no agreement could be reached, the matter has been 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.

It is important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Ms C. Rather it reflects the informal nature of our service, its remit and my role in it.

The relevant rules and industry guidelines say that insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when deciding what I think is fair and reasonable in the circumstances of Ms C's complaint.

Cancellation and voidance of the policy

Vitality initially cancelled the policy as Ms C stopped paying her premiums in April 2022. I don't think it was unreasonable for Vitality to do this as Ms C was no longer paying the premium to cover her for any new claims. But Vitality did continue to investigate her existing claims following which they decided to void the policy.

The policy was voided because Vitality said Ms C attempted to make claims for pre-existing conditions and misrepresented her symptoms and condition history to try to secure cover under the plan. It says that, under the rules of CIDRA, it has the right to void the policy.

The rules under CIDRA are very clear about when an insurer can take action. The rules say that, if a misrepresentation has occurred but that the insurer would have entered into the contract on the same terms anyway, then this misrepresentation doesn't qualify. Ms C took out her private medical insurance policy on a moratorium basis, which means she wouldn't be covered for any conditions she had received treatment for in the past five years. This means she didn't have to answer any health questions at the time of applying for the cover.

Vitality has confirmed that it would have provided her with the same policy, even if it had been made aware of her full medical history. As Vitality has confirmed it would have still provided Ms C with a policy, any misrepresentation it feels she has made, doesn't qualify – meaning Vitality cannot avoid the policy for that reason. So, I'm not satisfied that Vitality acted fairly.

However, in the letter Vitality sent to Ms C in September 2022, it also referred to the following part of the policy:

> *4.4 DISHONESTY/FRAUD*
>
> *We believe our customers are honest, and the contract between us is based on mutual trust. Representations including statements and information provided by you or any insured dependants are relied on in assessing the terms of cover. In the event that any of the information provided by you or any insured dependant is wrong or incomplete we may have the right to cancel cover with effect from inception and/or to decline claims made under this plan.*
>
> *If any claim is in any respect dishonest or fraudulent or if any dishonest or fraudulent means or devices are used by you, any member of your household or anyone acting on your or their behalf to obtain benefit under your plan (including any benefits under the Healthy Living Programme), then all benefits under your plan may be lost and you may have to return to us any payments already made as a result of any dishonest or fraudulent actions.*

For Vitality to be able to rely on this part of the policy wording to cancel the policy, it would need to show that it was provided with incorrect or incomplete information by Ms C in order to obtain benefit under the policy. Vitality has said that Ms C has attempted to make claims for conditions that she had suffered from prior to taking out the policy – which would therefore be excluded - and that information regarding her medical history wasn't provided to enable them to fully investigate the claims.

So, I will now need to consider if I think any of the claims made were known to be pre-existing but were submitted to Vitality in any event.

Claim for shoulder pain

When the claim was made in early 2021, Ms C completed a form regarding her previous medical history. On this form it asks a question about the history of the condition:

> *'Have you ever suffered from episodes of this condition before, even if medical advice wasn't sought at the time?'*

Next to this question there are two boxes with either '*Yes*' or '*No*' next to them. There is a tick in the box next to the '*No*'. So, I'm satisfied Ms C completed the form to say she had not suffered from previous episodes of neck and shoulder pain prior to the claimed event.

Vitality has provided evidence to show that Ms C sought medical attention in 2019. The letter from the consultant states that she presented with '*several years' worth of worsening pain in her left scapula*'. And it has referred to history it has from a previous policy held for Ms C and noted that a claim was made for shoulder pain in 2017. Vitality has said that it did request the MR from the treatment provider, but that Ms C didn't provide her consent for these to be released.

I've thought about this very carefully. I do appreciate that there are occasions where someone may not remember a particular episode of treatment and may fail to disclose at the point of claim all of their history. However, Ms C has had a historic problem with her shoulder which appears to have been known about for at least four years before she made this claim. And the issue was ongoing as Vitality has provided evidence to show treatment took place in 2019 for shoulder pain. I therefore think it is more likely that Ms C would have been aware that she had a previous history of shoulder pain when making the claim. However, she didn't disclose this. I also note that she refused Vitality access to the MR for one of the providers. Ms C has said this was because she was frustrated with the ongoing investigations and that she didn't see it was necessary. While I can appreciate she was frustrated with how long it was taking to assess the claims, insurers must be able to investigate claims fully and so I don't think it is unreasonable for Vitality to have wanted to see the details of this treatment and specifically, the medical records.

In the circumstances, I'm satisfied that, based on the evidence provided, that it was reasonable for Vitality to cancel the cover using the dishonesty/fraud condition under the policy.

Claim for abdominal pain

Ms C completed an online claim form for abdominal pain in early 2021. On the form she stated that the symptoms started in December 2020 and that she hadn't suffered from these symptoms or anything like this before. Vitality requested a form be completed by her GP, but Ms C said her GP was unwilling to complete the document and so her referral letter and other medical records were provided instead.

The referral letter stated that Ms C has a history of the symptoms that she was presenting with. When Vitality was able to review her MR, it noted that there was an entry regarding abdominal pain in early July 2020 and an ultrasound of the area was completed the day before the policy was taken out. Her GP notes also show she discussed a referral to a gastroenterologist for these symptoms a few days after the policy had been incepted.

Based on this information, Vitality declined Ms C's claim, saying it related to pre-existing symptoms. I don't think this was unreasonable as there does appear to be several previous instances where abdominal pain has been detailed. It is important to note that this doesn't appear to have been mentioned by Ms C when making the claim. Ms C has subsequently said that this claim was declined incorrectly, and that it related to a further claim she made

for abdominal pain which was gynaecological in nature. I appreciate Ms C's point, but I haven't seen any medical reports to show that the claim made was unrelated to any previous symptoms she has had for abdominal pain. Therefore, based on the evidence available, I'm satisfied that Vitality has acted fairly when declining the claim as being related to a pre-existing condition.

Claim for gynaecological problem

Ms C has said she is unhappy with the delays in resolving this claim which led to her having to change consultants three times. She said that due to the nature of the condition, this meant she had to be examined by different specialists. She is also unhappy that she was referred to an oncology team when she didn't have cancer. Vitality has said that it needed medical evidence in order to process her claim and that this is what caused the delays. And it has acknowledged that the referral to the oncology team was an error, based on her diagnosis.

The claim made was for the cash benefit as Ms C had seen a consultant and undergone a procedure through the NHS. The policy includes a benefit for treatment received via the NHS that would have been covered by the policy. Ms C said she wanted a private referral and so approval was given for Ms C to see a private consultant and continue her treatment on that basis.

I can see that the case was referred to Vitality's oncology team, who deal with patients that have been given a cancer diagnosis. But Ms C's condition wasn't cancerous. I can appreciate why this may have caused upset to Ms C. Vitality has confirmed that this was an error but, as a result of the type of condition Ms C had, it continued using the oncology team to oversee her treatment. I don't think that was unreasonable, considering the medical condition.

Vitality has said that it needed medical evidence before it could agree Ms C's claim and that it asked for discharge summaries following the NHS procedure. Ms C stated that such documentation wasn't available, and Vitality agreed to pay the cash benefit on that occasion. From the information I've seen, it does appear that Vitality made it clear that such medical evidence would be needed for any future claims. So, when claims were made for other procedures later, I think Ms C would have been aware that she needed to provide the relevant evidence in support of her claim.

Having looked at Vitality's notes, I can see that, following her private consultation, Ms C made contact to say that she had been advised to have a repeat procedure in six months' time. However, Ms C said she had also received contact for the procedure through the NHS and so she was thinking of continuing with NHS treatment and claiming the cash benefit. I haven't seen anything to show that this was as a result of any delays as it seems the procedure was completed after the six months as recommended by the specialist.

I'm aware that, as Vitality hadn't received the access to MR for one of the claims and further claims were being made, it requested access to the records for all of the conditions being claimed. This request meant that all claims were placed on hold which did impact the progress of this case. I understand this was frustrating for Ms C, but Vitality is entitled to investigate the claim and so I don't think it was unreasonable for it to request further information. I can see that, after receiving the MR, Vitality did make a payment for the outstanding cash benefit for the procedure undertaken.

General Medical Council (GMC) registration

In the letter to Ms C declining the claims and voiding the policy, Vitality referred to Ms C's GMC registration. Ms C says she found this threatening and saw no reason for this to be mentioned. Vitality said this was to show that she is not a layperson and therefore would have been more aware of the information that would be relevant in respect of her medical conditions and pre-existing symptoms. I'm persuaded that someone who is from a medical profession is more likely to understand the need to fully declare any previous history of a condition, so I don't think that it was unreasonable for Vitality to put this in its letter.

I've noted that Ms C has said that this point was raised in relation to knowledge surrounding her gynaecological condition, not pre-existing conditions. However, I'm not persuaded this is the case. The letter refers to this point under a comment relating to not providing all the relevant symptom history – I haven't seen anything where it refers specifically to the gynaecological condition.

Overall, I'm persuaded that it was reasonable for Vitality to have made the point regarding Ms C's understanding of what would be required when making a claim.

Conclusion

I do appreciate that Ms C has had a number of conditions for which she has had to seek treatment and that this whole process has not been easy for her. However, I'm satisfied that she would have been aware of the need to be open about her previous medical history in relation to some of these conditions. When Ms C completed the forms for her shoulder and abdominal pain claims the information provided hasn't matched the history detailed in the MR. And it appears there were delays in providing her consent to access her MR. In addition, Ms C refused consent for Vitality to contact one treatment provider. Taking all of this into account, while I don't think it was fair for Vitality to use CIDRA as the basis for voiding the policy, I'm satisfied that it was fair and reasonable for Vitality to rely on the quoted policy term when cancelling the cover.

And while there were delays in processing Ms C's gynaecological claim, this was impacted by the delay in obtaining access to her medical records on her other claims. As Vitality had concerns relating to the non-disclosure of pre-existing conditions on other claims, I don't think it was unfair that they requested these details for all of the cases.

My final decision

For the reasons stated above, I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C to accept or reject my decision before 28 June 2023.

Jenny Giles
Ombudsman