DRN-4352341

The complaint

Miss T complains about the way Vitality Health Limited handled a claim she made on a personal private medical insurance policy.

Miss T's represented by Mr W.

What happened

The background to this complaint is well-known to both parties, so I've simply set out a summary of what I think are the key events.

Miss T was insured under a personal private medical insurance policy. Cover under the policy began on 5 September 2022 and the policy was taken out on a moratorium basis.

In February 2023, Miss T got in touch with Vitality to make a claim on her policy for neck and other pain. She'd spoken with Vitality's virtual GP, who felt Miss T needed physiotherapy. Miss T started having physiotherapy treatment.

However, when Vitality considered Miss T's claim, it noted that the GP had stated that Miss T's symptoms pre-dated the start date of the policy. So it thought Miss T's symptoms were a pre-existing condition and therefore, specifically excluded under the terms of the moratorium. It turned down Miss T's claim.

Miss T provided further information to Vitality, which showed the start date of her symptoms had been around a month after the policy began. And Miss T's GP sent a letter in mid-late March 2023 which also stated that Miss T's symptoms had begun at the end of September 2022.

In late April 2023, Vitality asked for further information from Miss T's GP. And it had also asked for more information from the virtual GP. In mid-June 2023, Vitality was in a position to reassess and accept Miss T's claim.

Mr W was very unhappy with Vitality's handling of the claim. He'd made a number of calls chasing up Vitality's response and he was unhappy with the delays in Vitality's decision-making. He said Miss T had been left in pain and that that her condition had declined back to her pre-treatment level.

Vitality acknowledged there'd been delays in its handling of Miss T's claim and that she'd been caused trouble and upset. So it offered to pay Miss T £150 compensation and to send her flowers.

Mr W didn't accept Vitality's offer and he asked us to look into Miss T's complaint.

Our investigator didn't think Vitality's offer of compensation was enough to put things right. So he recommended that it should pay Miss T a total of £250 compensation.

Vitality disagreed. It considered that the investigator was punishing it for the actions of the virtual GP – a third party company. So the complaint's 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.

Having done so, I've decided that Vitality should pay Miss T a total of £250 compensation and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably.

In this case, Vitality initially agreed to cover Miss T's physiotherapy. However, it received information from the virtual GP which indicated that Miss T's symptoms began *before* the policy was taken out, which would mean that it fell within the scope of the moratorium clause. I don't think it was unreasonable for Vitality to conclude, at that point, that based on the available medical evidence, the claim wasn't covered.

As Miss T disputed that her symptoms had begun before the policy started, I think it was reasonable and appropriate for Vitality to ask for more medical evidence in order to further assess the claim. I don't think it was unfair for Vitality to ask for further GP records, or for evidence from the virtual GP. It seems that once Vitality received evidence which showed that Miss T's condition hadn't pre-existed the policy start date, it accepted the claim and authorised the treatment. This is in line with the policy terms.

However, I don't think Vitality handled its reassessment of the claim in a fair or timely way. While I appreciate it needed further third-party medical evidence and it couldn't control when that would be received, Vitality's notes suggest that there were times when weeks would go by before the claim was reviewed, or more evidence was requested by the team handling the claim. It's clear that Mr W had to repeatedly chase Vitality for updates and little information was forthcoming. And in my view, the notes suggest the claim could have been progressed, assessed and accepted some weeks sooner than it was. Miss T was without treatment for around four months and it appears to me that this period could have been reduced by a few weeks.

Mr W told us that Miss T's condition regressed during this period, to her pre-treatment position. He told us that she was in real pain and found it difficult to sleep. As I've explained, I don't think it was unreasonable for Vitality to have initially turned down the claim, or to ask for more evidence. So it wouldn't be reasonable for me to award compensation for the whole period Miss T was without treatment.

However, as I've explained, I do think the claim could have been progressed and approved a few weeks earlier than it was. So I think these delays likely caused Miss T to suffer additional unnecessary pain and distress. And I don't find that the compensation of £150 which Vitality has already offered Miss T is sufficient to reflect the impact the unnecessary delay in approving the claim is likely to have had on her. Instead, I agree with the investigator that a total award of £250 compensation (inclusive of the award Vitality's already offered) is fair, reasonable and proportionate in the circumstances.

Overall then, I direct Vitality to pay Miss T total compensation of £250 to recognise the impact of its claims handling on her. Mr W told us that Miss T doesn't want the flowers Vitality offered, so I'm not including this in my award.

My final decision

For the reasons I've given above, my final decision is that I direct Vitality Health Limited to

pay Miss T £250 compensation (inclusive of the £150 it's already offered).

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss T to accept or reject my decision before 31 October 2023.

Lisa Barham
Ombudsman