DRN-4433391

The complaint

Mr M is unhappy that Western Provident Association Limited declined a claim he made on a group private medical insurance policy. He's also unhappy with the guidance he was given during the sale of the policy.

What happened

Mr M wanted to set up a group medical insurance scheme to cover the employees in the company he works for. I'll refer to the company as 'Company A'. Mr M brings a complaint in his own capacity as a member of the group scheme.

Mr M had prostate cancer and had his prostate removed in 2015. He says he continues to go to a specialist each year for peace of mind to complete a PSA test.

Company A was given the option of a moratorium policy or a fully medically underwritten policy. Before taking out the policy a representative from Company A got in touch with WPA to query whether Mr M's previous diagnosis would be caught by the moratorium and was told it wouldn't be.

Mr M joined the scheme on 1 June 2021. As a member of the group scheme Mr M had to complete an application form. He had to tick a box to say that he understood he would be unable to claim for any condition which existed during the five years before the date he joined, unless he had a two-year clear period.

In May 2022 Mr M was diagnosed with metastatic prostate cancer and was granted full cover. However, WPA declined to cover further treatment because they said Mr M's claim fell within the policy moratorium. They said he'd had professional advice or monitoring in the five years before joining the scheme. In summary, they say this was because he'd had annual PSA tests and sought advice about prostate cancer in the five years before joining the scheme.

Mr M complained to WPA but they maintained their decision to decline the claim. Unhappy, Mr M complained to the Financial Ombudsman Service.

Our investigator looked into what had happened and didn't uphold the complaint. He thought that WPA had fairly applied the moratorium because Mr M had attended appointments for ongoing consultations and tests. Mr M didn't agree and asked an ombudsman to review the complaint. He said that a PSA test wasn't 'treatment' and he was given clear assurances by WPA that his regular PSA tests would not compromise his health cover. He also said WPA's

desire to secure the company health insurance policy led to them providing misleading and false information regarding the cover. So, the complaint was referred to me to make a decision.

I asked WPA whether they'd been able to locate any calls between Mr M and WPA. They said they'd done a search and they hadn't been able to locate any calls before the policy was taken out. They said they'd need exact dates, times and the name of the person who

took the call to be able to carry out further searches.

I also asked WPA why they hadn't explored the information in an email from Company A in more detail but they said there was no reason to do so, based on the information they had about Mr M's medical history. WPA confirmed they'd provided Company A with advice about the policy and highlighted that the definition of 'treatment' included any form of medical care.

In July 2023 I issued my first provisional decision explaining that I was intending to uphold Mr M's complaint and award £1500 compensation.

Mr M responded with details of a policy he'd held before Company A took out the group policy which, he said, would have covered him in the circumstances. This policy was with an insurer I'll refer to as 'V'.

WPA didn't agree, in summary, that Mr M had given accurate information about his medical history.

Having reviewed the further information and representations I issued a second provisional decision in October 2023. I said:

> I've reconsidered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.
>
> As I outlined in my provisional decision The relevant rules and industry guidelines say that WPA have a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.
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> I've taken into account WPA's further comments, and the information provided by Mr M. Having done so I'm still intending to uphold this complaint and direct WPA to put things right in a different way.
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> Mr M joined the scheme in June 2021 so the relevant period I need to consider is the five years prior to him joining the scheme. I don't agree that Mr M provided WPA with incorrect information (via Company A) when he said:
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> > I can confirm that Mr M [redacted] had his prostate operation in January 2015 and has been clear and discharged ever since. He goes to a specialist yearly on his own accord for his own peace of mind, his PSA has been less than 0.1 for a number of years now. This is more than 6 years ago so I suppose it falls outside the moratorium anyway…
>
> WPA's position is that Mr M hadn't been discharged from his consultant's care and that they didn't decline on the basis of 'peace of mind' tests.
>
> Mr M had been cancer free since his operation and his PSA had been consistently undetectable. He had some urinary and other symptoms related to the surgery but I think the primary purpose of the reviews with his consultant were to check his PSA albeit he may have been given some general reassurance about some of his post-operative urinary symptoms. I also bear in mind that Mr M was also being seen privately so I think this also partly explains why there is no specific 'discharge' letter as Mr M chose to continue to have his PSA tests with the same consultant. So, I don't think it's fair to conclude the information Mr M gave via Company A as inaccurate or untrue.
>
> In any event, even if I accepted WPA's representations on this point, I don't think that

leads to a fair and reasonable outcome in the circumstances of this particular case.

I think it would have been reasonable for WPA to seek further clarification from Company A or Mr M on the circumstances surrounding his diagnosis and treatment particularly given that the treatment referred to was within a year of the relevant timeframe for the moratorium period. For example, it was open to them to clarify the nature of the appointments Mr M was having and obtain clearer information about his medical history, particularly bearing in mind they were relying on information from a third party which was very brief and scant on detail.

I also think that WPA ought reasonably to be aware that this is a common area in which consumers often have trouble as moratoriums are complex and it's often easy to forget the nuances of their medical history with the passage of time. This is a core feature of the policy and one in which it can be difficult for consumers to navigate.

I think there was a missed opportunity in the email exchange between Company A and the appointed representative to get a proper understanding of Mr M's circumstances before saying he'd be covered. I bear in mind that WPA's appointed representative was advising Company A about the policy and, whilst I'm not considering a mis-sale complaint, I think that there was a greater responsibility to engage with this information than in a non-advised sales process. So, I don't agree it was unreasonable in this case to expect the appointed representative to question elements of the information given in relation to an applicant's medical history, especially when this was provided by Company A rather than Mr M himself and was so general.

I don't think it is central to the outcome whether cover was technically withdrawn, or the further claim benefit was denied by WPA. The result was the same as Mr M wasn't covered for his treatment. So, this point hasn't changed my thoughts about the overall outcome of this complaint.

WPA denied Mr M's allegation that their desire to get Company A's business led them to provide false and misleading information. This was set out in the background to the complaint because it's one of Mr M's complaint points. I have made no finding on this point because I don't think it's central to the outcome of this complaint but it's relevant background because it's one of the things Mr M has raised in his complaint.

Putting things right

The information provided before I made my provisional decision didn't indicate that Mr M was already covered by a private medical insurance policy. However, he's now demonstrated he had a policy with V which would have offered him cover had he stayed with them. The policy had been in force since 2012 and there were no exclusions applied to it. Mr M had received private treatment when he was diagnosed with cancer during the life of the policy.

I'm now persuaded it's most likely that Mr M has been caused further detriment by WPA's failure to explore his medical history further. I think that had they done so it would have highlighted issues with the moratorium period and identified that Mr M may have issues claiming on the policy. I think if Mr M had been aware that he may have been caught by the moratorium it's unlikely he'd have cancelled his policy with V. I think it's most likely he'd have stayed with V, knowing that he benefited from full cover. I'm also persuaded that if Mr M had stayed with V it's most likely that his treatment would have been covered. I've looked at the full policy terms and policy certificate and, on balance, I think he'd have been able to claim successfully.

Taking into account all of the above I'm no longer persuaded it's fair and reasonable for WPA to decline the claim. I think Mr W has been caused a significant financial loss by their failure to explore his circumstances prior to joining the policy.

He's funded his own treatment, whereas if he'd stayed with V he'd have most likely had the full benefit of private cover. I think Mr M is out of pocket as a result. So, I now think that WPA should reassess the claim without reference to the moratorium and in line with the remaining policy terms and limits. Mr M ought to be aware that he may need to provide further information about his treatment to WPA and evidence of the expenses he incurred.

I also remain of the view that WPA should pay Mr M £1500 compensation for the associated loss of expectations and the distress and inconvenience caused by not having the cover he expected at a very difficult and challenging time.

I can't predetermine any future claim Mr M may need to make in relation to his prostate cancer but I'd expect WPA to bear in mind my findings in relation to this complaint. And Mr M would also be entitled to make a further complaint if he's unhappy with the settlement of this claim or any future claim decision.

So, I'm intending to direct WPA to put things right by:

- Reassessing the claim in line with the remaining policy terms and without applying the moratorium period to the claim.
- Paying Mr M £1500 compensation for the distress and inconvenience caused by the impact of not having the cover he expected.

Mr M accepted my provisional decision. WPA made further submissions. In summary they said:

- Mr M said he'd been discharged – that wasn't true
- They had no reason to question the accuracy of the information provided – it was untrue and they shouldn't be held responsible for the consequences
- To waive the application of underwriting based on an insured person providing inaccurate information seriously prejudices other customers
- They had searched extensively for calls between Mr M and WPA but haven't been able to locate them.

So, I need to make 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.

Having considered the further representations by WPA this hasn't changed my thoughts about the outcome of this complaint.

I haven't found their further representations persuasive in the specific circumstances of this case.

I remain persuaded that there are credible reasons for the information Mr M gave to WPA, via the appointed representative and Company A prior to the policy being taken out. But, in any event, I think it's still fair and reasonable to uphold Mr M's complaint.

As I outlined in my provisional decision Mr M was providing information to WPA via Company A and the appointed representative. The information given by Company A was high level and fairly vague. I think there was information provided which ought to have prompted WPA to take further action before responding to the query and offering cover. I particularly bear in mind that this information wasn't coming from Mr M directly, it was coming from a third party who was summarising a complex health issue in a just a few lines.

I think there were a number of indications that the situation was more complex. Company A told WPA:

> I can confirm that Mr M [redacted] had his prostate operation in January 2015 and has been clear and discharged ever since. He goes to a specialist yearly on his own accord for his own peace of mind, his PSA has been less than 0.1 for a number of years now. This is more than 6 years ago so I suppose it falls outside the moratorium anyway…

Company A didn't, for example, outline what happened in the specialist's appointments or what they meant by 'clear' or 'discharged'. I remain of the view that there was an opportunity to explore these points in more detail with some straightforward follow up questions.

There were a number of reasons Mr M could have continued to see the specialist and I don't think it's fair and reasonable for WPA to simply to rely on the statement that he'd been 'discharged' in isolation. This statement was made by a third party who was unlikely to have a detailed understanding of the nuances of Mr M's health condition or what the ongoing specialist appointments entailed. Furthermore, the use of the word 'discharged' alongside the statement that 'he goes to a specialist yearly' was contradictory in itself. And I think it's also important to note that the events referred to were in close proximity to the relevant moratorium period. So, I think WPA ought to have done more to explore Mr M's circumstances before giving reassurance that he'd not be caught by the moratorium.

This was a key aspect of cover which was likely to be very important to Mr M. I'm not persuaded by WPA's representations that they fairly relied on the statement that Mr M had been 'discharged'. I think the wider context of the statement, and that it was provided by a third party, is important too. I remain of the view that Mr M wasn't treated fairly in all the circumstances. A few simple questions of clarification would have, in my view, most likely flushed out some important information about Mr M's circumstances.

I've considered what WPA has said about the impact on other customers. However, for the reasons I've explained, I don't think WPA has treated Mr M fairly. My decision focuses on the specific facts of this case.

WPA has said that it's searched extensively for calls Mr M says that he made but hasn't been able to locate them. I remain satisfied I have enough information to reach a fair and reasonable outcome based on the available evidence. So, that doesn't change my thoughts about the outcome of this complaint.

For the reasons I've outlined above, and in my two provisional decisions, I'm upholding Mr M's complaint as I think it's fair and reasonable to do so.

Putting things right

WPA need to put things right by:

- Reassessing the claim in line with the remaining policy terms and without applying the moratorium period to the claim.

- Paying Mr M £1500 compensation for the distress and inconvenience caused by the impact of not having the cover he expected.

My final decision

I'm upholding Mr M's complaint and direct Western Provident Association Limited to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 6 December 2023.

Anna Wilshaw
Ombudsman