DRN-4574921

The complaint

Miss M and Mrs M have complained about the way Vitality Health Limited ('Vitality') dealt with a claim.

Miss M is Mrs M's daughter.

What happened

Miss M and Mrs M have a private medical insurance policy, underwritten by Vitality.

Cover began for Miss M in June 2021 on a moratorium underwriting basis.

Miss M had a condition for which she was advised to have yearly check ups. During one of her check ups for her hearing, Miss M was referred to a specialist.

Mrs M made a claim but Vitality declined cover due to the moratorium.

Mrs M complained and unhappy with Vitality's response, referred her complaint to the Financial Ombudsman Service.

Our investigator looked into the complaint but didn't think Vitality had incorrectly or unfairly declined the claim.

Mrs M disagreed and in summary said the recent check ups weren't related to Miss M's original condition for which she was discharged in 2014.

And so the case 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.

Having done so, I don't think this complaint should be upheld. I'll explain why.

- The background to this complaint is well known to both parties so I won't repeat everything here. Instead, I will focus on what I consider to be key.

- The relevant rules and industry guidelines say an insurer should handle claims promptly and fairly. And shouldn't unreasonably reject a claim.

- The policy terms confirm Vitality will not pay for treatment of any medical condition or related condition which in the five years before the cover start date the insured may: *have received medical treatment for *had symptoms of *have asked advice on or *to the best of their knowledge were aware existed. This is called a pre-existing medical condition. The policy goes on to confirm cover can be provided if the insured hasn't consulted anyone, including check ups for two continuous years after the cover start date.

- Miss M had surgery in 2014 and was discharged to her GP's care. She was advised to have her ears checked and a hearing test performed once a year whilst at school age.

- Vitality explained the claim was correctly declined as Miss M had been using hearing aids and had been having routine appointments for her hearing. This meant that her condition was excluded under the moratorium underwriting terms.

- I note Mrs M says the condition she claimed for had been resolved in 2014 and so the moratorium shouldn't apply. She says the check-ups are not regular treatment for her original condition. But the medical evidence is clear that Miss M would need regular check-ups and that her hearing should be checked regularly as a result of the original treatment. This would make it a pre-existing condition under the terms of the policy so I don't think Vitality unfairly declined the claim.

- Additionally Mrs M is unhappy with the time it took Vitality to deal with the claim but it initially declined it very quickly and then reviewed the claim again within a reasonable time when Mrs M expressed her dissatisfaction. So I won't be asking it to do anything further.

My final decision

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

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss M and Mrs M to accept or reject my decision before 12 March 2024.

Shamaila Hussain
Ombudsman