DRN-4874723

The complaint

Mr M and Mrs P are unhappy with Western Provident Association Limited's (WPA) decision to decline their claim. They're also unhappy with how long it took.

This complaint is brought by Mr M and so I'll refer to all submissions as being made by him personally.

What happened

Mr M has private health cover with WPA. In September 2023, he sought treatment and so claimed on his policy later that month on 26 September. Mr M said his symptoms began around September 2022. His claim was declined on 16 November 2023. Mr M said WPA took too long to decline the claim. He'd like more compensation as he's unhappy with how WPA treated him during that time.

WPA said Mr M had suffered with his condition prior to taking out the policy in September 2020 and hadn't been symptom free for two years since then. It said no cover was available in the circumstances. It also conceded there were delays, however, that these could've been avoided had Mr M been clearer about his previous medical history. WPA said it needed to gather Mr M's medical history in order to better understand whether Mr M had a history of this condition.

Our investigator agreed with WPA's position that Mr M's pre-existing condition wasn't covered. She explained Mr M hadn't satisfied the moratorium underwriting criteria and therefore his claim was declined fairly. She agreed there were some delays in reaching that decision and so she felt £100 compensation for the poor service was fair.

WPA agreed with her findings, however, Mr M didn't. He said, in summary, that he'd been through a difficult time with WPA and that £100 compensation wasn't enough. And so, it's now for me to make a final 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 done so, I've decided not to increase the compensation recommended by our investigator. I say that because I think it fairly compensates Mr M for the distress and inconvenience caused. I'll explain why.

The relevant rule that applies here is in the insurance code of business sourcebook (ICOBS) which says WPA must handle all claims promptly and fairly and must not reject a claim unreasonably.

I'm satisfied WPA declined Mr M's claim fairly because he didn't satisfy the moratorium underwriting criteria. Mr M's policy doesn't provide cover for pre-existing conditions, unless he's had a trouble-free period for at least two years;

• *“Any pre-existing medical condition(s) which you (or any applicant) had during the five years before your cover starts will not be covered for at least two years.*

• *Pre-existing conditions are medical condition(s) and other directly related conditions, for which treatment was received and/or medication was prescribed or professional advice was sought, or where symptoms existed (whether or not diagnosed).*

• *If you (or any applicant) do not have symptoms, treatment, medication or advice for pre-existing conditions for two continuous years after the policy starts, these will then be covered within the terms of the policy”*

I should highlight Mr M took this policy with WPA in September 2020.

Mr M’s medical history shows he suffered with the condition he claimed for in February 2020, December 2020, and August 2021. The referral letter for this particular claim listed his symptoms as having started around September 2022. And so, I’m satisfied the medical evidence shows that Mr M hadn’t been symptom free for a two-year period and therefore WPA correctly declined to cover the treatment.

In terms of delays, I’ve thought carefully about the impact this had on Mr M. There were some service issues on WPA’s part, namely it issued a letter on 6 November 2023, saying it’d cover the consultation costs for Mr M’s treatment and the delays assessing his medical records. However, I note that WPA honoured its commitment in that letter and paid its share of the consultation costs, meaning Mr M benefited through its mistake here.

In addition, the delay in assessing Mr M’s medical report was relatively short at around two weeks and therefore I consider the £100 compensation to accurately and fairly acknowledge the distress and inconvenience caused here. I understand Mr M’s argument that he feels largely put out by these issues, but I think WPA acknowledged its errors and compensated him fairly.

My final decision

My final decision is that I’m upholding Mr M and Mrs P’s complaint and Western Provident Association Limited must now pay £100 compensation for the service issues experienced.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr M and Mrs P to accept or reject my decision before 24 July 2024.

Scott Slade
Ombudsman