DRN-4910411

The complaint

F, a limited company, complains about the way BUPA Insurance Limited administered its group private medical insurance policy.

F is represented by Mr B.

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.

F held a group private medical insurance policy. At renewal in October 2022, as F had changed its bank account details, Mr B completed a new direct debit mandate (DDM) and posted the form to BUPA.

However, it seems BUPA didn't receive the DDM. Therefore, the new mandate wasn't set up and direct debit collections continued to be attempted from F's previous account. These payments effectively bounced, meaning no premiums were paid. In March 2023, BUPA noticed that policy premiums hadn't been received and it got in touch with F. Mr B told BUPA that F would settle the missed payments by the end of the month.

As the premiums weren't paid up by the end of March 2023, BUPA lapsed the policy.

Mr B was very unhappy with the way BUPA had administered F's policy and he asked us to look into F's complaint. In brief, he said BUPA had pre-authorised claims between October 2022 and March 2023, even though premiums had been outstanding. He said BUPA hadn't told F about the failed premium collections for around five months. He explained that BUPA had clawed back claims it had paid from medical practitioners which had led to collections activity proceeding against policy beneficiaries. He added that beneficiaries had also had to pay for their own private treatment. And he said that beneficiaries had incurred tax liabilities for the policy as a benefit in kind, despite no policy having been in place.

Ultimately, BUPA acknowledged that it hadn't handled things as well as it should have done. It said that subject to the payment of the failed premiums by BACS, it would reinstate the policy with no break in cover. It also said it would consider any claims which would have been payable during that period. And it offered F £1000 compensation.

Our investigator thought it was fair and reasonable for BUPA to require F to pay the full outstanding premiums before it would reinstate the lapsed policy. That's because she was satisfied that BUPA would cover both the 'clawed-back' claims and assess claims which would otherwise have been covered once the policy was reinstated and backdated. She said she couldn't comment on whether the compensation BUPA had offered was fair.

I issued a provisional decision on 1 July 2024, which explained the reasons why I thought BUPA had made a fair offer to settle F's complaint. I said:

'The relevant regulator's principles say that financial businesses must pay due regard to the

interests of their customers and treat them fairly. I've taken those principles into account, along with other relevant regulatory rules and guidance, when deciding whether I think BUPA treated F fairly.

Both parties acknowledge that in October 2022, Mr B told BUPA that he intended to renew F's policy and that he intended to change the bank account F's premiums were debited from. BUPA sent Mr B a blank DDM and I think it's most likely Mr B completed the relevant DDM and posted it back to BUPA, as he's consistently said.

Unfortunately, it doesn't appear that BUPA received the DDM and therefore, following renewal, it continued to attempt to debit the monthly premiums from F's old account, which failed. BUPA acknowledges that despite payments bouncing in November and December 2022 and January and February 2023, it didn't get in touch with F to chase-up the outstanding premiums until mid-March 2023. Its email said that failure to bring the account up to date could result in the plan being cancelled. BUPA gave F its BACs details so that the bounced payments could be paid. It isn't clear why it didn't make contact with F much sooner than it did to alert it to the missing premiums. I think it ought reasonably to have got in contact with F some months sooner to give it an earlier opportunity to bring the policy up to date.

BUPA's also acknowledged that a number of claims were pre-authorised following the 2022 renewal. So it seems to me that BUPA had a number of opportunities to tell F about the missing payments between November 2022 and March 2023 and to give it the chance to bring the account up to date.

I can see that Mr B promptly responded to BUPA to say that F aimed to bring the payments up to date by the end of March 2023. But no BACS payment was made by the end of March 2023. And so, on 30 March 2023, BUPA wrote to F to state that the policy would be cancelled with effect from 1 October 2022 unless a BACS payment was received by mid-April. As no payment was received, BUPA cancelled the plan.

BUPA accepts that it made mistakes in its administration of F's policy. It accepts it ought to have sent overdue payment requests sooner than it did, that claims shouldn't have been authorised and that its staff gave Mr B incorrect information. On that basis, while strictly, BUPA said it is out of time to reinstate F's policy from October 2022, it's agreed to do so on payment of the missed premiums by BACS. It's also said it will consider and pay any claims which were or would have been eligible under the policy once the account is up to date. F doesn't consider this to be a fair offer, as it says payments were clawed-back and because there was no policy for its beneficiaries to access. I've thought about this carefully.

Mr B has provided us with a plausible explanation as to why F wasn't aware the payments had bounced, as he says F's accounts are outsourced. I can also entirely understand why Mr B and F's scheme beneficiaries wouldn't have been aware of a problem while claims were being pre-authorised. Nonetheless, I think once F was on notice that the policy was in arrears and that payment needed to be made by BACS, it could have taken steps to rectify things. While I understand why F might wish for the back-payments to be taken by direct debit, I think BUPA has repeatedly made it clear that any outstanding amount must be paid by BACS. It isn't clear to me why F didn't bring the account up to date in March 2023, using the details it was given or why it's still chosen not to make payment in this way.

It's unfortunate that BUPA clawed back claim payments it had made from medical practitioners. This had a knock-on effect on beneficiaries. But BUPA has offered to reinstate the policy, on the same terms, with effect from 1 October 2022 and it's said that it will consider and pay any claims which were or would have been eligible for cover under the terms of the contract. This means that clawed-back previously paid claim payments will be

reimbursed to beneficiaries and that any eligible treatment which members paid for privately will be considered in line with the policy terms. And as such, F's group scheme members will effectively have had the benefit of the policy from October 2022 onwards with no break-in cover or change in underwriting. In my view, this is a very fair offer from BUPA. That's because I don't think it would be fair or reasonable for me to require BUPA to provide backdated cover for F when the relevant premiums haven't been paid. It remains open to F to pay the outstanding premiums to BUPA by BACS so that policy reinstatement can take place.

BUPA also offered F £1000 compensation. I don't agree with our investigator that I can't make a finding on whether I think this offer is fair. I can consider whether I think this offer is enough to reflect the inconvenience F was caused as a result of BUPA's failure to highlight the bounced direct debits and for the misinformation later given by its staff. In my view, £1000 is a fair and reasonable offer to reflect F's wasted management time as a result of dealing with BUPA's acknowledged mistakes. I'm satisfied this offer is proportionate to take into account the overall inconvenience I consider F has been caused by BUPA's errors in administering the group scheme.

In the round, I currently find that BUPA has made a fair offer to settle this complaint.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

BUPA had nothing further to add.

Mr B made further representations on F's behalf, which I've summarised:

- He felt that the contract between F and BUPA was that payments would be made by direct debit. And that BUPA was sitting on a valid mandate when it cancelled the policy. So he considered it had made a variation in the terms of the contract without consultation with F. He questioned whether this was good practice, legal and in line with the regulator's rules;
- F had requested to make payment by direct debit and BUPA's request that it make payment by alternative means was an attempt to cover-up its own mistakes;
- He considered that the departments involved in the handling of this matter had provided conflicting information.

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 still think BUPA has already made a fair offer to settle this complaint and for the same reasons I set out in my provisional decision.

I've carefully considered Mr B's further representations on F's behalf and I've taken into account his submissions. I've also looked carefully at the terms of business for F's group scheme which formed the basis of the contract between F and BUPA. It states:

'In consideration for Our operation and funding of the Scheme, You shall pay the Subscriptions.'

While it's clear F had opted to pay its group premiums by direct debit, it doesn't seem to me that there was a contractual requirement for BUPA to *only* require or accept payments by this method. Had it received the DDM from F in October 2022, I think it's most likely that it

would have set it up with the relevant bank and monthly payments would have been taken. I've seen no evidence though to suggest BUPA received the DDM and chose not to action it. And I don't find BUPA has acted unreasonably or failed to act in line with its regulatory obligations by requiring F to pay the outstanding premium balance by BACS, when the total balance is significantly more than the amount of each agreed monthly direct debit payment. Nor do I find this to be any attempt by BUPA to try and cover-up its mistakes – it simply seems to me to be a reasonable request so that the outstanding premium balance can be settled in a one-off payment.

I can see that Mr B did have contact with different departments at BUPA during the course of this matter and I appreciate he feels BUPA's communications with F were conflicting. But in the round, I think BUPA's emails were sufficiently clear about what had happened, why the policy had been lapsed and what needed to happen before the policy could be reinstated. And I also find that the compensation BUPA has already offered would fairly take into account any inconvenience F might have experienced as a result of communicating with different departments at BUPA.

Overall, while I appreciate Mr B's strength of feeling about this matter, I still find that BUPA has already made a fair offer to settle this complaint.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I find BUPA has made a fair offer to settle this complaint.

I direct BUPA Insurance Limited to:

- Reinstate F's policy, subject to the payment of the outstanding policy premiums by BACS by F;
- Consider and pay any previously clawed-back eligible claims and consider any claims which would have been eligible under the policy in line with the policy terms;
- Pay F £1000 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask F to accept or reject my decision before 22 August 2024.

Lisa Barham
Ombudsman