DRN-4924310

The complaint

Mr B complains about the way that Vitality Health Limited has handled a claim he made on a personal private medical insurance policy.

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.

In November 2023, Mr B took out a personal private medical insurance policy with Vitality after cover ended on a corporate plan. The new policy was taken out on moratorium underwriting terms. This meant that Vitality wouldn't cover any medical conditions a policyholder had in the five years before the policy began.

Unfortunately, in January 2024, Mr B was diagnosed with colon cancer. So he got in touch with Vitality to make a claim. Vitality required Mr B to complete an access to medical records form (AMR) and obtain a GP statement which confirmed when Mr B had first experienced symptoms. The GP stated that Mr B's first signs and symptoms of the condition were noted on 12 December 2023.

Given the proximity of the symptoms to the policy start date and as Mr B had made a claim in May 2023 for Irritable Bowel Syndrome (IBS) under the corporate plan, Vitality considered it needed more information before it could validate the claim. So, on 1 February 2024, it wrote to Mr B's GP to ask for all of its records relating to Mr B's condition.

Despite Vitality's chasers to the GP in March, April, May and June 2024, it didn't provide Mr B's medical records. So Vitality remained unable to make a claims decision.

Mr B was very unhappy with the way Vitality has handled his claim. He said that he'd developed cancer symptoms after the policy had begun, but in any event, he said he'd been told all of his pre-existing medical conditions would be covered. He thought Vitality had prevented him from accessing treatment, meaning that he was at risk of the cancer spreading. He didn't consider that Vitality had treated him in a positive or supportive way. And so he asked us to look into his complaint.

Our investigator didn't think Vitality had treated Mr B unfairly. She thought the policy terms made it clear that Mr B had moratorium cover and that Vitality was entitled to ask for medical information in order to assess a claim. In the circumstances, she thought it was reasonable for Vitality to require more information before it could decide whether the claim was covered. And while she considered Vitality could have potentially chased the GP more frequently, given the GP's failure to respond to either Vitality or Mr B's requests to send the information, she didn't think this had caused any delays to the overall handling of the claim.

Mr B disagreed. In summary, he said Vitality had used NHS delays to its gain and that requiring medical information would only delay the claim and benefit Vitality. He told us that the delays had exacerbated his stress and he felt that neither we nor Vitality cared. He questioned what he was paying policy premiums for. He said that due to NHS delays, his

cancer had spread beyond the initial tumour site and meant he'd needed chemotherapy. He maintained that he'd been told at the outset that he was covered for all pre-existing medical conditions and that he felt it was deplorable that Vitality would rely on his previous claim for IBS to decline a claim for colon cancer. He considered there was an inference that he had delayed seeking a diagnosis and treatment until the personal policy was in place. And he asked for a more compassionate review of his complaint.

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, whilst I'm very sorry to disappoint Mr B, I don't think Vitality has handled his claim unfairly and I'll explain why.

First, I'd like to say how sorry I was to read about Mr B's diagnosis and the impact his condition has had on him. I don't doubt what a difficult, worrying and upsetting time this has been for him.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations such as industry principles and guidance and the policy terms, to decide whether I think Vitality has treated Mr B fairly.

I've first considered the policy terms and conditions, as these form the basis of Mr B's contract with Vitality. While Mr B says he was told that all pre-existing conditions would be covered, his policy certificate shows that he took out personal cover on moratorium underwriting terms. Page 10 of the policy document explains moratorium cover and I've set out the relevant section below:

'Before starting your cover, you did not have to answer any health questions on your application form or undergo a medical examination. Instead, each claim is assessed on the information provided by you and, if necessary, a GP (or other medical practitioner) when you claim.

…

We don't pay claims for the treatment of any medical condition or related condition which, in the five years before your cover started:

- *you have received medical treatment for, or*
- *had symptoms of, or*
- *asked advice on, or*
- *to the best of your knowledge and belief, were aware existed.*

This is called a 'pre-existing' medical condition.'

And page 32 of the contract says:

'Sometimes, particularly if you claim in the first one or two years after joining us, we may need you to send us a fully completed claim form to help us assess your claim. We will normally ask for details of your medical history for at least the previous five years, with sections for both you and your GP to complete. We will not pay fees charged by a medical

practitioner for completing a claim form, and we will be unable to assess the claim or pay for any treatment before we receive the claim form.'

In my view, the moratorium policy terms make it clear that Vitality won't pay claims if a policyholder has had symptoms of a condition in the five years before the policy began. And that Vitality may ask for medical evidence to allow it to assess a claim. I'd add that it isn't unusual for private medical insurers to request medical evidence from a policyholder's GP or treating specialist when assessing claims. Nor do I generally think there's anything inherently unfair or unreasonable in them doing so.

I understand Mr B received an upsetting and unforeseen diagnosis in January 2024. But the AMR form stated that Mr B had first experienced signs or symptoms of his condition around three weeks after the personal policy began. And it seems that Mr B asked for Vitality's support with IBS symptoms around six months before the policy began. I understand some IBS symptoms can be similar to colon cancer symptoms. Therefore, I don't think it's unreasonable for Vitality to conclude it needs more medical information about Mr B's condition before it can decide whether or not the claim should be paid.

Vitality's notes show that it requested information from Mr B's GP a few days after it received the AMR. It's chased this information up by email in March, April, May and June 2024 and I can see it's called the practice too. Like the investigator, I think, given the seriousness of Mr B's condition, Vitality ought to have been more proactive in chasing up the GP more regularly.

With that said, Mr B has also told us that he called the GP to chase up the evidence and Vitality said the GP told it that the medical records would be sent 'as soon as possible'. Despite both Mr B and Vitality's chasers, the practice still hadn't sent the evidence over five months after it was requested. So it seems to me that even if Vitality had chased the evidence up more regularly, it's unlikely it would have resulted in the records being sent any sooner. And therefore, I don't think I could reasonably find that Vitality has caused any unreasonable delays to the overall handling or assessment of Mr B's claim.

I sympathise with Mr B's position because I understand how important it is to him to seek private treatment. But I don't think Vitality has acted unfairly by requesting further medical information. And in these circumstances, I don't think it's unreasonable for Vitality to require the GP's records to allow it to fully assess the claim in line with the policy terms.

Mr B has also raised further complaint points with us since making his complaint to Vitality, including about the information it holds on him; it's handling of his claim for IBS; and effectively, about the value of his premiums. As the investigator explained, these are new complaint points which Vitality hasn't yet had a chance to look into. Therefore, I can't comment on them as part of this complaint. It's open to Mr B to make a separate complaint to Vitality about those issues should he wish to. I note Mr B also says he was told his policy would cover all pre-existing medical conditions. If he feels he was mis-sold the moratorium policy, this would also be a new complaint point which he'd need to raise with the policy seller.

Overall though, I don't find Vitality has treated Mr B unfairly and so it follows that I'm not telling it to do anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B to accept or

reject my decision before 26 August 2024.

Lisa Barham
Ombudsman