DRN-4951087

The complaint

Mrs A complains that Western Provident Association Limited (WPA) has turned down a claim she 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.

Mrs A took out a personal private medical insurance policy with WPA in February 2023. The policy was set-up on a moratorium underwriting basis. This meant that WPA wouldn't cover any pre-existing conditions which Mrs A had suffered from in the five years before the policy began.

In March 2023, Mrs A called WPA to make a claim as she'd been experiencing menorrhagia. She'd obtained a referral from a virtual GP to see a gynaecologist. WPA agreed to cover Mrs A for an initial consultation and some tests. It told Mrs A it would need to see a specialist report; referral and clinic letters before further cover could be agreed.

Subsequently, the gynaecologist provided a specialist report, which provided a diagnosis of menorrhagia. The report stated that Mrs A hadn't experienced any symptoms of menorrhagia between 2018 and 2023, but the gynaecologist also didn't provide a symptom start date. And WPA doesn't appear to have received a copy of Mrs A's referral letter or clinic letter at that point either. So it asked for more medical information.

Mrs A underwent an ultrasound and was later diagnosed with adenomyosis. The gynaecologist also let Mrs A know that she'd been found to have an underactive thyroid (Mrs A was subsequently diagnosed with Hashimoto's Disease). The gynaecologist suggested that Mrs A could undergo ablation treatment once she'd been treated for the thyroid condition.

WPA requested further medical evidence to allow it to assess Mrs A's claim. It asked her GP for her full gynaecological history. And it re-requested the referral letter from the virtual GP.

Mrs A's records showed she'd experienced gynaecological symptoms in 2022; had been referred for a pelvic ultrasound and had been referred to a gynaecologist in 2022. Therefore, WPA felt it needed further medical information to allow it to assess the claim.

After some back and forth, and after Mrs A had to chase WPA for updates on the claim, a claims decision was ultimately made in early December 2023. Shortly before, WPA had received a copy of the referral letter from the virtual GP which stated that Mrs A's symptoms had begun 11 days prior to the beginning of the policy. And it also felt that the symptoms Mrs A had experienced in 2022 were symptoms of the adenomyosis she'd been diagnosed with in 2023. So it concluded that Mrs A's claim was caught by the moratorium clause and it turned down the claim.

Mrs A was very unhappy with WPA's decision. She said she hadn't told the virtual GP that

her symptoms had begun in mid-February 2023. She said she'd had to seek treatment for Hashimoto's disease on the NHS, which had been delayed. And she also said her policy premiums had significantly increased. She asked us to look into her complaint.

WPA let us know that Mrs A had sent it a copy of her call with the virtual GP which showed that she hadn't stated a symptom start date which pre-dated the policy application. But it maintained that as Mrs A had experienced symptoms of adenomyosis in the five years before the policy began, her claim wasn't covered.

Our investigator thought it had been fair for WPA to conclude that Mrs A's claim wasn't covered by the policy. And he also thought it had been reasonable for WPA to request further medical information. But he did think WPA had unreasonably delayed the progression of the claim at points and that it had failed to keep Mrs A updated. So he recommended that it should pay her £100 compensation.

WPA accepted the investigator's view but Mrs A did not. So the complaint was passed to me to decide.

We asked WPA to explain why it hadn't covered Mrs A for a claim for Hashimoto's disease. It told us that it *had* accepted cover for Hashimoto's and that it had covered three consultations with an endocrinologist and investigations between February and June 2024.

I issued a provisional decision on 18 July 2024 which explained the reasons why I thought WPA should pay Mrs A total compensation of £250. I said:

'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 regulatory principles, guidance and relevant considerations, when deciding whether I think WPA has treated Mrs A fairly.

It seems there are three key issues for me to decide. First, was it fair for WPA to turn down Mrs A's claim for treatment of adenomyosis? Second, were there any unreasonable delays in the acceptance of the claim for Hashimoto's? And third, did WPA handle the overall claim fairly? I'll deal with each point in turn.

Was it fair for WPA to turn down the adenomyosis claim?

I've first considered the policy terms and conditions, as these form the basis of the contract between Mrs A and WPA. The policy was taken out on moratorium underwriting terms. Mrs A's policy certificate says:

'You cannot claim for any pre-existing condition that occurred during the five (5) years prior to the start date of your policy. Benefit will be considered for pre-existing conditions where you have been free from symptoms, treatment, medication or advice for two (2) years from the policy start date. All claims must be pre-authorised.'

Page 31 of the contract says:

'If you have moratorium underwriting you will not be eligible to claim for at least two years, for any condition(s) which you had during the five years before your policy starts or which occurred in the first 14-days after you joined us. We call these pre-existing conditions.'

Page 27 of the policy defines what WPA means by a pre-existing condition as follows:

'Any condition, disease, illness or injury, whether symptomatic or not. This includes:

• Anything for which you have received medication, advice or treatment: or
• Where you have experienced symptoms, whether the condition has been diagnosed or not, before the start of your cover: or
• Any symptoms or condition, whether diagnosed or not, which occurs in the first 14-days of cover, unless agreed and accepted by us in writing in advance.'

In my view, the policy terms make it clear that WPA won't pay claims if a policyholder has experienced symptoms of a condition in the five years before their policy began, even if there hasn't been a formal diagnosis.

WPA considered all of the available medical evidence and concluded that Mrs A had been experiencing symptoms of adenomyosis in the five years before the policy began. So like the investigator, I've carefully considered the available medical records to decide whether I think this was a fair and reasonable conclusion for WPA to draw.

I've looked carefully at Mrs A's GP records. I can see that in May 2022, around nine months before the policy began, Mrs A visited her GP with symptoms of abdominal pain and bloating and her monthly period had also been unusual. In August 2022, Mrs A was referred to gynaecology, for symptoms which included significant pelvic pain and a history of pelvic pain and bloating. She underwent an ultrasound in August 2022 which was 'suggestive of pelvic congestion syndrome.' The ultrasound results also refer to a history of recurrent pelvic pain and bloating. It doesn't appear that Mrs A underwent any further gynaecological treatment at that time.

WPA's senior clinical case manager states that pelvic pain and bloating are symptoms of adenomyosis. I'm not a medical expert and so it would be inappropriate for me to make a clinical finding or to substitute clinical opinion with my own. Having considered the NHS website though, it seems clear that pelvic pain and bloating are symptoms of adenomyosis. And it's also clear that Mrs A was experiencing those symptoms for at least nine months before the policy began. So, on balance, I don't currently think it was unfair or unreasonable for WPA to conclude that Mrs A's claim for treatment of adenomyosis was excluded by the terms of the moratorium.

I appreciate Mrs A feels that the symptoms of menorrhagia and pelvic pain can be difficult to distinguish, but that it could be argued they're separate. I've considered this carefully. But I don't currently think there's enough medical evidence to show that there was no link between Mrs A's pre-existing symptoms and her subsequent development of menorrhagia and diagnosis of adenomyosis. It's open to Mrs A to obtain further medical evidence in support of her claim though, should she wish to do so, and to send this to WPA for its review. I'd expect WPA to assess any such new evidence in line with the policy terms.

Overall though, on the evidence before me, I currently don't think it was unfair or unreasonable for WPA to turn down Mrs A's claim for the treatment of adenomyosis/menorrhagia.

Was there an unreasonable delay in the acceptance of the claim for Hashimoto's disease?

I can see that in November 2023, Mrs A sent WPA a copy of a clinic letter dated 31 July 2023. This letter stated, amongst other things, that Mrs A had been found to have an underactive thyroid and the gynaecologist recommended that Mrs A should see an endocrinologist. They also said that they would see Mrs A again once the thyroid issue had been resolved.

It isn't clear whether Mrs A made a formal claim for an endocrinology referral ahead of

sending the clinic letter to WPA, or indeed, that she did so at that point. I can see though that a letter from WPA to Mrs A on 8 December 2023 refers to a new 'condition' of both adenomyosis and Hashimoto's Disease before going on to direct Mrs A to the moratorium terms and explaining that the claim appeared to fall outside of cover. So I can entirely understand why Mrs A may have believed that a potential claim for an endocrinology referral had also been declined or would be declined.

Mrs A told us that she'd had to seek treatment on the NHS for Hashimoto's Disease and had experienced delays in treatment as a result. WPA says that it's covered endocrinology treatment since February 2024. But it seems to me that given WPA accepts Hashimoto's Disease is covered under the policy; it was in a position to distinguish between Mrs A's claim for adenomyosis and a potential endocrinology claim by December 2023 at the latest.

None of the follow-up communications - including WPA's final complaint response letter - refer to Mrs A's new diagnosis of an underactive thyroid – instead referring only to menorrhagia. I currently think Mrs A might have potentially been able to arrange a private endocrinology referral and treatment a few weeks earlier than she did had WPA distinguished between the two conditions when it wrote to her in December 2023. And she may also have been in a position to seek treatment for adenomyosis sooner too, even if this treatment wasn't covered by WPA. I say that because the gynaecologist indicated that Mrs A needed to resolve her underactive thyroid before returning for treatment. So I think Mrs A has been caused some unnecessary frustration and upset as a result of WPA's oversight on this point.

Did WPA handle the overall claim fairly?

I can see that several months passed between the original claim in May 2023 and its ultimate decline in December 2023. With that said, it does appear that much of the delay was caused by WPA needing further medical evidence before it could make a claims decision. Based on the medical evidence I've seen; I can see that it was often incomplete and raised further questions. I don't think it was unfair for WPA to require additional medical evidence to validate whether or not Mrs A's claim was covered. That's because it's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. And based on the referral letter WPA was sent, I don't think it was unfair for it to originally conclude that Mrs A had been experiencing menorrhagia before the policy began, although it now accepts that Mrs A didn't give the virtual GP the information which was recorded.

However, I do think WPA made clear errors too, largely between September and December 2023. It didn't request some of Mrs A's medical information as promptly as it should have done. It asked for information it already had. And it didn't provide Mrs A with meaningful updates at times during this period, meaning she had to chase things up. I'm satisfied this caused Mrs A unnecessary trouble, upset and inconvenience when she was already experiencing painful and worrying symptoms.

Taken together with the delay in accepting Mrs A's claim for an underactive thyroid, I currently don't think the £100 compensation WPA has already agreed to pay is enough to reflect the impact of its actions on Mrs A. So I intend to direct WPA to pay Mrs A total compensation of £250.

Mrs A has also referred to the increase in her policy premium. However, it doesn't appear that she's previously complained to WPA about this issue. Under our rules, a financial business must be given eight weeks to look into and respond to a complaint before we can potentially help with it. So if Mrs A feels WPA has calculated her premium unfairly, she'll need to complain to WPA about that issue before we can potentially investigate it.'

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

Both Mrs A and WPA let me know that they accepted my provisional 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, as both parties have accepted my provisional findings, I see no reason to change them.

So my final decision is the same as my provisional decision and for the same reasons.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I partly uphold this complaint.

I direct Western Provident Association Limited to pay Mrs A £250 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs A to accept or reject my decision before 4 September 2024.

Lisa Barham
Ombudsman