DRN-4957602

The complaint

Mr T is unhappy that HMCA Insurance Ltd have added an exclusion to his medical care plan.

What happened

Mr T took out a medical care plan in 2016. He had an existing health condition at the time he took out the policy related to his heart ('the heart condition'). Following Mr T receiving treatment related to the heart condition HMCA applied an exclusion to the policy.

Mr T didn't think this was fair and complained to HMCA but they maintained their decision was fair. Unhappy, Mr T complained to the Financial Ombudsman Service. Following the complaint being referred to the Financial Ombudsman Service HMCA made an offer to Mr T to try and resolve the complaint.

Mr T didn't accept that offer and so our investigator looked into what happened. He didn't uphold the complaint as he was satisfied HMCA had complied with their obligations at the point of sale and had fairly applied the exclusion in line with the policy terms.

Mr T didn't agree and asked an ombudsman to review the complaint. In summary, he says he wouldn't have taken out this policy if he'd been aware HMCA could apply an exclusion in such circumstances. Mr T also made some further new complaint points which have been referred to HMCA to consider as a new complaint.

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.

The sale of the policy

Mr T wasn't advised by HMCA to take out the insurance policy. The relevant rules and industry guidelines say that they needed to ensure that he was given enough information to decide if the policy was right for him. That means they needed to give him clear, fair and non-misleading information about the policy.

Mr T complains that, had he known HMCA could apply an exclusion to the policy for long term health conditions, he wouldn't have taken it out. I'm satisfied, on balance, Mr T was given clear, fair and non-misleading information about the policy.

The advisor did mention in the call they would honour future acute episodes of pre-existing conditions. Mr T was also sent detailed information about the policy including the rules of membership and a key facts document. I've seen a sample of the documentation which were issued to Mr T and I'm satisfied they are most likely representative of the information Mr T was sent.

The key facts document has a section called, 'significant features and exclusions'. It says:

> Long term conditions which are recurrent, persistent or incurable are not covered. These are commonly known as ‘chronic’ conditions. (See condition 3.3.2 for a full description).

3.3.2 of the policy terms says:

> When a condition is first diagnosed as being Long-Term (and did not exist prior to enrolment) benefit will be provided for such diagnosis and any necessary treatment for one initial episode only. Subsequent treatment is not covered. When these circumstances occur the Association will issue an appropriate endorsement to the certificate. The Association provides a discretionary Long-Term Illness Grant which can be made available to those with a Long-Term Illness to assist transition to NHS care.

Therefore, I think HMCA did make it sufficiently clear that endorsements could be added to the policy for Long-Term conditions. If Mr T had concerns about how this might impact his use of the policy it was open to him to query this and seek further information. And he had the option to cancel the policy if it didn’t meet his needs. Furthermore, Mr T was sent annual renewal documentation throughout the life of the policy which also referenced these terms.

Taking all of the above into account I’m satisfied Mr T was provided with enough information to decide if the policy was right for him.

<u>The application of the endorsement to the policy</u>

I’ve also considered whether it was fair and reasonable for HMCA to apply the exclusion to the policy.

An acute condition is defined as:

> Any disease, illness or injury of rapid onset, severe symptoms and brief duration.

A long term illness is defined as:

> A medical condition that has become either recurrent, persistent or incurable.

The endorsement said:

> No benefit is payable towards the investigator or treatment of Atrial Fibrillation or any other condition related therefrom.

Mr T was successfully treated for Atrial Fibrillation in 2016 and made a claim on the HMCA policy for treatment which took place in November 2023. The claim form said that this had been diagnosed in 2000/2001. It went on to say that Mr T had exhausted pharmaceutical options and intervention was required.

I don’t think the endorsement was unreasonably applied given the terms of the policy and Mr T’s medical history. I think HMCA reasonably concluded that this was a condition which was recurrent, persistent or incurable.

I appreciate that this now leaves Mr T in a difficult position as it will be difficult and expensive to change to another provider who will offer him the cover he wants. However, in the circumstances of this case, that’s not something that is as a result of anything HMCA has done wrong.

HMCA did make an offer to Mr T to remove the endorsement to enable him to seek alternative cover. However, for the reasons I've outlined above, I'm not upholding this complaint as I don't think HMCA have treated Mr T unfairly.

My final decision

I'm not upholding this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 17 January 2025.

Anna Wilshaw
Ombudsman