DRN-5110281

The complaint

Mrs C and Mr C have complained that Vitality Life Limited declined a claim they made under their Vitality Life Plan.

What happened

Mrs C and Mr C took out a Vitality Life Plan through an independent financial adviser in 2015. This provided life and serious illness cover for Mr and Mrs C – the level of serious illness covered was indicated to be Primary cover. It also included children's cover.

The Plan was for a fixed term of 18 years with an account value of £120,000 on a decreasing term basis.

In 2024 Mr C unfortunately suffered a heart arrest and was treated for ventricular fibrillation. He made a claim under his policy. Vitality declined the claim as Mr C had Primary cover which covered severity levels A to D. This didn't include angioplasty or cardioversion for cardia arrhythmia. These were classified as severity level F and only available to those with Comprehensive cover.

Unhappy, Mrs C and Mr C referred their complaint here. Our investigator didn't recommend that it be upheld. They didn't consider that Mr C's claim was covered by his policy.

Mrs C and Mr C appealed.

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.

Although I've summarised the background to this complaint - no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts.

The regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the relevant law, the policy terms and the available evidence, to decide whether I think Vitality treated Mrs C and Mr C fairly. Having done so, I've reached the same conclusion as our investigator. I'll explain why.

Firstly it is important to note that I am not considering the sale of the policy as Vitality didn't sell it to Mr and Mrs C. I don't know why (or if) Primary Cover was recommended as Mr and Mrs C say they would have taken the most comprehensive policy given the family history. For the purposes of the complaint made against Vitality, it is not disputed that Primary Cover was selected.

With regards to the documentation Vitality sent after the policy had been taken out the policy

terms and conditions state: *Your plan schedule shows whether you have Primary or Comprehensive Serious Illness Cover with primary cover you are covered for severity levels A,B,C & D with comprehensive cover you are covered for all the severity levels from A to G.*

Mr and Mrs C's schedule confirmed that their level of cover was Primary. I've seen a copy letter sent to them on 2 June 2015. An updated Plan Schedule was enclosed – the letter advised: *Please read carefully as your Plan Schedule outlines details of your plan.* I've also seen the adviser's copy dated 27 April 2015 – which Mr and Mrs C sent to this Service. The schedule confirmed they type of Serious Illness Cover Mr and Mrs C had was Primary Cover. I find that the documentation that Vitality sent was clear. But if Mr and Mrs C had any concerns that the policy wasn't what they wanted or had understood they had purchased, they had the opportunity to call Vitality. The telephone number and email address were set out on the documentation sent.

I do understand the point Mr and Mrs C make about Mr C's procedure. They felt that regardless of the procedure - stents or bypass - Mr C's condition was the same. But the policy terms make clear that Primary Cover provides cover for severity levels A – D, whilst Comprehensive cover includes cover for severity levels A – G. Mr C's procedure (Angioplasty or Cardioversion for Cardiac Arrhythmia) falls under severity level F, which isn't included under Primary Cover. This is set out in the Plan Provisions document at page 84 under 'Heart and Artery category – specified conditions of defined severity'. Mr C hasn't suggested that the medical evidence indicates his medical event has been wrongly categorised.

I appreciate that Mr and Mrs C have paid their premiums in good faith for several years. It is unfortunate that because of the severity level, Mr C wasn't covered when he went to make a claim. I accept how disappointing it would have been to be advised his claim wasn't eligible. But in all the circumstances I don't find that Vitality treated him unfairly, unreasonably or contrary to his policy terms by declining his claim.

I'm sorry that my decision doesn't bring Mr and Mrs C welcome news.

My final decision

For the reasons 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 Mrs C and Mr C to accept or reject my decision before 6 May 2025.

Lindsey Woloski
Ombudsman