DRN-5131669

The complaint

Mr D is unhappy with Western Provident Association Limited (WPA) because it declined his private medical insurance claim. Mr D also says the information provided during the sale was unclear, unfair and misleading.

What happened

Mr D took out a private medical insurance policy in October 2023. The policy was taken out online and directly with WPA on a moratorium basis on a non-advised basis. This means that no medical underwriting took place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required. The plan is a moratorium and means any pre-existing conditions from the previous five years of starting the plan are excluded. And pre-existing medical conditions can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan. The policy underwriter is WPA.

Mr D has an annual medical check-up with a private GP. In December 2023, this showed an elevated level of cholesterol and abnormal lipids which meant that Mr D's GP referred him to a cardiologist.

In January 2024, Mr D had a consultation with a cardiologist and WPA authorised this as well as simple tests. The cardiologist recommended further investigation and for Mr D to have an ECG, an echocardiogram and CT scan. WPA authorised a further consultation with the cardiologist and requested the clinic letter from the consultation in January 2024.

In February 2024, the cardiologist recommended further investigation and recommended a CT coronary angiogram and a stress cardiac MRI scan. Mr D requested authorisation for these and WPA said it needed to confirm eligibility. It requested the clinic letter from the consultant.

Mr D submitted a claim to WPA for the investigations. WPA declined it due to a pre-existing medical condition to which cholesterol was a related condition.

Mr D made a complaint to WPA as he didn't think his heart condition was pre-existing. It responded in April 2024 and said as the policy was set up on a moratorium basis, Mr D wasn't covered from October 2018 to 2023 until he had a two-year symptom-free period. As it is a moratorium policy, no medical history was provided at the start of the policy and any underwriting is done at the time of a claim. So, Mr D's medical history was assessed at the point he made a claim, and this showed high cholesterol readings and as this was related to heart disease, it declined cover for the CT coronary angiogram as it was an investigation of the coronary arteries. The information showed Mr D had a history of abnormal lipids which is a known risk factor for coronary heart disease which relates to symptoms present during the five years prior to taking the policy out. WPA said had the policy been taken on a full medical underwriting basis, there would have been exclusion set on the policy for this.

Unhappy with WPA's response, Mr D brought his complaint to this service. Our investigator didn't uphold the complaint. He didn't think WPA had declined the claim for further tests

unfairly. And he didn't think the way WPA set out information about the policy during the sale was unfair or unreasonable.

Mr D disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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 relevant 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 terms of this policy and the circumstances of Mr D's claim, to decide whether I think WPA treated him fairly.

At the outset I acknowledge that I've summarised this complaint in far less detail than Mr D has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern our service allow me to do this as we are an informal dispute resolution service. I'm satisfied I don't need to comment on every individual point to be able to fulfil my statutory function.

Has the claim been declined fairly?

The starting point is the policy as it forms the basis of the insurance contract between Mr D and WPA.

The policy was set up on a moratorium basis. I've already explained what moratorium means above so I won't repeat this again. But any conditions during this moratorium period are not eligible for a claim and are called pre-existing conditions.

Page 35 of Mr D's policy booklet defines pre-existing conditions as:

> *'Pre-existing conditions – subject to the underwriting of your policy*
>
> *• 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.'*

The symptoms can be diagnosed or not.

And related condition is described on page 32 as:

> '*A related condition is where a current UK body of reasonable medical opinion consider another symptom, disease, illness or injury to be related to or associated with an excluded condition.'*

WPA declined the claim for further investigation due to Mr D's medical history which shows high cholesterol (hypercholesterolaemia). I've reviewed the information WPA provided, and this shows his cholesterol levels from 2011 to 2023 to be over 5.0 mmol/L which is considered medically to be high. The information shows during the five years prior to taking out the policy, Mr D's cholesterol to be high. Mr D's policy terms and conditions states there is no cover for a pre-existing condition where the symptoms are diagnosed or not. So, on this basis I don't think declining the claim was outside the terms of the policy as high cholesterol is a condition of coronary heart disease. As the claim was for further investigation related to heart disease, I don't think it was unfair to decline the claim.

Mr D says he understood that pre-existing conditions personal to him were excluded before purchasing the policy. He also says that he didn't understand that related conditions were also excluded because the personal exclusions page on the policy makes no reference at all to related conditions.

Related conditions on WPA's website states that high cholesterol or hypercholesterolaemia is a related condition to a number of heart conditions. Whilst it doesn't exactly say it's related to coronary heart disease; I think on balance it's sufficient because high cholesterol isn't related to the one heart condition but a number of heart conditions. The tests which Mr D is claiming for here are specifically for investigating coronary heart disease.

I've also considered the results from the consultation Mr D had. This states a check will be carried out of the coronary arteries which would relate to the history of high cholesterol.

And in terms of a current UK body of reasonable medical opinion, the NHS website confirms the risk of developing coronary heart disease is significantly increased if you have high cholesterol.

Mr D says his cholesterol has never reached the point where his GP has considered it necessary to put him on statins. I appreciate this. But there is a regular history of high cholesterol and in December 2023 the risk was considered high enough for further tests to be carried out. Having medication supports the managing of the symptoms but the policy terms say the symptoms can be diagnosed or not – Mr D's medical history shows high cholesterol readings for the previous five years before the policy inception. And the NHS website confirms there is a strong link between high cholesterol and coronary heart disease.

In summary, therefore, I'm not persuaded that the claim was declined unfairly by WPA.

Information provided during the sale of the policy

Mr D took this policy out on a non-advised basis, online and directly with WPA. He says the information he was given at the point of sale was unclear, unfair and misleading.

In the case of a non-advised sale, the relevant rules say that an insurer should provide the customer enough information to decide if the policy is right for them which includes exclusions about pre-existing medical conditions, the key policy benefits and limitations on the level of cover, the policy excess and any restrictions on how quickly they can access treatment.

I've considered the information WPA provided during the process of buying the policy. I can see Mr D was given a choice between taking out a moratorium policy or a full medical underwriting policy. In order to choose which option, both underwriting methods were explained in terms of how WPA assesses any pre-existing medical conditions. And an underwriting guide was provided to read through. Specifically, under the heading '*Key*

information', pre-existing conditions was defined (the same as in Mr D's policy terms and conditions) and it also stated:

> *'When we refer to condition(s), the term also includes any related condition(s) and any undiagnosed symptom(s). A related condition is where a current UK body of reasonable medical opinion considers another symptom, disease, illness or injury to be related to or associated with a condition.'*

Under the section '*New to health insurance'*, it states:

> *'Benefit is not provided for pre-existing long-term medical conditions (and related conditions) which are likely to require regular or periodic treatment, medication or advice. This is because the moratorium period starts each time you receive such treatment, so it's unlikely you'll ever have two consecutive years free of symptoms and/or treatment.*
>
> *Examples include, but are not limited to:*
>
> *• Diabetes;*
>
> *• Uncontrolled hypertension;*
>
> *• Fibromyalgia; and*
>
> *• Multiple sclerosis.'*

Further details were provided about related conditions on WPA's website. It states:

> '*Where a personal exclusion applies or if you have chosen underwriting on a moratorium basis, many long-term conditions will be exempt from cover including their related conditions. For ease we have highlighted some of the more common long-term conditions and provided examples of those that are generally recognised to be related to these.*
>
> *Please note this list is not exhaustive.'*

Hypercholesterolaemia is listed here as a long-term condition. Heart disease is listed as a related condition to hypercholesterolaemia. Whilst it doesn't exactly refer to coronary hear disease, it's clear that a related condition to high cholesterol is heart disease. So, I think the information provided during the process of applying for the policy is sufficiently clear.

On the page where Mr D was given a quoted premium for the policy, documents were included for further information – the Insurance Product Information Document (IPID), a guide to the policy document, and a policy brochure.

Based on the questions Mr D completed and the options he chose, a '*Complete Health'* policy was the product that met his needs and the one he took out.

Additionally, I can see Mr D received a welcome letter and his certificate of insurance from WPA. The letter clearly refers Mr D to the policy documents and a '*Guide to your Policy'* document. These documents provide information again which he was referred to during the online sales process. Mr D was asked to read through the documents and ensure he was happy with the cover and all his details were correct. He needed to contact WPA if changes needed to be made.

Having carefully reviewed the online sales process, I don't agree that there was a lack of clarity by WPA. I can see Mr D was guided through the application process and relevant information about the policy was provided at each stage, this included information about related conditions.

And I'm satisfied that WPA provided information as set out in the relevant rules and guidance by the insurance industry regulator, the Financial Conduct Authority (FCA) and within the Insurance Conduct of Business Sourcebook (ICOBS).

I've thought about what happened in the context of the overarching Consumer Principle 12 under the Consumer Duty. Consumers are expected to take responsibility for the decisions they make about products and services. To do this, businesses must give them the information they need, at the right time, and presented in a way they can understand. That way they can make informed decisions. Key information was provided upfront to Mr D, and cross-references and links were provided to further details. So, I don't think Mr D has been treated unfairly. The information WPA provided enabled Mr D to take responsibility of choosing the policy that met his needs by giving him the appropriate information at the time of the sale. Having looked at the information WPA provided to Mr D, this is in line with the requirements of the relevant industry rules and guidance and in line with the Consumer Duty requirements.

What I've decided

Overall, I'm not persuaded that WPA declined Mr D's claim outside the terms and conditions of his policy, and I don't think it has done this unfairly. And I also think Mr D was treated fairly by WPA in providing information and communicating in a way that was clear, fair and not misleading. I've noted that WPA has paid for the initial consultations and tests that Mr D required and therefore it didn't completely decline Mr D's, only the part which involved further investigation into coronary heart disease. I don't this is unfair or unreasonable.

I'm sorry to disappoint Mr D but it follows therefore that I don't require WPA to do anything further.

My final decision

For the reasons given above, I don't uphold Mr D's complaint about Western Provident Association Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr D to accept or reject my decision before 17 January 2025.

Nimisha Radia
Ombudsman