DRN-5193881

The complaint

Mr S complains that Western Provident Association Limited ("WPA") hasn't accepted a claim under his private health insurance policy.

What happened

Mr S has held a private health insurance policy since 12 March 2022, provided by WPA. The policy was underwritten on a moratorium basis. This meant that treatment for pre-existing medical conditions Mr S had in the five years prior to taking out the policy, or which occurred in the first 14 days after joining WPA, were excluded from cover for at least the first two years. Benefit would be considered for these conditions where the policyholder had been free from symptoms, treatment, medication or advice for two years from the policy start date.

Mr S made a claim on 23 January 2024 due to nasal congestion. WPA authorised the initial consultation and out-patient tests on 29 January 2024. It said it was unable to authorise more complex investigations, such as a CT scan, until it received a completed report from the specialist.

Mr S notified WPA on 1 February 2024 that the specialist had referred him for a CT scan, but WPA said it still needed the completed report before it could authorise this. This was sent to WPA on 16 February 2024. In this report, the specialist answered "no" to the question *"Has the patient experienced these or similar symptoms between 12/03/2017 and 12/03/2022?"* The consultant diagnosed Mr S with a deviated nasal septum.

WPA then asked Mr S for a copy of his medical history from his GP. Mr S provided a summary on 26 March 2024, which didn't set out any current or past problems relating to nasal congestion. WPA then wrote to Mr S' GP on 15 April 2024 and asked for all medical information relating to any ENT (ear, nose, throat) conditions including nasal blockage from 12 March 2017 to present date. Mr S sent this information to WPA on 3 June 2024.

WPA declined Mr S' claim on 12 June 2024. It said that a consultant had said in their report dated 13 April 2024 that Mr S had a two-to-three-year history of nasal blockage. As Mr S' policy started on 12 March 2023, WPA said the moratorium term applied. However, WPA paid the outstanding bills as a gesture of goodwill due to the service it had provided. It accepted it hadn't been clear about the information that was needed to progress the claim. Unhappy with WPA's decision to decline the claim, Mr S brought a complaint to our service.

One of our investigators looked into what had happened. Having done so, he didn't think WPA had acted fairly or reasonably when it declined the claim, based on the evidence available. So, he thought WPA should accept Mr S' claim and pay him £400 for the distress and inconvenience caused.

Mr S thought the outcome the investigator reached was fair, but WPA didn't. In short, it said the only clear record of Mr S' symptoms start date was the consultant's letter of 13 April 2024.

Mr S then provided another letter from this consultant, dated 23 October 2024. In this the consultant had amended the reference to Mr S' symptoms as *"blocked nose bilaterally for 1 year"*. WPA said this didn't change its position, and it considered the consultant's original letter written at the time of the appointment to be a true reflection of the discussion at the time. It said this was because Mr S had requested an amendment to his records, nearly six months after the original appointment, and Mr S advised the consultant couldn't recall the original appointment.

As no agreement was reached, the complaint has 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.

Industry rules set by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of Mr S' complaint.

The policy terms set out the moratorium underwriting as follows:

"*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.*

If you do not have any symptoms, treatment, medication or advice for pre-existing conditions for two continuous yours after the Policy starts, benefit will then be available. We refer to this as a two year clear period."

The policy terms define "pre-existing conditions" under "What Is Not Covered" section as follows:

"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."*

I've considered all the available medical evidence on this case to decide if WPA acted fairly by saying Mr S' claim related to a pre-existing condition. The key consideration here is if it's more likely than not that Mr S experienced symptoms in the five years before his cover started, or in the first 14 days of cover.

Mr S first had a private consultation on 7 January 2024, and these notes say that Mr S had had problems breathing through his nose, and that he *"messaged a GP about this last year"*. The consultant concluded that Mr S *"presented with bilateral nasal blockage for a year or so"*.

WPA has referred to a clinic letter from a specialist on 1 February 2024 in which the consultant mentioned Mr S had *"been troubled with nasal blockage which is getting worse"*. WPA hasn't provided a copy of this letter, but I don't think this makes a difference to the outcome, as based on WPA's explanation, this letter doesn't refer to any timescale of Mr S' symptoms. This specialist then completed the report WPA requested, in which they answered "no" to the question *"Has the patient experienced these or similar symptoms between 12/03/2017 and 12/03/2022?"*

Mr S' GP records show a telephone consultation on 21 February 2024 where the notes refer to *"nasal congestion for a long time now"*. And Mr S saw a consultant on 13 April 2024 and these notes refer to *"blocked nose, both sides, for 2-3 years"*.

WPA says the consultant report from April 2024 shows Mr S' symptoms started before the policy start date, and therefore the claim is caught by the moratorium terms. It has also referred to inconsistencies in Mr S' testimony of when his symptoms began.

However, I think Mr S has been consistent in saying his symptoms began after he took out his policy. I don't think it's unusual for a policyholder to not remember the exact start date of symptoms such as Mr S'. The medical notes from 7 January 2024 suggest Mr S' symptoms started around early 2023, and a specialist confirmed in the report requested by WPA that Mr S hadn't experienced similar symptoms in the five years before the policy started.

The GP notes from 21 February 2024 are generic and don't give a specific timeline. The only evidence which suggests Mr S' symptoms may have started before the policy start date is the consultant's report on 13 April 2024. This refers to symptoms for *"2-3 years"*. But I find this timescale wide and generic. It also doesn't confirm when Mr S' symptoms started, or that they definitely started prior to the policy start date. That is, if the symptoms started two years previously, the claim wouldn't be caught by the moratorium terms.

I find the combination of the report from 7 January 2024, the report Mr S' specialist completed for WPA in February 2024, as well as Mr S' testimony, to be more persuasive evidence that his symptoms likely weren't pre-existing, as per the policy terms.

I've also considered the other report Mr S has since sent from the consultant who he saw on 13 April 2024. I think it's unlikely a medical professional would change their report if they had any concerns about the accuracy of the amendment. So, I think this further persuades me that it's more likely than not that Mr S' symptoms weren't pre-existing, as per the policy terms.

Whilst I think it was reasonable for WPA to request the evidence it did to assess Mr S' claim, I don't think the decision it reached was fair and reasonable in light of that evidence. This meant that there has been a delay in Mr S being able to access further treatment, and this would've been worrying and frustrating for him. WPA has also accepted it could've been clearer in explaining why it needed the information it did, to reach a decision on the claim. Overall, I think the compensation our investigator recommended is fair and reasonable in the circumstances.

My final decision

My final decision is that I uphold Mr S' complaint and direct Western Provident Association Limited to accept and pay the claim in line with the remaining terms and conditions of the policy, and pay Mr S £400 for the distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 11 February 2025.

Renja Anderson
Ombudsman