DRN-5196095

The complaint

Mr and Ms T are unhappy that Right to Health LIMITED (RH) mis-sold her private medical insurance policy.

Ms T is the lead complainant on this complaint. For ease therefore I'll refer to Ms T in this decision even though the policy is joint with Mr T.

What happened

Ms T took out a private medical insurance policy in January 2018. RH sold the policy on an advised basis as a switch from her previous provider.

Ms T took the policy out so that her pre-existing medical condition was covered, and her medical history was disregarded. The policy also provides cover for Mr T and their children.

In April 2024, Ms T contacted her policy provider to request approval for a claim. She was told her pre-existing condition wasn't covered as it was considered to be chronic. The policy provider said it would cover her for the condition until the new policy year in January 2025.

Ms T made a complaint to RH as she said the policy didn't meet her needs and was mis-sold to her. She said she'd paid premiums for cover that she didn't have.

RH didn't agree that the policy was mis-sold. It said based on the documents provided to Ms T at the point of sale, the policy was switched from her previous provider with the condition covered on the new policy. Ms T was sent a welcome letter and the policy documents by the new policy provider and that had information about chronic conditions not being covered. She also had a 14-day cancellation period.

Unhappy, Ms T brought her complaint to this service. Our investigator didn't uphold the complaint. She didn't think the policy was mis-sold by RH.

Ms T 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 industry rules and guidance state that in an advised sale, the seller needs to make sure the policy is right for the consumer. In this case RH sold the policy.

I've looked at the point-of-sale documents and information about what happened during the sales process.

The sale took place in 2018 but the sales call recording is no longer available. This isn't unusual due to the time that's passed.

I've therefore considered the available information. RH completed documents at the time of the sale. These include a demands and needs statement and a fact find. A welcome letter was also sent by the policy provider. It's clear in all of these that the policy was sold on the basis that Ms T's pre-existing condition would be covered. There's no dispute that this was her requirement for her to take the policy out. And from the documents I've seen, it's also clear that the policy switched based on Ms T's medical history being disregarded. The joint policyholders – Mr T and the children – were taking the policy out on a moratorium basis. This therefore suggests to me that the policy was sold taking into consideration specifically Ms T's needs as only she had the medical history disregarded.

The demands and needs letter confirmed that a '*Switch*' underwriting basis was recommended as Ms T had no treatment pending and not seen a consultant in the previous 12 months. It says all Ms T's medical conditions under her previous policy will continue to be covered under the new policy. It also says the recommendation was based on the competitiveness of the premium, previous medical conditions and benefits of the contract. Additionally, the recommendation provided a list of events the policy would cover, and this included '*Pre-existing conditions covered as per your existing policy – for Ms T only'* and '*Cover for short term acute medical conditions'*. For the purposes of her private medical insurance policy, Ms T's condition wasn't considered to be short term but long-term and chronic.

The policy documents – the Insurance Product Information Document (IPID), the policy terms and conditions and a welcome letter were sent to Ms T after the sale. These all confirm that long-term or chronic conditions won't be covered.

Having looked at everything, there's no evidence that RH told Ms T that her specific medical condition would be covered – only that her pre-existing medical conditions would be covered. There is a subtle difference here and while I understand the strength of feeling Ms T has, I'm not persuaded the policy was mis-sold to her. Ms T received the demands and needs letter and the post-sale policy documents and these confirmed that acute conditions would be covered, and chronic conditions wouldn't be covered. Ms T also had the option to cancel the policy or make any changes within 14 days of starting the policy.

I appreciate finding out that the medical condition isn't covered is frustrating and very disappointing. But that doesn't mean the policy was necessarily mis-sold. From the information available, RH sold the policy to ensure Ms T's pre-existing medical conditions were covered and there's no information to say that the specific pre-existing medical condition will be covered. Whilst Ms T's specific condition is considered to be chronic by the insurer is a matter between the insurer and Ms T and it doesn't mean the policy was mis-sold.

I also understand Ms T's comments that she would never have taken out the policy had she known she didn't have cover for her pre-existing medical condition. She says she already had the standard cover. But there's not enough evidence to persuade me that the policy was mis-sold so I can't reasonably say that RH ought to refund the premiums she's paid on the policy. Ms T had access to all the information that was provided at the time of the sale and post-sale to decide whether that was a policy suitable for her specific needs. Whilst RH had responsibility to ensure the policy met her needs, I think Ms T also had some responsibility.

In the circumstances of this complaint, I'm sorry to disappoint Ms T but I don't think the policy was mis-sold. It follows therefore that I don't require RH to do anything further.

My final decision

For the reasons given above, I don't uphold Mr T and Ms T's complaint about Right to Health

LIMITED.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T and Ms T to accept or reject my decision before 20 March 2025.

Nimisha Radia
Ombudsman