DRN-5197470

The complaint

Mr L is unhappy that AWP P&C SA (AWP) declined his private medical insurance claim.

What happened

Mr L has a private medical insurance policy which he took out on 29 May 2024.

The policy is underwritten by AWP and taken on a moratorium basis. This means that no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required. 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.

On 19 June 2024, Mr L contacted AWP to start a claim for an injury to his elbow. He said he'd visited his GP on 18 June 2024 who'd provided a referral letter. Mr L explained he'd been on a fitness camp from 31 May 2024 to 7 June 2024 and the injury left a lump which had been there for a couple of weeks.

AWP declined the claim. It said the GP letter confirmed the lump had been there for the previous six weeks, so it considered this to be a pre-existing medical condition. AWP said the claim wasn't covered under Mr L's policy terms and conditions.

Mr L provided a second letter from his GP which said the lump had been there for two weeks. AWP considered this but maintained its position to decline the claim. Mr L brought his complaint to this service. Our investigator upheld the complaint. He didn't think it was fair and reasonable for AWP to disregard the second letter from the GP. This was because the GP didn't refuse to provide a second letter and he would have reviewed the information with Mr L before providing this.

AWP disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me.

I issued a provisional decision to both parties on 20 November 2024. I said the following:

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 L's claim, to decide whether I think AWP treated him fairly.

I've started by looking at the terms and conditions of Mr L's policy as they form the basis of his insurance contract with AWP. Page 36, section 11 of the policy document states that there is no cover for pre-existing conditions. These are medical conditions a policyholder had before their cover started with AWP. This means any medical conditions, including

symptoms and undiagnosed conditions and other related conditions that are experienced in the five years before the cover started won't be covered unless AWP has agreed to provide cover for that medical condition. Generally, this type of cover under a moratorium policy isn't unusual.

The key issue in dispute is the information provided within the GP letters about how long Mr L has had the problem on his elbow. I've considered carefully both the GP letters.

Based on the information first presented to AWP by Mr L – the GP letter dated 18 June 2024 shows the problem had been there for the six weeks. There's no indication that there were any other medical issues relating to this problem except for sharp pain and some discomfort. AWP declined the claim on this basis, and I don't think this was unfair as it confirms the problem on Mr L's elbow had been there for six weeks.

The amended letter dated 25 June 2024 from the GP shows the only thing changed was that the problem had been there for two weeks rather than six weeks. Everything else remained the same. Mr L said the first letter was incorrectly completed and he'd therefore asked the surgery to provide a further letter. He said the injury took place after he'd been on the fitness camp. I can't see an explanation from the GP about why there was an error. The GP seems to have amended the letter based on what Mr L has requested and self-reported. So, it's not unreasonable to think the GP has only written the referral letters on both occasions because this is what Mr L has asked for.

Having reviewed everything carefully, I think the first letter is more persuasive as it's the most contemporaneous and therefore, on balance, carries more weight in the circumstances. There is no further explanation from the GP to confirm why they made an error in the first letter and no explanation of the cause of the injury in the referral itself. I note that the GP letters are based on self-reported symptoms and on information provided by the patient – in this case Mr L. So, whilst there is an argument for an error having been made in the first letter and stating the injury was there for six weeks, I think this was most likely reported by Mr L to the GP. Mr L had sight of the letter before he sent this to AWP. I think it's likely he would have reviewed the information contained within the letter before sending this to AWP also. But even if he hadn't, the referral letters seem to be based on self-reported symptoms which the GP noted – on both occasions.

Mr L took out the policy on 29 May 2024. He went on the fitness camp on 31 June 2024 and returned on 7 June 2024. He sustained the injury while on the camp and went to see his GP on 18 June 2024. And according to the first letter, the GP reports that he had the injury for six weeks. So, based on the terms and conditions, Mr L's injury to the elbow would be considered as pre-existing and therefore no cover would be available. I think this is fair.

Whilst the second letter provides amended information that shows the injury was there after the policy was taken out, I don't find this as persuasive and therefore I would consider the first letter has more weight. I also haven't seen any persuasive evidence from the GP which leads me to reach a different outcome. The first GP letter is the most contemporaneous and I can't disregard that. Mr L's contact with the GP was the first one and any symptoms he reported to the GP would have been, on balance, the most accurate.

Whilst I don't doubt there is an injury and that the resulting problem needs to be looked at medically, the change in the letter of itself isn't sufficient evidence to persuade me otherwise. Ultimately, AWP has assessed the claim alongside the terms and conditions of the policy. And this says if there are pre-existing medical conditions before the cover started, there is no cover available. So overall, I don't think the claim has been declined unfairly by AWP.

For these reasons, my intention is not to uphold the complaint.

I now invite parties to let me have any more comments or evidence by 4 December 2024.

AWP responded to my provisional decision and said it had nothing further to add.

Mr L didn't respond.

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.

As I received no further comments from either party, I see no reason to depart from the intended outcome I reached in my provisional decision. I've provided my reasoning in the provisional decision.

Overall, I don't think AWP declined Mr L's claim outside the terms and conditions of his policy and I don't think it did this unfairly. It follows that I don't require AWP to do anything further.

My final decision

For the reasons given above, I don't uphold Mr L's complaint about AWP P&C S.A.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 9 January 2025.

Nimisha Radia
Ombudsman