DRN-5219428

The complaint

Mr B and Mrs B have complained about the decline of a claim and the service received from Western Provident Association Limited (WPA).

What happened

Mr B and Mrs B joined Mrs B's employer's private medical insurance scheme on 1 January 2022. The policy was underwritten on a moratorium basis. The policy terms explained this 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 Scheme membership starts. We call these pre-existing conditions.

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

When applying for your Scheme membership, although you do not have to provide us with full medical details we may request more detailed information from your GP/Specialist for each new condition claimed for.

If, when you joined, you suffered any condition that requires regular monitoring, management, advice or medication, such conditions will never be eligible for benefit. This is because you will not have had a two year clear period, as explained above.

This means that you will not be able to claim for:

• Any conditions that existed during the five years before the date that you joined us, unless you have a two year clear period after your join date.

Under the **What Is Not Covered** section of the policy, it sets out under **Excluded conditions:**

- *Any related condition(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 an excluded condition.*

Mrs B made a claim in March 2022 for symptoms of abdominal pain reported to have started in January 2022. WPA authorised the claim for investigations and later, surgery. WPA then requested GP records and based on the information contained therein it declined the claim. It said that Mrs B had a pre-existing condition within the five years prior to the policy commencing and two symptom free years hadn't passed.

WPA accepted that it hadn't handled Mrs B's claim well and ultimately offered £350 in compensation.

Our investigator thought this was fair. Mrs B appealed. In summary she disagreed that the

claim had been for investigations into pelvic pain – rather they had been for abdominal pain and cyst of ovary which was anatomically different. She also didn't agree that she had had tests for endometriosis before 2022 – she said that the HSG test wasn't used to test for or diagnose endometriosis. Mrs B said she had suffered from chronic pelvic pain, but this was more than five years before the policy started. Finally, she explained why she felt her medical notes were inaccurate.

As no agreement has been reached the matter has been passed to me to determine.

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.

I'd also like to reassure Mr B and Mrs B that while I've summarised the background to this complaint and the submissions made in response to our investigator's view, I've carefully considered all that's been said and sent to us. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

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 law; the terms of the insurance contract; and the available medical evidence to decide whether I think WPA handled Mrs B's claim fairly. Having done so, and although I'm very sorry to disappoint Mr B and Mrs B, I agree with the conclusion reached by the investigator. I'll explain why:

- Mrs B's GP records from November 2021 indicate that she had received a diagnosis of endometriosis. I haven't disregarded Mrs B's comments about the accuracy of these records, and I accept that the diagnosis referred to in the notes was not the result of a test specifically for endometriosis. But I don't find that it was unfair for WPA to rely on the recorded history or treat it as accurate.

- I agree that Mrs B's claim was initially for abdominal pain, not pelvic pain. When WPA received confirmation of the diagnosis on the Specialist report (I'll refer to the Consultant Gynaecologist as Dr JB) signed on 29 April 2022, confirming *Left and Right ovarian cysts diagnosed, likely endometriosis, treatment plan was laparoscopy +/- ovarian cystectomies and excision of endometriosis* the claim was updated.

- Dr JB had also written to Mrs B's GP. His letter dated 5 April 2022 says that Mrs B was reviewed by a fertility specialist and an ultrasound scan demonstrated ovarian cysts, likely endometrioma. He agreed with the fertility specialist's recommendation for a laparoscopy with excision of endometriosis together with ovarian cystectomy. For the avoidance of doubt, I'm satisfied that the ovarian cysts were related to or associated with the diagnosis of endometriosis.

- WPA advised Mrs B that it needed to check whether benefit was available for the proposed procedure. As Mrs B had moratorium underwriting, I don't find that was unfair or unusual. But what was most unfortunate was the timing as Mrs B had arranged the surgery to go ahead and was anxiously waiting for confirmation that it would.

- WPA recognised that its handling of Mrs B's claim caused her distress for both the way she was spoken to on the telephone and for the very late notification that her claim wouldn't be covered. I note Mrs B's comments about this and fully accept that it

would have been very distressing for Mrs B and indeed Mr B, and I note that she needed to borrow money to pay for the procedure. But WPA have now offered £350 in compensation, and in the circumstances, I find that is fair.

- I'm sorry that my decision doesn't bring Mr and Mrs B welcome news. But in all the circumstances I don't find that WPA has treated Mr and Mrs B unfairly or contrary to their policy terms by declining the claim for the cost of the operation.

My final decision

My final decision is that Western Provident Association Limited has made a fair offer of compensation and should now pay Mr B and Mrs B £350 – it may deduct any compensation if already paid in relation to this claim.

I don't uphold the complaint regarding the payment for surgery.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B and Mrs B to accept or reject my decision before 18 March 2025.

Lindsey Woloski
Ombudsman