DRN-5225125

The complaint

Mr and Mrs M complain that Vitality Health Limited declined a claim Mrs M made on a private medical insurance policy.

What happened

Mr and Mrs M joined a group private medical insurance scheme offered by Mrs M's employer in May 2023. On the same day Mrs M was having a procedure on the NHS. During that procedure it was identified that she had an enlarged appendix. The appendix was removed, and subsequent tests revealed that it was cancerous.

Mrs M made a claim on the policy for a follow up procedure related to the finding of cancer. Ultimately, this claim was declined by Vitality because they considered it to be a pre-existing condition. They said Mrs M had experienced pelvic pain since at least April 2023. Vitality also made the decision to remove Mrs M from the policy. They referenced the policy terms in relation to fraud and dishonesty. Mrs M complained to Vitality but they maintained their decision was fair. However, they did offer Mrs M £100 compensation for failing to respond to requests for call backs. Mrs M complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold the complaint. In summary, she thought Vitality's decision to decline the claim was fair, bearing in mind the medical evidence in relation to Mrs M's pelvic pain. Mrs M didn't agree and asked an ombudsman to review her complaint. She provided a further letter of clarification from her consultant and other evidence in support of her position. This information didn't change our investigator's thoughts about the outcome of the complaint. So, the complaint was referred to me to make a decision.

In December 2024 I issued a provisional decision. I said:

> The relevant rules and industry guidelines say that Vitality has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.
>
> <u>The policy terms and conditions</u>
>
> The policy terms and conditions say that:
>
> > We don't pay claims for the treatment of any medical condition or related condition which, in the five years before your cover started:
> >
> > • you have received medical treatment for, or
> >
> > • had symptoms of, or
> >
> > • asked advice on, or
> >
> > • to the best of your knowledge and belief, were aware existed.
>
> This is called a 'pre-existing' medical condition.

The terms go on to say:

> What this means in practice
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> Your cover for medical conditions can be broken down into three categories:
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> • Medical conditions that are covered from the first day of your insurance – these are conditions that occur for the first time after your cover start date
>
> • Pre-existing medical conditions that become eligible for cover after at least two years continuous insurance on the plan. We will cover them if you have not received any treatment, advice or medication for that condition for a continuous period of two years after your cover start date
>
> • Pre-existing medical conditions that we permanently exclude from your cover. We exclude these because you will need regular or periodic treatment, advice or medication and you will never be able to remain free of this help for any continuous two-year period.

The medical evidence

Mrs M stated on her claim form that she'd not had symptoms relating to the appendicular tumour. When Mrs M's GP completed the claim form he also noted that Mrs M had no symptoms and stated it was an incidental finding.

I've also considered the evidence from Mrs M's NHS consultant. Mrs M was referred for a laparoscopy in May 2022 due to deep dyspareunia and painful heavy periods. The consultant noted that she had a tender uterus and was very tender during assessment.

In April 2023 Mrs M says that she was admitted for the procedure, but it was cancelled as surgery ran over. That's consistent with the information Vitality has referred to which suggests the procedure didn't take place. On 16 May 2023 the procedure took place and that's when the enlarged appendix was discovered.

The consultant's letter from August 2023 stated that Mrs M had been referred with some pelvic pain and abnormal bleeding. She said:

> This was initially thought to be a gynaecological problem. At the time of surgery, which was performed on 16 May, she however was found to have an abnormal appendicular mass, in addition to endometriosis, and this was certainly likely to be the cause of her pain. This was an unexpected finding… and as I think the appendicular mass was the cause of her pain, and unexpected, it would be perfectly reasonable to cover her…

On 14 September 2023 the consultant wrote to Vitality to say that Mrs M:

> Was referred to me with pelvic pain and abnormal vaginal bleeding. She underwent a laparoscopy, and had some endometriosis treated under my care, on 16 May 2023.
>
> At the time of the surgery she was found to have an abnormal looking appendix with a large appendicular mass which was an unexpected finding…. The appendicular mass was not the cause of her pain and was a new unexpected finding, and I would be grateful if you could therefore cover her

> claim as her surgery has been done in the private sector.

More recently, in June 2024, the consultant clarified that Mrs M:

> Initially presented with problems of gynaecological origin, with postcoital bleeding, deep dyspareunia and heavy painful periods. This was mentioned in my letter in May 2022. The deep dyspareunia is usually a leading cause for pelvic pain and often related to an underlying condition called endometriosis. During an examination on 9 May 2022, she had a tender uterus… these symptoms led her to undergo laparoscopic surgery on 16 May 2023. It was during this surgery she was suspected to have endometriosis as the cause for her pain and this was confirmed and treated at the time.
>
> At that time a completely incidental finding was made of an enlarged appendix, which was removed by the surgical team. This was not related to her presenting pain and not a pre-existing condition… It is important to note that her presenting symptoms were not related to the appendicular tumour or to any pre-existing cancerous condition.

Did Vitality unfairly decline the claim?

There's no dispute that the finding of the enlarged appendix and subsequent cancer diagnosis was an incidental finding during an investigative procedure for suspected endometriosis. In summary, Vitality's position is that she was experiencing symptoms of pelvic pain prior to the policy starting and therefore she'd already sought advice or treatment for symptoms relating to the appendicular tumour.

Mrs M's policy start date was, ultimately, the 12 May 2023. So, that's the relevant date for the purposes of my decision. The policy terms don't state that cover will be declined if the condition existed at the point the policy was taken out. So, the key issue for me to determine is whether it was reasonable for Vitality to conclude that Mrs M's diagnosis fell within the definition of a pre-existing condition.

Vitality relied on notes from April 2023 which refer to pelvic pain when concluding Mrs M experienced symptoms before taking out the policy. However, I think those brief notes need to be read in the wider context of the much more detailed information contained within the consultant's referral which is much more specific about the pain Mrs M was experiencing. I also note that there are inconsistencies in the information within those notes which weren't explored in more detail.

The more detailed information specifically referred to deep dyspareunia (pain during intercourse), painful heavy periods and a tender uterus. I also note that on 16 May 2023 Mrs M was diagnosed with, and treated for, endometriosis. That was the condition her NHS consultant was investigating.

Mrs M's consultant did state that the appendicular mass was the cause of her pain. So, I can understand why Vitality initially relied on that information to reject the claim. However, Mrs M provided more information from her consultant in September 2023 and, more recently, in June 2024. I think it would have been reasonable for Vitality to obtain more detailed information from the consultant in September 2023. For example, it was open to them to ask further and specific questions about the use of the terminology of 'pelvic pain' or why the pain symptoms were no longer being attributed to the appendicular tumour. I think, had Vitality done so, it would have elicited more detailed information about the initial symptoms Mrs M was referred for and what link, if any, there was to the tumour.

Having considered all the medical evidence I'm not persuaded it was reasonable for Vitality to conclude that Mrs M was experiencing symptoms pain related to an appendicular tumour.

In reaching that conclusion I bear in mind the consultant's initial referral letter which gave details about the nature of Mrs M's symptoms. And, on balance, I don't think it was reasonable for Vitality to conclude there was a connection with the appendicular tumour. I think the overall evidence indicated it was most likely connected to the gynaecological condition she was diagnosed with and treated for on 16 May 2023. I accept it's possible that some of Mrs M's symptoms were connected to the enlarged appendix and tumour. However, I think the medical evidence suggests that it's more likely they were connected to the endometriosis.

I therefore don't think it was reasonable for Vitality to conclude Mrs M had experienced symptoms or received advice or treatment in relation to symptoms of an enlarged appendix or appendicular tumour. I therefore don't think it was reasonable for Vitality to decline the claim, particularly once they were in receipt of the further information from Mrs M's consultant in September 2023.

Was it reasonable for Vitality to remove Mrs M from the policy?

Mrs M was removed from the policy as Vitality concluded she'd attempted to backdate the policy to circumnavigate the decision to decline the claim. As Vitality relies on the fraud and dishonesty exclusion it's for them to show, on the balance of probabilities, that the exclusion applies.

I'm not persuaded that Vitality has demonstrated it is most likely Mrs M acted dishonestly. And I don't think their actions to remove her from the policy were fair and reasonable. Mrs M's employer confirmed that she was first eligible to join the group scheme on 12 April 2023, following successful completion of her probation. Mrs M completed the forms on 9 May 2023 and was it sent to the broker on 10 May 2023. Her employer says that they were notified by their broker that the cover had been started with the wrong date (16 May 2023) and therefore they asked for a correction which led to the start date being agreed as 12 May 2023.

I can also see that Vitality's notes indicate Mrs M's employer didn't send confirmation of the instruction to add Mrs M to the plan until 12 May 2023 which is why that was the agreed start date of the policy (as opposed to 16 May 2023).

Mrs M said she was fully aware that her existing medical condition wouldn't be covered. She'd been waiting for the surgery since May 2022, and I don't think there's any indication her condition changed or significantly worsened. It seems more likely to me she completed the forms for her employee benefit a few weeks after she'd passed her probation, once she was entitled to access the benefit. There's no evidence that at the point she chose to enrol she could have been aware that the appointment on 16 May was likely to lead to the diagnosis of an appendicular tumour.

Based on the available evidence, I'm not persuaded that the issue about changes to the start date was driven by Mrs M seeking to circumnavigate the claim decision or amount to sufficient evidence of any dishonest intention on her part. She'd been recently entitled to join the scheme, which she did, and then received notice of her diagnosis of the appendicular tumour. So, I don't think it's surprising that this prompted some activity by Mrs M and her employer to clarify the start date of the policy. Given the context that Mrs M's employer has provided, and Vitality's own notes, I'm not persuaded it was fair and reasonable to remove Mrs M from the policy.

Distress and Inconvenience

I think Vitality's actions have caused Mrs M distress and inconvenience. I think this situation added to her distress at an already difficult time. She was also, in my view, removed from the policy unfairly. I think Vitality should pay Mrs M a total of £500 compensation to reflect the impact of the distress and inconvenience caused over a period of several months.

Putting things right

I'm intending to direct Vitality puts things right by:

• Reinstating Mr and Mrs M's membership to the group insurance policy if the group scheme remains in force (if Mr or Mrs M do not wish to be added back onto the policy, they should let me know in response to my provisional decision)

• Assessing Mrs M's claim in relation to any private treatment she undertook following her claim being declined. If Mrs M is unhappy with the settlement of that claim she may be entitled to make a further complaint to the Financial Ombudsman Service.

• Paying Mrs M £500 compensation for the distress and inconvenience caused by her claim being unfairly declined and being removed from the group scheme.

Mrs M accepted my provisional decision. Vitality agreed that the request to add Mrs M to the policy was genuine and agreed to add Mrs M to the policy (subject to the policyholder paying the premiums). They said the claim remained declined, but they were happy for it to be re-assessed. They said they would want a further response from the consultant who changed their decision. So, I need to make a decision.

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.

Vitality now accepts that Mrs M's actions in relation to the backdating of the policy were genuine. Vitality has also agreed to reinstate Mr and Mrs M's membership to the group policy (subject to the premiums being paid by the policyholder). I think that's fair reasonable in the circumstances.

The only remaining issue in dispute is the claim – Vitality said that this remained declined and they wanted further information from the consultant. I've thought about whether it's fair and reasonable for Vitality to obtain further information as they've suggested. In the circumstances of this complaint I don't think it is. I say that because:

- In my provisional decision I set out in detail why I didn't think it was reasonable for Vitality to conclude that Mrs M had a pre-existing condition.

- Vitality hasn't provided any further information or evidence in support of their position. Therefore, I don't think there's persuasive reasons for me to reach different conclusions to those which I set out in my provisional decision.

- I've thought about whether it would be fair and reasonable for Vitality to obtain more

medical information from the treating consultant. I don't think there's further information which, at this stage, the consultant can add which is likely to significantly alter the outcome of the claim. I think the consultant has provided adequate further information in the information provided in September 2023 and in June 2024.

For the reasons I've outlined above, and in my provisional decision, I'm upholding this complaint.

Putting things right

Vitality needs puts things right by:

- Reinstating Mr and Mrs M's membership to the group insurance policy (subject to the policyholder paying the relevant premiums).

- Assessing Mrs M's claim in relation to any private treatment she undertook following her claim being declined. If Mrs M is unhappy with the settlement of that claim she may be entitled to make a further complaint to the Financial Ombudsman Service.

- Paying Mrs M £500 compensation for the distress and inconvenience caused by her claim being unfairly declined and being removed from the group scheme.

My final decision

I'm upholding Mr and Mrs M's complaint about Vitality Health Limited and direct them to put things right in the way I've outlined above.

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

Anna Wilshaw
Ombudsman