DRN-5226661

The complaint

Miss C is unhappy with the claims process under her BUPA Insurance Limited (BUPA) private medical insurance policy.

What happened

Miss C has a private medical insurance policy with BUPA since October 2021.

In May/June 2024, she contacted BUPA to make a claim and seek authorisation to see a therapist. A claim form was provided by BUPA for completion by the GP. However, the GP surgery had a fee of £125 for the form to be completed. Miss C was unhappy with this process and so made a complaint to BUPA.

BUPA responded and said the information Miss C was required to complete is part of the claims process and needed to validate the claim. The policy terms and conditions confirm the process. It also said it would contribute £50 towards the cost of the fee required by the GP surgery.

Unhappy, Miss C brought her complaint to this service. Our investigator didn't uphold the complaint. He didn't think BUPA had acted unreasonably in requiring the claim form to be completed and for the GP surgery to provide Miss C's medical information. He also said it was fair that BUPA offered to pay £50 towards the surgery's fee as the policy terms state a £15 contribution would be made.

Miss C 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say that insurers must handle claims promptly and fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when making my final decision about Miss C's complaint.

At the outset I acknowledge that I've summarised this complaint in far less detail than Miss C has, and in my own words. I won't respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern our service allow me to do this as we are an informal dispute resolution service. The key issues in dispute here is that Miss C is unhappy with her GP having to complete a medical questionnaire and that the GP would charge £125 for doing this.

In terms of the fee a doctor charges for completing the medical questionnaire, this isn't an issue I can look into. This service doesn't have the remit to look into what a doctor does or doesn't charge. I therefore won't be commenting on this.

I will look into whether I think it's fair and in line with the terms and conditions of the policy for BUPA to request for the medical questionnaire to be completed.

I've started by looking at the terms and conditions of Miss C's policy as this forms the basis of her insurance contract with BUPA.

On page 11, the policy states: '*if you need to claim, we may ask you for some information about your symptoms and when they started before we can pre-authorise any treatment'*.

Miss C took the policy out on a '*Full medical underwriting'* basis. And on page 12, '*Full medical underwriting'* section states:

> '*When you apply for a policy, we look at your and your dependants' (if any) medical history, and let you know which specific symptoms or conditions you had before aren't covered. It's important that you send us your completed application form so we can confirm what is and isn't covered by your policy.*
>
> *Depending on your symptoms and how long you've been covered, when you contact us to claim, we may need to check that your symptoms or conditions started after you joined the policy. We may also ask your doctor for more information, and they may charge for this. If your treatment is covered by your policy, you can claim £15 towards the cost of the medical report.'*

From the information available, Miss C didn't complete and return her medical history form. BUPA therefore put the policy on risk not knowing what could or couldn't be excluded. It also based the premium Miss C paid on this basis. I can see that this information was also requested on Miss C's membership certificate on renewal of the policy but wasn't completed and returned by her. So, BUPA is entitled to request this information when Miss C submitted her claim and that's in line with the policy terms. I don't think it's unreasonable therefore for BUPA to ask for this information before the claim could be authorised.

BUPA's policy terms also confirm that a doctor may charge for having to provide a patient's medical information. And if the claim is covered, £15 would be reimbursed. In Miss C's case, BUPA has said it would reimburse £50. Whilst I appreciate paying £125 places a financial burden on Miss C, this is the claims process and without this information, it can't be progressed. An insurer is entitled to make reasonable enquiries to satisfy itself that a claim is covered under a policy. I understand this inevitably involves an element of inconvenience for a policyholder, but the onus is on the policyholder to provide proof in relation to their claim.

I acknowledge that Miss C has provided information from her GP and a letter from her therapist. However, I can't comment on these as they don't form part of this complaint. Miss C will have to provide this information to BUPA directly should she wish to pursue her claim.

BUPA is unable to progress the claim without the medical information it's requested from Miss C. I'm sorry to disappoint Miss C and understand she's going through a difficult time. But I'm not persuaded BUPA has acted outside the terms of Miss C's policy or that it's acted unfairly in asking Miss C and her doctor to complete the medical information so it could assess her claim. It follows therefore that I don't require BUPA to do anything further.

My final decision

For the reasons given above, I don't uphold Miss C's complaint about BUPA Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss C to accept or reject my decision before 20 March 2025.

Nimisha Radia
Ombudsman