DRN-5235093

The complaint

Mr C is unhappy that Vitality Health Limited (Vitality) declined his private medical insurance claims and subsequently cancelled the policy and kept the premiums.

Mr C is being represented by his wife, Mrs C, on this complaint.

What happened

On 30 June 2023, Mrs C completed a 'Business Healthcare' private medical insurance policy application form through a broker. Mrs C signed the declaration on the form on behalf of Mr C. The policy started on 1 July 2023. The policy was switched from a different provider on a 'Continued Personal Medical Exclusions'. Vitality is the underwriter of the new, switched policy.

Shortly after 1 July 2023, Mrs C submitted a claim for a groin condition that Mr C was suffering from. The claim was accepted. Following this, further claims were submitted for Mr C's medical issues. Vitality requested Mr C's medical history in November 2023, which was received in February 2024. The subsequent claims were reviewed and declined. Vitality did a review of all the claims and said that Mrs C would have been aware of the need to claim when the policy was set up - diagnostic tests were planned and anticipated and Mr C's medical history showed the claims were linked to past medical conditions. Vitality said Mrs C deliberately misrepresented information so the policy was cancelled and the treatment that took place for Mr C wasn't eligible and wouldn't be covered.

Mrs C made a complaint to Vitality. It maintained its decision not to cover the claims and to cancel the policy.

Unhappy, Mrs C brought the complaint to this service. Our investigator didn't uphold the complaint. He thought it was reasonable for Vitality to say that a deliberate misrepresentation had been made. And under the relevant law and the policy terms and conditions, it is allowed to cancel the policy and decline any claims.

Mrs 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.

It's important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Mr C. Rather it reflects the informal nature of our service, its remit and my role in it.

The relevant rules and industry guidelines say that insurers must handle claims fairly and

shouldn't unreasonably reject a claim. I've taken these rules into account when deciding what I think is fair and reasonable in the circumstances of Mr C's complaint.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation the insurer must show it would have offered the policy on different terms or not at all if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

I've gone on to think about this when looking at Mr C's complaint and his individual circumstances. Vitality has said Mr C acted dishonestly or fraudulently. He failed to take reasonable care not to make a misrepresentation when Mrs C signed the declaration on the policy application form on his behalf. The application form is dated 30 June 2023.

The declaration stated:

> *'I declare to the best of my knowledge, no applicants to be covered have any day-patient or in-patient treatment or diagnostic tests planned or anticipated, and in the last three years, no applicants to be covered have had consultations or treatment for any heart, cancer, mental health issues, behavioural illnesses, behavioural disorders or psychiatric conditions.'*

Day-patient is defined in the policy as:

> *'A patient who is admitted to a hospital or day-patient until because they need a period of medically supervised recovery but does not occupy a bed overnight.'*

Out-patient is defined in the policy as:

> '*A patient who attends hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.*

And treatment is defined as surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

Vitality says Mr C didn't disclose all the medical information he should've done when the policy was taken out. It says Mr C's medical records show that day-patient and in-patient treatment was likely for Mr C and that diagnostic tests were shown to have been scheduled. These should have been declared on the application for the policy.

The policy was taken out on the basis of 'Continued Personal Medical Exclusions' – no exclusions were transferred or applied by Vitality. This means cover was provided by another insurer and the new application was on the basis of continuing with the underwriting terms that applied to any insured persons under that policy. The application would have been accepted on the following basis:

> *'Where you were previously medically underwritten:*

- *Either exactly the same personal medical exclusions that applied to you and your insured dependants under your previous insurance plan continue to apply under this plan, or*

- *The same personal medical exclusions applied to you and your insured dependants by your previous insurance plan continue to apply under this plan and additional personal medical exclusions imposed by us also apply.'*

Mr C's broker contacted Vitality on 10 July 2023 to get an urgent claim registered for Mr C due to a groin pain and that he'd been referred to a urologist. The advisor asked if Mr C had any history of this previously and the broker said this was for a new area of pain. The broker explained a referral had been provided by the GP. Mrs C said the referral was given by their GP following this call to Vitality and she's provided a copy of the letter. Whilst Vitality says there was no referral from the GP, the evidence from Mrs C, provided later, shows there was a referral, but this was made after the broker called Vitality. The process to validate a claim is to first get a referral from a GP and Vitality would need this before it can provide authorisation for a claim. It's unclear why the referral letter was provided much later, and I can see there's been some confusion on this issue.

I've been provided with Mr C's medical information. I've considered this and there's evidence that Mr C was under the care of consultants for various medical conditions, including groin issues and further investigations were under way.

Mrs C says Mr C's claim was for groin pain in a new area and therefore she didn't declare this in the application. I've considered a letter dated 10 January 2022 which suggests that Mr C's groin issues were long standing and since 2021. The consultant states Mr C was experiencing pain and continues to do so. On 6 January 2023, the consultant states Mr C was experiencing significant pain in the groin area and needs an ultrasound. I think it's likely therefore Mr C's symptoms were related and whilst they may not have been exactly the same, it's more likely than not the evidence shows a link. There's evidence that Mr C was experiencing unknown groin pain less than a month before the policy commenced and that he was taking various medications. And based on the medical records, it seems Mr C had changes in his symptoms. Whilst the consultant says Mr C was no longer in pain, I can see that regular reviews were taking place and that he was still under the consultant's care. I'm not persuaded therefore the claim was for a new medical condition but for one that was linked.

I've also considered a letter dated 9 May 2023 where Mr C was referred for liver investigation and the letter confirms the medications Mr C was taking. There's no evidence that Mrs C declared the groin issues, the ultrasound that was recommended, the referral for liver investigation, or the medications that Mr C was taking.

I've considered Mr C's further medical records which show that in May 2023, a review took place and noted an opiate reduction programme and bone density scans were scheduled in March 2023 and in July 2023. I acknowledge Mrs C's comments that the bone density scan was never attended by Mr C. I understand but regardless of this, there's no evidence that Vitality was made aware of the treatment to reduce opiate for Mr C or that a bone density scan was scheduled.

A letter dated 25 May 2023, an MRI scan was recommended to look at the bowel and the issue of stones for further investigation. This was before the claim for groin issues. And there's no evidence that Mrs C declared that the scan was anticipated to Vitality at the time of the application or at the time of the claim.

Mrs C signed a declaration that Mr C had no day-patient or in-patient treatment or diagnosis

tests planned or anticipated. I think the medical information shows there were already issues with Mr C's groin, prior to taking out the policy. And I think Mrs C should have declared this to Vitality at the very least. The medical records show that Mr C was taking medications and recommendations were provided by consultants for an ultrasound scan and an MRI scan so diagnostic tests were planned.

The policy that Mr C took out was underwritten at the point of sale and based on the information provided by Mrs C, the policy went ahead, and Vitality made underwriting decisions which included the premium to be paid on the policy.

It's important for consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). Based on the information available, by signing the declaration on the application form, Mrs C hadn't provided accurate medical information about Mr C.

I've reviewed the declaration Mrs C signed and agreed to. I think it was clear and therefore not unreasonable that Vitality should have expected Mrs C to have disclosed Mr C's medical history, including any pending tests and investigations.

Vitality has referred to an email dated 29 June 2023 between Mrs C and the broker. I've reviewed the email. This says Mrs C wanted to use the policy within a week or so of the policy start date. I note Mrs C says this was sent to the broker in jest. Whilst I acknowledge her comments, having reviewed what happened, she did in fact make a claim as she said she would. So, on balance, it's more persuasive to me that Mrs C had the intention to make a claim soon after taking out the new policy.

I've noted Mrs C's comments about whether various appointments and treatments took place and that some of Mr C's conditions were new and not related. However, I've taken account of all the medical evidence and Mr C's medical history. On balance, the overall evidence provides, on balance, more persuasive weight that Mr C was suffering from medical conditions at the point of taking the policy out and that there were pending tests and investigations expected. The evidence also shows that Mr C was suffering from groin issues before the policy inception. I'm not persuaded this was a new issue. A health insurance policy is a short-term contract and on the basis of the declaration completed on the application form, Vitality made underwriting decisions on the policy which included the premium Mr C had to pay. I think Mrs C therefore failed to take reasonable care when she completed the declaration.

I've gone on to think about whether failing to take reasonable care makes a difference in this case.

Vitality has classified the qualifying misrepresentation as deliberate or reckless. It has provided evidence which shows what would have happened if the correct information was entered at the time of taking out the policy in July 2023. It says had the information been accurately provided, it wouldn't have offered cover to Mr C at all for the policy. So, Vitality has cancelled the policy and kept the premiums Mr C has paid. I've carefully reviewed the underwriting evidence. This shows that had Mrs C accurately declared Mr C's medical conditions, Vitality would not have offered the policy at all. This means I'm satisfied that Mr C's misrepresentation was a qualifying one.

CIDRA sets out the remedies available to an insurer in the case of deliberate or reckless misrepresentation. CIDRA is concerned with disclosure and representations made by a consumer to an insurer before a consumer contract is entered into or varied. And the law sets out the specific actions an insurer can take where the misrepresentation has been a qualifying one.

It goes on to further to say that a qualifying misrepresentation would be deliberate or reckless if the consumer:

- Knew the information they provided was untrue or misleading or did not care whether it was untrue or misleading; and

- Knew that the matter to which the misrepresentation related was relevant to the insurer or did not care whether or not it was relevant to the insurer.

Having reviewed everything carefully, the declaration Mrs C was required to agree to was clear. She should have been aware to answer this accurately, based on Mr C's medical history - and the onus was on her to do so. I've considered that there's sufficient evidence Mr C already had medical conditions related to the groin area, in particular, and there were pending tests and investigations. The declaration completed wasn't consistent with Mr C's medical history and records provided. I'm satisfied therefore that Vitality is entitled to cancel the policy and keep the premiums as set out under CIDRA. Vitality has said any claims whether they were paid at the time of the claims or thereafter are not eligible for cover. Therefore, Mr C and Vitality will have to liaise directly regarding any outstanding payments/invoices.

I note that Mrs C has said Vitality should have informed her earlier that the claims wouldn't be covered and is unhappy about this. There's a separate complaint on this issue so I won't be commenting on this here.

Overall, I've reviewed everything carefully and I do understand that Mr C and Mrs C will be disappointed. But Vitality has followed the law as set out in CIDRA and I don't think its acted unfairly. In line with the policy terms and conditions and CIDRA, Vitality is entitled not to pay the claims as it's shown the misrepresentation was a qualifying one and one that was deliberate or reckless. I think that's fair based on the available evidence. So, I'm satisfied the decision to cancel the policy and keep the premiums is also fair and reasonable.

My final decision

For the reasons given above, I don't uphold Mr C's complaint about Vitality Health Limited

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C to accept or reject my decision before 10 February 2025.

Nimisha Radia
Ombudsman