DRN-5248567

The complaint

Mr R has complained that BUPA Insurance Limited declined a claim he made on a private medical insurance policy.

What happened

In July 2024, Mr R made a claim on the policy for investigative tests for a suspected medical condition. Bupa declined the claim on the basis that the condition was pre-existing.

Our investigator thought that Bupa had acted reasonably in declining the claim, in line with the policy terms and conditions. Mr R disagrees and so the complaint has been passed to me for 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.

The ombudsman was established to be a quick and informal service. This doesn't mean we apply any less rigour or care in reaching our decisions. But it does mean that we might not respond to every point in the way that Mr R might expect. He has made detailed submissions in support of his complaint and, although I will not be addressing them all, I would like to assure him that I have read and considered everything he has provided.

Firstly, it's important to make clear that we are not the industry regulator. We have no power to regulate the financial businesses we cover, nor to direct them to change their processes or procedures. Our role is to investigate individual complaints made by consumers to decide whether, in the specific circumstances of that particular complaint, a financial business has done something wrong which it needs to put right. Whilst I appreciate Mr R feels strongly that diagnostic tests should be supported and not defined as treatment, and that the definition of pre-existing medical conditions is too wide ranging in including generalised symptoms, this isn't something which I can reasonably consider. My role here is to decide whether, on the facts of this case, Bupa treated Mr R fairly.

I've carefully considered the obligations placed on Bupa by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Bupa to handle claims promptly and fairly, and to not unreasonably decline a claim.

Insurance policies aren't designed to cover every eventuality or situation. An insurer will decide what risks it's willing to cover and set these out in the terms and conditions of the policy document. The test then is whether the claim falls under one of the agreed areas of cover within the policy.

It is not in dispute that the policy doesn't cover pre-existing medical conditions. The matter at hand is whether the condition Mr R has claimed for could be considered pre-existing.

Looking at the policy terms, the definition of 'pre-existing condition' is:

‘Any condition, disease, illness or injury including related condition which you had before your effective underwriting date and:

- *you received medication, or advice or treatment for it, or*
- *you’ve had symptoms of it, or*
- *you knew you had it*

whether the condition was diagnosed or not.

By a related condition we mean any symptom, condition, disease, illness or injury which in our reasonable medical opinion is associated with another symptom, condition, disease, illness or injury.’

At the time of purchasing the policy in May 2024, Mr R had a diagnosis of diabetes and had started receiving treatment for it. He had a number of symptoms which, at that time, were attributed to the diabetes. However, as some of these symptoms failed to respond to treatment, it was suspected that they were the result of a second, separate, medical condition. He says this was first recognised on 18 June 2024.

Mr R says that Bupa appears to have treated the second condition as pre-existing simply because some of its symptoms overlap with those of diabetes. He has explained how the suspected second condition is not something resulting from diabetes but is, instead, completely distinct. As such, it could not be considered to be a ‘related condition’ under the policy terms.

I accept that Mr R did not know or suspect that he had a secondary condition. And based on the available evidence, I am satisfied that there was no diagnosis, or even a suggestion of another condition, prior to the policy start date. Mr R has pointed out that, although he is having tests for a particular condition – to rule it in or out – he hasn’t received a definitive diagnosis as yet. However, as set out in the clause above, these circumstances do not preclude it from being classed as a pre-existing medical condition under the policy terms.

It seems clear that the symptoms of the second condition were distinct from those caused by the diabetes – because they failed to improve once his treatment for diabetes had begun. I also appreciate that the symptoms of the second condition were only recognised as such on 18 June 2024. But again, this also doesn’t mean it can’t be classed as a pre-existing condition.

The most relevant issue is whether Mr R had experienced symptoms prior to the policy start date. Although the symptoms were not identified as relating to a second condition until later, it was nevertheless the case that he was having symptoms prior to taking out the policy.

Overall, I’m not persuaded that Bupa has conflated the two conditions, or that it considers them to be related. It has declined the claim on the basis of Mr R having symptoms of the second condition, which is all that is necessary to meet the definition of a pre-existing condition under the policy terms.
I’ve thought very carefully about what Mr R has said and I have a great deal of sympathy for his situation. However, the question is whether the circumstances are covered under the policy terms, and unfortunately, they are not. On balance, I consider that Bupa has acted reasonably in declining the claim.

Mr R says he wouldn’t have bought the policy if he’d been told that any symptom he’d ever experienced could result in related conditions being deemed pre-existing.

Bupa needed to ensure that the policy he was buying was suitable for him. During the sales call he was given the option of buying a more expensive policy that would cover pre-existing medical conditions. He was aware that diabetes, as a chronic condition, wouldn't be covered. And he confirmed that he hadn't consulted the doctor for anything else apart from diabetes in the last two years. Therefore, I consider that Bupa acted reasonably in informing him that the diabetes, and a few other minor conditions, would be excluded from cover.

Bupa also needed to provide information about the policy that was clear, fair and not misleading. As our investigator has mentioned, it did inform him that testing or symptoms would render any further investigations or diagnosis as pre-existing. On balance, I consider that this information was clear. Even if it hadn't been, I don't think it would have made a difference to Mr R at the time. That's because he thought all of his symptoms related to diabetes. So, I think it's likely he would have bought the policy in any event. Based on the available evidence, I'm unable to conclude that the policy was mis-sold.

I'm very sorry to disappoint Mr R, I appreciate the difficulty of his situation and the ongoing uncertainty of his health issues. But, based on the available evidence, I'm unable to uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R to accept or reject my decision before 27 February 2025.

Carole Clark
Ombudsman