DRN-5265686

The complaint

Mrs S complains that Vitality Health Limited has turned down a claim she made on a group private medical insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Mrs S is insured under a group private medical insurance policy. The policy began in March 2018 and was taken out on a moratorium basis. This means that Vitality won't pay claims for any conditions a policy beneficiary had in the five years before the policy was taken out *unless* they'd had a two-year period after the policy started where they hadn't seen a GP or taken any medication for that condition.

In April 2023, Mrs S made a claim on the policy because she needed to undergo hysterectomy surgery. During the call, Vitality's call handler concluded that Mrs S' claim might be excluded by the terms of the moratorium. So Vitality asked Mrs S' GP to complete a 'Condition Information Request' (CIR) form to obtain some more information about her condition.

Based on the CIR and, subsequently, Mrs S' medical records, Vitality decided to turn down the claim. It concluded that Mrs S had been experiencing menorrhagia before the policy began. And it considered menorrhagia had been a symptom of the condition causing the claim. It noted Mrs S had seen her GP in October 2019 and 2020 and had undergone treatment in 2021, 2022 and 2023. So it considered Mrs S' claim was excluded by the moratorium terms.

However, Vitality acknowledged that it hadn't handled Mrs S' call as well as it should have done and it offered to send her some flowers.

Mrs S was very unhappy with Vitality's decision and she asked us to look into her complaint. She'd-self-funded treatment and paid for her consultations and surgery. She was concerned that Vitality had discriminated against her on the grounds of her age and sex.

Our investigator didn't think Vitality had treated Mrs S fairly. She didn't think there was sufficient medical evidence to show that Mrs S' claim was caught by the moratorium. So she recommended that it should pay Mrs S' claim, together with interest. She also recommended that it should pay Mrs S £100 compensation to reflect the upset it had caused her during the initial claims call.

Vitality initially responded to agree to pay Mrs S £100 compensation. It didn't agree to pay the claim. But it did offer to write to Mrs S' GP to ask for more medical evidence to allow it to reconsider the claim.

The investigator put Vitality's offer to Mrs S, but she didn't accept it. The investigator maintained that she felt the claim should be paid. And therefore, Vitality asked for an

ombudsman to make a decision.

The complaint was passed to me to decide.

I issued a provisional decision on 19 December 2024, which set out why I thought it would be fair and reasonable for Vitality to obtain more medical evidence and to reconsider Mrs S' claim.

'First, I'd like to reassure Mrs S that while I've summarised the background to her complaint and her submissions to us, I've carefully considered all she's said and sent us. I was sorry to hear about the impact Mrs S' symptoms have had on her life and I do hope she's recovering well from the surgery.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as industry principles and rules, the policy terms and the available medical evidence, to decide whether I think Vitality handled Mrs S' claim fairly.

I've first considered the policy terms and conditions, as these form the basis of the group scheme contract. The policy was taken out on moratorium terms. Page 34 of the policy explains how moratorium underwriting works. It says:

'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.

However, subject to the plan terms and conditions, a pre-existing medical condition can become eligible for cover providing you have not:

• consulted anyone (e.g. a GP, dental practitioner, optician or therapist, or anyone acting in such a capacity) for medical treatment or advice (including check-ups), or
• taken medication (including prescription or over-the-counter drugs, medicines, or injections) for that pre-existing medical condition or any related condition for two continuous years after your cover start date.'

I think the policy terms make it sufficiently clear that Vitality won't pay claims for conditions (including symptoms) a policyholder had had in the five years before the policy began unless they'd effectively been trouble free for a two-year period. Vitality considers that Mrs S' claim is excluded by the moratorium terms. So I've looked carefully at the available medical evidence to decide whether I think this was a fair conclusion for Vitality to draw.

Based on the information Mrs S gave Vitality during the initial claims call, I don't think it was unreasonable for it to request a completed CIR from her GP. I've considered the CIR carefully. The form asked when Mrs S' symptoms started. The GP answered '2020'. They stated: 'Contacted GP practice in 2020 to commence investigation'. The GP also stated that the symptoms had first been mentioned to a GP in 2020. They listed the treatment that had been advised for Mrs S, including HRT, followed by other treatments and investigations in 2021, 2022 and 2023.

The CIR also included a GP's statement. This said that Mrs S was suffering from menorrhagia post-menopause and that her first symptom date had been in 2020. Underneath, the GP was asked when Mrs S had first booked an appointment for that condition and the GP answered: 'October 2019'. They stated:

'As per last gynae letter, patient went through menopause in 2015 & in 2017, started having some…bleeding. Initially thought to be HRT.'

The GP also added: 'PV bleeding in 2017, thought to be due to HRT. Bleeding stopped after stopping HRT.'

In my view, the medical information set out on the CIR is contradictory in nature as to when Mrs S first experienced symptoms of menorrhagia and its duration. The evidence suggests that Mrs S had experienced symptoms of menorrhagia before the policy began and that she'd sought medical advice and treatment for that condition in 2019, 2020, 2021, 2022 and 2023. So I can understand why Vitality felt it needed more evidence in the form of medical records because the CIR indicated that Mrs S' claim could be caught by the moratorium.

Next, I've looked at Mrs S' medical records which provided detailed GP notes back to 2018 (with less detailed records back to 2006). Unfortunately, I can't see what was discussed with the GP in 2017, given the records don't go back that far. In October 2019, Mrs S spoke with her GP about experiencing bleeding after starting HRT. Mrs S' GP appointments in 2020 appear to focus on the management of menopausal symptoms rather than bleeding and refer to starting a new form of HRT. This seems to be inconsistent with what the GP recorded on the CIR. In February 2021, the GP recorded that Mrs S had a three-month history of heavy bleeding and referred her for a scan. And in March 2021, the GP noted that Mrs S 'had a history of heavy bleeding'.

The records show Mrs S' symptoms of menorrhagia continued during 2021, 2022 and 2023. In June 2022, the notes indicate that Mrs S had a 'gynae review' in 2020 where a polyp had been found. In December 2022, the notes show that Mrs S' symptoms had worsened and that she'd had symptoms for 'many years' with investigations having taken place twice previously. And in late March 2023, the GP noted Mrs S' symptoms of menorrhagia having been ongoing for five years. In April 2023, the GP recorded that Mrs S had 'continuing post-menopausal menorrhagia' and that 'she had had ongoing issues since 2017.'

Ultimately, once Mrs S had undergone surgery, her consultant noted that Mrs S had adenomyosis and endometriosis.

Taking together all of the medical evidence, I don't think it provides a sufficiently clear picture as to whether Mrs S' claim is caught by the moratorium or not. It's possible that Mrs S' earlier bleeding in 2017 was down to HRT but the medical records also refer to her experiencing issues since 2017. The notes indicate that Mrs S had been experiencing issues for a number of years – but it isn't clear enough that those issues pre-date policy inception in early March 2018. Nor is it clear whether Mrs S did undergo medical treatment or consultation for menorrhagia in 2019. And while there's reference to a gynae referral in 2020, it isn't clear why Mrs S was referred to gynae, whether it was linked to heavy bleeding or exactly when that referral took place. So I don't think there's enough here to fairly and reasonably show that the claim isn't covered. And it follows that I don't find Vitality had enough evidence on which to fairly and reasonably turn down the claim.

On the other hand, I don't think it's unreasonable for Vitality to require more medical evidence before it's in a position to make a claims decision. So I currently think the fair and reasonable outcome to this complaint would be for Vitality to request more medical evidence

and to reconsider Mrs S' claim in line with the policy terms and condition.

In my view, although I'm not a claims handler and it isn't my role to tell Vitality what evidence it should and shouldn't ask for, I don't think it would be unreasonable for Vitality to request Mrs S' medical notes for the five year period prior to her taking out the policy, along with copies of any referrals that took place to gynaecology between March 2013 and the point Mrs S made the claim, as it previously offered to do. It's also open to Vitality to request targeted evidence from Mrs S' treating specialist and GP regarding any potential link between her previous symptoms and her claim should it wish to.

Vitality is obliged to reconsider the claim in line with its regulatory obligations. If Mrs S is unhappy with the outcome of any reassessment of her claim, she may be able to bring a new complaint to Vitality and subsequently to us about that issue alone.

I appreciate Mrs S feels Vitality has discriminated against her given its decline of her claim. It's not our role to say whether a business has acted unlawfully or not – that's a matter for the Courts. Our role is to decide what's fair and reasonable in all the circumstances. In order to decide that, however, we have to take a number of things into account including relevant law and what we consider to have been good industry practice at the time. So although it's for the Courts to say whether or not Vitality has breached the Equality Act 2010, we're required to take the Equality Act 2010 into account, if it's relevant, amongst other things when deciding what is fair and reasonable in the circumstances of the complaint.

In this case, I've explained the reasons why I don't think Vitality has treated Mrs S fairly and reasonably and how I think it must put things right. I hope that it helps Mrs S to know that someone impartial and independent has looked into her concerns.

Notwithstanding this, it's clear that Vitality didn't handle Mrs S' claims call as well as it should have done and that it didn't treat her with appropriate empathy. Mrs S explained the trouble and upset this caused her at an already very difficult time. So I agree with our investigator that Vitality must pay Mrs S £100 compensation.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

Vitality accepted my provisional findings.

Mrs S was unhappy with my provisional decision and I've summarised her responses to it:

- She was devastated with my provisional findings and wanted someone to believe the truth and allow her to move on;
- She considered my provisional decision didn't provide either a settlement or resolution because I'd given Vitality a second bite at the cherry, despite concluding that it hadn't acted fairly. She thought Vitality should pay her the compensation our investigator had recommended;
- In April 2023, she'd used family savings to pay for her treatment because she knew her condition wasn't pre-existing and because Vitality had assured her it would reimburse her costs once it received the evidence it needed;
- Mrs S questioned who would pay for the medical evidence, given Vitality had previously required her to bear the costs of obtaining medical evidence. She also provided other examples of how she felt Vitality had treated her unfairly – i.e. not receiving cashback and not responding to phone calls or emails. She said she had no trust or confidence in Vitality restarting the process;
- She questioned too whether she needed to remain with Vitality in order to potentially bring a future complaint to us;

- She felt the small consumer has no chance against a large organisation.

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.

Having done so, whilst I'm very sorry to disappoint Mrs S and I understand my decision will cause her further upset, my final decision is the same as my provisional decision and for the same reasons. I'll now go on to address Mrs S' additional points.

I appreciate that Mrs S feels that my provisional decision doesn't provide a resolution or settlement to her complaint. However, when Mrs S brought her complaint to us, Vitality had concluded that it had enough medical evidence to turn down her claim. I explained in my provisional decision why I didn't think Vitality had enough medical evidence to turn down Mrs S' claim and therefore, why I didn't think its original claims decision was fair. Following my provisional decision, Vitality's now agreed to ask for more medical evidence to allow it to reassess the claim. This is an offer of settlement which it's open to Mrs S to accept. And should Mrs S accept my decision, Vitality would be obliged to reconsider her claim in line with the regulator's rules and principles.

It's clear Mrs S has concerns about the costs she may incur in obtaining further medical evidence. The policy terms say that sometimes, Vitality will require a completed claim form before it can assess a claim (as it did in this case) and that it won't cover the fees a GP charges for completing that form. However, the policy also says:

'If we do need a report to help us assess or monitor an ongoing claim, we will pay a reasonable fee for that report.'

As such, it appears that in Mrs S' case, Vitality may request medical evidence at its cost. But if Mrs S is unhappy with any fees she may incur as a result of Vitality requesting further information to assess her claim, she should get in touch with it to complain about that issue alone.

I understand Mrs S has lost confidence with Vitality and that's she unhappy with the service she's received overall. But, as I explained, I don't think there's enough evidence to show that Mrs S' claim is payable, given the contradictory nature of some of the available evidence, and so I'm still persuaded that the fair and reasonable outcome is for Vitality to ask for further medical information to allow it to reach a claims decision.

It isn't my role to tell Mrs S whether or not to cancel the group scheme policy with Vitality. Generally though, an insurer would require a group scheme to remain in force while it assesses a claim. But generally, Mrs S wouldn't need an active policy in order for us to be able to look into a complaint about something that happened while a policy was active.

I do sympathise with Mrs S' position, as I appreciate this claim has been ongoing for around 19 months. I also understand she paid for the surgery personally. But I have to make a decision based on what I consider to be fair and reasonable in all of the circumstances and which is independent and impartial. And, for the reasons I've given, I think the fair outcome here is for Vitality to ask for more medical evidence to assess whether or not Mrs S' claim is covered. If Mrs S is unhappy with the outcome of that claim reassessment, she may be able to complain to us about that issue alone. I'm still satisfied that Vitality must also pay Mrs S £100 compensation to reflect the impact of its poor handling of her initial claims call.

Putting things right

I direct Vitality Health Limited to:

- Reconsider Mrs S' claim, in line with the policy terms and conditions, subject to any reasonable, additional medical evidence it considers it requires to fairly assess this claim; and
- Pay Mrs £ £100 compensation.

Vitality must pay the compensation within 28 days of the date on which we tell it Mrs S accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't think Vitality Health Limited has handled this claim fairly and I direct it to put things right as I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S to accept or reject my decision before 14 February 2025.

Lisa Barham
Ombudsman