DRN-5271993

The complaint

Mr S1 and Mr S2 complain that they didn't receive sufficient communications from Vitality Health Limited ('Vitality') about the payment of an excess under a private medical insurance policy.

What happened

Mr S1 and Mr S2 were insured under a group private medical insurance policy, underwritten by Vitality.

In March 2022, Mr S1 made a claim under the policy. In 2024, Mr S2 complained to Vitality because Mr S1 was being chased by the treatment provider for payment of a £100 policy excess.

Vitality said, under the policy terms and conditions, an excess of £100 was payable to the treatment provider and both Mr S1 and Mr S2 had been notified in July 2022 that this was owed, via Vitality's 'Member Zone'.

Unhappy, Mr S1 and Mr S2 brought the matter to the attention of our service.

One of our investigators looked into what had happened and said she didn't think Vitality had acted unfairly or unreasonably in the circumstances. Mr S1 and Mr S2 didn't agree with our investigator's opinion, so the complaint has been referred to me to make a decision as the final stage in our process.

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.

I'm sorry to hear that Mr S1 has been unwell, and I understand this situation impacted upon him at what will have been an already difficult time.

When making this final decision, I've taken into account relevant industry rules and guidance as well as what I consider to be good industry practice, to reach an independent and impartial outcome which is fair to both parties involved.

Mr S1 and Mr S2's certificate of insurance clearly set out that a policy excess of £100 was payable in line with the terms and conditions and, based on the evidence I've seen, the fact that an excess was payable was also discussed when this claim was first made in March 2022.

Vitality has provided correspondence that was sent to Mr S1 via its 'Member Zone' in July 2022 confirming that an excess payment of £100 was due for treatment he'd received. Correspondence was also sent to Mr S2 as the principal policy member in July 2022, again via Vitality's 'Member Zone', confirming that an excess payment of £100 was due for Mr S1's treatment. The correspondence sent to Mr S2 didn't go into any detail about what Mr S1's treatment was or the medical condition which the treatment was for.

Emails were sent to Mr S1 and Mr S2 to notify them that information relating to a claim was in the 'Member Zone' for them to view.

I understand Mr S1 was unable to access the 'Member Zone'. If Vitality had been made aware of this then I'd expect it to have made arrangements to communicate with Mr S1 in a different way. But Vitality wasn't told that Mr S1 couldn't access the 'Member Zone' and the onus was on Mr S1 to tell Vitality if there were issues with his account.

I think it would be impractical and disproportionate to expect Vitality to check if each and every member is accessing their 'Member Zone' information. And I don't agree that any difficulties which may have been experienced by other employees of Mr S2's company mean it would have been reasonable for Vitality to assume that Mr S1's account would be affected too and to automatically adjust its method of communicating with him without his express agreement.

I appreciate that Mr S2 wasn't receiving treatment and, therefore, says he had no reason to check the 'Member Zone'. However, I don't think it's unreasonable to expect the principal member to check their account details if they are sent a notification about a policy related matter. As I've already mentioned, the correspondence sent to Mr S2 via the 'Member Zone' didn't contain any details about Mr S1's medical condition or treatment, and I'm satisfied that the email notification sent to Mr S2 was clear that the information in the 'Member Zone' related to a claim and that the email didn't resemble spam or marketing material.

I don't think there was any requirement for Vitality to send multiple reminders to Mr S1 and/or Mr S2 about the policy excess, and I also don't think it was necessary for Vitality to follow-up on its correspondence by post or direct email in these circumstances. The correspondence that was sent to Mr S1 and Mr S2 didn't require any response to be sent back to Vitality – it was simply notification that the policy excess needed to be paid to the treatment provider directly – so I don't agree with Mr S1 and Mr S2's submissions that Vitality should have been aware that the notifications hadn't been viewed.

I accept Mr S1 and Mr S2 say they had an insurance policy which would have covered the cost of this excess, so they had no reason not to pay it. However, like our investigator, I don't think this is relevant to the outcome of Mr S1 and Mr S2's complaint. I also don't think that any opinions of Mr S1 and Mr S2's insurance broker or the fact that Mr S2's employer subsequently changed private medical insurance providers are relevant either. Instead, the key issue for me to determine is whether I think Vitality complied with its obligations in notifying Mr S1 and Mr S2 that an excess was payable, and I'm satisfied that it did.

I'm sorry to disappoint Mr S1 and Mr S2, as it's clear they feel strongly about what happened. But I don't think Vitality has acted unfairly or unreasonably in the circumstances, so I won't be directing it to do anything further.

My final decision

My final decision is that I don't uphold Mr S1 and Mr S2's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S1 and Mr S2 to accept or reject my decision before 17 March 2025.

Leah Nagle
Ombudsman