DRN-5275087

The complaint

K has complained about the service it received from Vitality Health Limited.

K is represented by Mr F. For simplicity I will just refer to Mr F in the main, rather than to K

What happened

The background to this complaint is well known to the parties and not in dispute. In summary Mr F's healthcare insurance provider was ceasing to trade in the UK, so he wanted to consider alternative cover for his company, K.

Mr F purchased a policy with Vitality to begin in March 2023. In December 2023. He needed to make a claim which was not admitted. This prompted Mr F to review his policy.

Mr F then complained that Vitality mis-sold his policy. He says he was advised the policy would be like-for-like to a previous policy he held, however, there were many features that differed. This meant claims Mr F made were not covered, he says would have been covered under his previous policy.

Mr F feels Vitality created a false sense of security as it assured him the policy provided was like-for-like to his old policy. He also had concerns that Vitality was unable to provide phone call recordings which should include the reassurances he was given.

Our investigator considered the complaint but didn't recommend that it be upheld. Mr F appealed.

As no agreement was reached the matter was passed to me to determine. I issued a provisional decision as I came to a different conclusion to our investigator. I said as follows:

I've summarised the background to this complaint and here focus on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. I'm minded to uphold the complaint. I'll explain why.

- *Vitality has a duty to act honestly, fairly and professionally in accordance with the best interests of its customer. It must take reasonable care to ensure the suitability of its advice for any customer who is entitled to rely on its judgement. I've looked carefully to see if it has done so in the circumstances here.*

- *Mr F says that in the initial call, before he was transferred to the sales adviser whom I'll call "T", he said he was looking for a like-for-like policy. It is unfortunate that Vitality isn't able to provide that part of the call as it didn't record. However Vitality has provided an overview of the information it would have expected this 'Lead Generation agent' to share. Vitality say that he wouldn't have been able to promise to match any level of cover as this would have needed to be discussed with the sales team, who operate in an advice-based role after the agent refers the lead. Nevertheless I accept that Mr F mentioned that he was looking for a like-for-like*

policy when speaking to this agent. And it wasn't unreasonable for him to assume that the information was passed to T.

- *I've listened to the calls that Mr F had with T. In the first call T said that the lead generation agent had filled him in on K's situation. That agent was also sending across information to T. So again I think Mr F was entitled to assume that his "like for like" requirement had been passed to T.*

- *In the second call, shortly after the first, T identified Mr F's main need as wanting access to quick diagnosis and treatment. He said that he would tailor his advice to this requirement. T then asked if Mr F had the policy details to hand – he wanted to make comparisons. Mr F explained that he had top level 'Gold' cover with no excess and the monthly premium he was paying. T then tried to access the policy online he accessed the previous insurer's website, but it doesn't seem from the call that he did find the policy and asked Mr F about the various benefits that K had. Mr F read out some of the benefits from his policy. T then asked how much K was paying and advised that he would take him through the policy and the figure that he was looking at would be much lower. I think from the conversation that Mr F would have got the impression that that T wanted to know what K's current policy covered in order that he could ensure the cover he recommended was like for like, or at least, wasn't less than the cover K already enjoyed.*

- *T read out the main policy provisions of the Vitality policy. Overall I find T gave a fair summary and I note that at the end he said he'd send the quote over and some information about the rewards. Further calls were arranged and in one Mr F said he was awaiting a conversation with a third insurer. He said that he wanted like-for-like cover as "you've done for me".*

- *In all the circumstances I find that there was a mis-communication here. T gave full details of the Vitality policy he was recommending – but he didn't ensure that it was like-for-like with K's previous policy. And although the policy did offer benefits K's previous policy didn't have, the policy recommended wasn't like-for-like. It didn't include, for example, GP direct referrals for diagnostics. So I don't find Vitality treated K fairly.*

- *Vitality did offer K the option to cancel the plan, but Mr F has said that cancelling the policy isn't something K could accept as other members would lose their continuous cover. I do understand this. In deciding how to redress the matter I into account that K is paying substantially less now than it was previously and has comprehensive cover but, as noted above, without all the features of K's previous policy. Mr F only became aware of this when he sought to make a claim. To put things right Vitality should refund K any private diagnostic fees incurred by the member on K's policy to date, with interest. For Vitality to do this Mr F will need to provide receipted invoices. I don't propose to ask this to continue beyond the date of my decision.*

- *For completeness I would add that Mr F also says he wasn't aware he would need to use a Vitality approved consultant. I have only seen a summary of his old policy not the full policy document. It may be that this requirement is no different from his previous policy, so I make no finding in this regard.*

- *I think that K would have been inconvenienced by discovering that the policy purchased didn't include all the features of its previous policy. Mr F, on behalf of K spent time and effort arranging the policy, time which otherwise could have been spent on K's business. I find compensation is due for this inconvenience and I find that £600 is fair in all the circumstances.*

I invited the parties to provide any further comments or evidence for me to consider and said unless that information changed my mind, my final decision was likely to be along the lines of my provisional decision.

Vitality didn't agree with my provisional decision. It said it strongly disputed the outcome and in summary made the following points:

- There is no call recording or concrete evidence to support the claim that a like-for-like policy was requested. And no evidence that information was passed on to the sales adviser.

- Mr F didn't specifically ask for a like-for-like policy in his conversation with the adviser. And how was the adviser to know what was covered in his previous plan?

- The adviser based his recommendations on the information read out by Mr F – that level of cover was matched by Vitality. Aspects of the previous policy that differed from the Vitality policy were not communicated by Mr F, therefore how could the adviser know to discuss these aspects or to inform the member that they weren't covered?

- An assumption has been made, lacking concrete evidence, that the claims would have been approved by the previous insurer. How does the ombudsman know what would or wouldn't have been covered or if the claim would be accepted?

- The evidence shows that Mr F had read through the documentation – he didn't raise concerns about the policy not being like-for-like.

- Due to the urgency of the situation, as K's previous insurer was ceasing to trade, the adviser was entirely reliant on Mr F providing full and accurate information.

- Mr F chose Vitality rather than the insurer he had been directed to.

- The cooling off period allowed Mr F to review the terms and conditions, but he only became aware that the policy didn't include GP referred diagnostic tests when he sought to make a claim. He did not ask whether this was covered or read the documents.

- The plan was not mis-sold, therefore compensation is not appropriate. In any case the amount is extremely excessive.

Mr F on behalf of K accepted my provisional decision. He sent in further information regarding his previous policy and of two claims that had been paid for privately, but he believed would have been covered by his old policy. Additionally, he contacted the previous insurer who confirmed it would settle any claims for diagnostic tests which were referred by a GP. Mr F had asked the other policy members for details of diagnostic tests they had paid for but had not at the time of writing received details back.

Asked to comment on the award for inconvenience he said that a series of calls were made over an eleven-day period and dealing with the paperwork took 4-5 hours. Another 4-5 hours were spent raising the complaint with Vitality. Mr F commented that he and other members of the policy had been forced to use the NHS. He felt that the actual premiums paid should be refunded.

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, and having thought carefully about the submissions made in response to my provisional decision, I'm not persuaded to change my conclusion. I'll explain why:

- Mr F's testimony is that he asked for a like-for-like policy. I've listened to the call recordings and read the transcripts. I'm satisfied that the request was either passed on or Mr F believed it had been. The recorded conversations reflect that understanding. I've explained why I reached that conclusion in my provisional decision and won't repeat the explanation. But to elaborate if Mr F had been seeking different cover, it would have been reasonable to expect that request to have been aired. And it stands to reason that as T said he could beat the premium that K was paying he was comparing like with like, or there would have been no comparison. Vitality says there is no concrete evidence that such a policy was requested – but there doesn't need to be. Mr T's testimony *is* evidence and I found it to be plausible and corroborated by the phone calls.

- It may be that the adviser based his recommendation on the parts of K's previous policy that Mr K read out. I don't find that this was sufficient to ensure that the policy was like-for-like. Although he tried to look online for the policy, knowing how comprehensive these policies can be, I find the adviser should have made sure that he did see a copy. This way he would have been able to explain the differences in cover and price. Vitality says that the adviser was entirely reliant on Mr F providing full and accurate information about K's existing policy. So I find T should have made that clear. He should have explained that as he hadn't seen all the terms of K's previous policy, he was only able to set out what Vitality was able to offer. But that isn't how the conversation went.

- As I said in my provisional decision, I find that there was a miscommunication here. I accept that Mr F may have picked up during the cooling off period that there were differences and in particular that GP referral for diagnostics was missing. But as this was a this was a relationship of trust, Mr F on behalf of K was entitled to rely on the recommendation made, believing it was like-for-like. Had the mis-communication not occurred Mr F may not have chosen Vitality.

- Vitality has said that an assumption has been made that the claims would have been approved by the previous insurer. It's a fair point. However it isn't for this service to assess claims. Mr F has said that the previous insurer has confirmed the claims would have been paid. He can provide his previous insurance schedule and any claims related documents to Vitality. I do not require Vitality to pay any claims that wouldn't have been covered, it can make further assessment if it feels necessary to do so.

- In awarding compensation I have taken into account that K is a business and time dealing with this matter for Mr F is time away from K's business. As indicated, he has spent hours sorting the matter out and overall K has been caused inconvenience. I find compensation in the sum of £600 is fair. There is no basis, however, for me to require Vitality to return the premiums paid whilst cover has been in force.

My final decision

My final decision is that I uphold this complaint. I require Vitality Health Limited to:

- Refund K any private diagnostic fees incurred by the policy members to the date of this decision that would have been covered under K's old policy.

- Add simple interest to any refund at the rate of 8% per annum from the date the payment was made until settlement.

- Pay K £600 in compensation.

I make no further award.

Under the rules of the Financial Ombudsman Service, I'm required to ask K to accept or reject my decision before 5 March 2025.

Lindsey Woloski
Ombudsman