DRN-5290590

The complaint

Miss W is unhappy that Vitality Corporate Service Limited mis-sold her a private health insurance policy ('the policy').

All reference to Vitality includes its representatives.

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

Miss W feels very strongly that the policy was mis-sold to her. I know she'll be very disappointed but for reasons I'll go on to explain, I don't uphold her complaint.

Vitality recommended the policy to Miss W so not only did it need to ensure that it was suitable for her needs, but Vitality also needed to give her clear, fair and not misleading information about the main terms of the policy.

I've listened to the recordings of calls which took place between Miss W and Vitality's representative.

The calls reflect that Miss W had the benefit of private health insurance through her mum's company and she was considering switching.

Looking at the key features of the policy, including the basis on which it was underwritten, its cost, the excess, main benefits and exclusions, I haven't seen anything which persuades me that the policy was unsuitable for Miss W's needs.

I've seen nothing which persuades me that the policy wasn't affordable for Miss W at the time. It cost less than her previous policy and although she has told us she's a student, at the start of one of the calls the representative asks her what she does for work, and she confirmed her job. So, based on that, I'm satisfied that she was working at the time.

Miss W says that the policy was unsuitable because when making a claim she was asked to get her GP to complete a form so the claim could be assessed. She said this was costly and would typically cause claim delays as it would take time for the GP to provide this information, slowing access to treatment. She also says that the insurer told her that when a claim is made in the first 12 months of the policy it would request this information. She says Vitality should've told her this.

I haven't seen any supportive evidence that the insurer of the policy would always request a report from her GP for claims made in the first 12 months of the policy starting. And I can't see that's reflected in the policy terms.

However, in any event, it's not unusual for an insurer to ask for information from a GP when a claim is made on a private health insurance policy particularly if a claim is made not long after the policy's start date. I know Miss W says that her previous insurer didn't do that, and there could be many reasons why the decision was taken not to seek information from her GP when she made claims under that policy – including the length of time she'd been insured by it.

Ultimately, I don't think the insurer being able to ask her GP for more information when assessing a claim made the policy unsuitable in principle.

I'm also satisfied that Miss W was given clear, fair and not misleading information about the main terms of the policy.

Miss W says that if she'd been given more information about the insurer needing more information from her GP before agreeing to cover a claim, she wouldn't have taken it out.

However, towards the end of the sales call, Miss W was told that to assess whether a claim is eligible, the insurer may require further information from her GP. I think that was sufficient in the circumstances.

I don't think Vitality unreasonably failed to give Miss W any further information about the circumstances when the insurer might require information from her doctor / GP during the sales call. That's a matter for the insurer when assessing whether to cover individual claims made on the policy.

I don't think it was unfair of Vitality not to tell Miss W that there might be a cost associated with obtaining information from her doctor / GP or if requested by the insurer, the type of form she and the medical professional would be asked to complete.

I wouldn't reasonably expect Vitality's representative to proactively explore this with Miss W at the time of sale. And Vitality wouldn't know how much Miss W's doctor would charge for providing information.

At the end of the sales call, Miss W was also told that she would be sent policy documents, to read them carefully, and there would be details on how to make a claim. The policy terms have a section on when the insurer may need more information from her doctor. The policy terms also say that the insurer may pay towards the cost of a medical report and if so, the policyholder will need to pay any remaining amount. If Miss W was unhappy with that, then there was a cooling off period for her to cancel the policy.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss W to accept or reject my decision before 18 March 2025.

David Curtis-Johnson
Ombudsman