DRN-5351040

The complaint

Mr C has complained about the handling of a medical insurance claim by Vitality Health Limited.

Mr C is represented by Mrs C, but in the main I have referred just to Mr C for ease of reading.

What happened

The background to this complaint is well known to the parties.

In summary a business healthcare plan was commenced on 1 July 2023. In May 2024 Vitality cancelled the plan. It said that Mr C had made deliberate misrepresentations when the plan was taken out. A separate complaint was set up for that issue. This complaint concerned a distinct hospital stay for Mr C.

Vitality authorised an inpatient stay for Mr C In November 2023 but when it received a hospital report requested further information from the treating consultant. The information wasn't provided so Vitality chased for the information.

Mr C was re-admitted to hospital in January 2024. This stay was approved until 1 February 2024 when Vitality received answers and information it been requesting since November 2023. The information wasn't complete and Vitality requested the missing information. But on 2 February 2024 Vitality decided that it wouldn't approve any more treatment. It was concerned that there had been misrepresentations made when policy was applied for.

Vitality advised Mr C that cover was being declined on 9 February 2024. Mr C then discharged himself from the hospital, not wishing to incur further charges.

Our investigator originally concluded that Vitality should pay for any medical expenses incurred between 2 and 9 February 2024.

Mrs C said on behalf of Mr C that nothing after 23 November 2023 should have been authorised. She said that Vitality's service was the reason she had to complain which in turn resulted in the policy being withdrawn unfairly. So she said that the cases were "totally linked" and that if Vitality had communicated with them in November 2023 they wouldn't now be in the position that they were.

Vitality didn't accept the investigator's view. It said that cover had been confirmed up to 2 February 2024. The decision to decline additional cover after 2 February 2024 was made on 9 February 2024. It also said that Mr C was acutely unwell on 2 February 2024 and unlikely to have been well enough to go home at that time. Even if transfer to the NHS was a possibility, it would not have happened on 2 February 2024. Finally, Vitality said that it was unable to pay any claim as the plan had been avoided due to deliberate misrepresentation.

In the light of the further arguments on their other Vitality complaint which the investigator said would potentially affect the outcome on this complaint, the investigator put this

complaint temporarily on hold whist the other complaint was progressed. He said that we were unable to reach a reasonable outcome on this complaint until the other one was resolved.

Following a final decision in the other case he reviewed this complaint again and issued a second view. He said that in the light of the fact a decision had been made which determined that there was a deliberate misrepresentation when the policy was taken out, the insurer was permitted by law to treat the policy as if it had never existed and to decline all claims. He therefore didn't recommend that the complaint be upheld.

Mr C appealed.

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'd like to reassure Mr C that whilst I've summarised the background to this complaint and the detailed submissions made on his behalf by Mrs C, I've carefully considered all that's been said and sent to us. In this decision though I haven't commented on each point or argument rather I've focused on what I find is the key issue 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. Having done so and although I recognise that Mr C will be very disappointed my decision, I agree with the ultimate conclusion reached by our investigator. I'll explain why.

It isn't in dispute that the two complaints are connected. This complaint concerns Vitality's actions in relation to Mr C's hospital admission in February 2024.

Insurers have regulatory duties. These include to handle claims promptly and fairly and not to unreasonably reject a claim. But I can't disregard the final decision of an ombudsman in relation to the policy. Their conclusion that there was deliberate misrepresentation which meant that Vitality was entitled to avoid the contract and refuse all claims.

So even if I was able to conclude that there were errors on the part of Vitality, it wouldn't be fair and reasonable for me now to require Vitality to pay a claim under the policy. I don't find it would be fair and reasonable in the circumstances for me to require Vitality to make any other payment to Mr C either. This is because the policy has been avoided – that is cancelled from the start. I appreciate that Mr C doesn't agree with the conclusion reached there – but the decision marked the end of our process in relation to that complaint and I can't disregard it. It follows that I don't uphold this complaint.

I'm very sorry that my decision doesn't bring Mr C welcome news.

My final decision

My final decision is that I don't uphold this complaint.

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

Lindsey Woloski
Ombudsman