DRN-5411713

The complaint

Miss C complained that Vitality Life Limited declined a claim on her serious illness policy. Miss C was also unhappy with how long it took Vitality to assess her claim.

What happened

Miss C took out a life and serious illness policy with Vitality in June 2018. I'm sorry to hear about Miss C becoming unwell. She required surgery in October 2023. As a result, she raised a claim with Vitality.

Vitality declined Miss C's claim on the basis that she hadn't met any of the definitions for the listed conditions. Miss C was still unhappy and so raised a complaint, both about the claim outcome and the time the claim took to deal with.

Vitality partly upheld Miss C's complaint. They didn't agree that it had been incorrectly declined but they accepted there had been delays in assessing the claim. Vitality offered Miss C £400 compensation for the trouble and upset caused. Vitality had previously also upheld another complaint about delays which they'd offered Miss C £75 compensation. Miss C didn't agree with the outcome. She still thought the claim should be covered and so brought the complaint to this service.

Our investigator didn't uphold the complaint. They felt the compensation offered by Vitality for delays was reasonable. They also agreed that Vitality hadn't unfairly declined the claim. Miss C appealed. She said she'd been in hospital on many occasions. She also said she'd been mis-diagnosed which meant she hadn't been in hospital for further treatment more frequently. As no agreement could be reached, the complaint has been passed to me to make a final 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.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set up by the Financial Conduct Authority, say that an insurer must deal with a claim promptly and fairly, and not unreasonably decline it. So, I've thought about whether Vitality acted in line with these requirements when it declined to settle Miss C's claim.

Having done so, and whilst I appreciate it'll come as a disappointment to Miss C, I've reached the same outcome as our investigator.

At the outset I acknowledge that I've summarised her complaint in far less detail than Miss C has, and in my own words. I'm not going to respond to every single point made. No discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as it's an informal dispute resolution service. If there's something I've not mentioned, it isn't because

I've overlooked it. I haven't. I'm satisfied I don't need to comment on every individual point to be able to reach an outcome in line with my statutory remit.

I've reviewed both parts of this complaint separately below:

Claim decline

As a starting point, it's important to understand what the policy terms and conditions set out. The definition for the condition most relevant to Miss C is as follows:

"***Severe Gastrointestinal Disease – requiring hospitalisation***

Objective evidence of severe gastrointestinal disease with all of the following:

- *Disturbance of bowel function at rest with severe persistent pain for a minimum of 3 consecutive months*

- *Limitation of activity with continued restriction of diet and no response to medical therapy for a minimum of 3 months*

- *There have been 2 hospital admissions to treat this condition in the 12 months prior to claim*

For the above definition, the following are not covered:

- *Any hospitalisation for diagnostic purposes*

- *Any hospitalisation for other conditions*

- *Any hospitalisation relating to alcohol or drug misuse*

- *Irritable Bowel Syndrome*"

Vitality has accepted that Miss C suffered from disturbance of bowel function at rest with severe persistent pain and had limitation of activity with continued restriction of diet with no response to medical therapy both for a minimum of three consecutive months. However, Vitality declined the claim on the basis there hadn't been two hospital admissions to treat the condition in the 12 months prior to claiming. From what I've seen, Miss C didn't have two hospital admissions for treatment in the 12 months prior to claiming.

Miss C has said she was in hospital on multiple occasions. She's also said she was mis-diagnosed which meant she didn't attend hospital for treatment more frequently. I'm not downplaying or undermining Miss C's condition or the impact it had on her, but all bar one of the visits I can see were for diagnostic purposes and not for treatment, which as per the above definition, aren't covered under the condition. Whilst I appreciate that Miss C may have been mis-diagnosed, I don't think this makes a difference to the outcome. This is because there is no evidence that Miss C would have needed additional visits to hospital for treatment, as opposed to for diagnostics had her condition been diagnosed correctly earlier.

I'm very sorry that my decision doesn't bring Miss C more welcome news at what I can see is a very difficult time for her. But in all the circumstances I don't find that Vitality has treated Miss C unfairly, unreasonably, or contrary to the policy terms and conditions in declining the claim.

Claim delays

It hasn't been disputed that there were delays in the claim being handled. So, I only need to consider whether the compensation offered by Vitality is fair and reasonable. Vitality received the completed claim form in min-January 2024. The claim outcome was given to Miss C in early-September 2024. During this time, there were long periods where Vitality were waiting for medical information to be able to assess the claim. But there were also periods where the claim could have been worked more proactively.

I appreciate it must have been frustrating for Miss C to have to wait for the claim outcome on her claim. Especially due to the amount of time the outcome took whilst dealing with ill health and suffering from financial difficulties. Although this is a distilled version of events, I've considered everything in the round and I think Miss C has been caused considerable distress, upset and worry which has taken a lot of extra effort to sort out over several months. In line with our website guidelines, I think the total of £475 compensation, over two separate payments (£75 then £400), is fair and reasonable. So, I don't think Vitality need to pay anything further.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.
I don't require Vitality Life Limited to do anything further.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss C to accept or reject my decision before 28 April 2025.

Anthony Mullins
Ombudsman