DRN-5433575

The complaint

Mr F has complained that Western Provident Association Limited (trading as WPA) declined a claim he made on a private medical insurance policy.

What happened

Mr F purchased the policy in September 2023. He was diagnosed with osteoarthritis in June 2024 and required a right hip replacement. He therefore made a claim on the policy which WPA declined on the basis that his symptoms were pre-existing.

In response to the complaint, WPA maintained its decision to decline the claim. However, it offered to cancel the policy and refund the premiums from inception, subject to Mr F's acceptance of that offer within 14 days. As he didn't respond within that timescale, the offer was rescinded.

Our investigator thought that WPA had acted reasonably in declining the claim. However, she didn't think it was fair that it had rescinded its offer to refund the premiums, as this was contrary to the principles set out under The Consumer Insurance (Disclosure and Misrepresentations) Act 2012 (CIDRA). WPA subsequently agreed with our investigator's recommendation that a full refund of premiums should be made.

Mr F disagrees with our investigator's opinion and therefore the complaint has been passed to me for a 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.

I've carefully considered the obligations placed on WPA by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for WPA to handle claims promptly and fairly, and to not unreasonably decline a claim.

The policy terms state:

'*You have been accepted to join WPA based on the information you provided when you completed the Application Form; (…) We reserve the right to end and/or amend your Policy at any time should it transpire that you have not disclosed to us information and/or informed us of a change of circumstances that you ought to have done."*

Under "What Is Not Covered" the policy terms explain:

"6.31 Pre-existing conditions – subject to the underwriting of your Policy

• Any condition, disease, illness or injury, whether symptomatic or not. This includes:

- Anything for which you have received medication, advice or treatment;

Or

- Where you have experienced symptoms, whether the condition has been diagnosed or not, before the start of your cover.'

Additionally, the policy details:

'7.5.1 Full Medical Underwriting (FMU)

FMU means your policy does not pay for conditions that you already had when you joined. (…)

This means that you will not be able to claim for: (…)

• Any conditions that existed before the date that you joined us, that fall within the questions in the Application Form."

This means that you will not be able to claim for:

• Any conditions that existed during the five years before the date that you joined us".

7.6 Your Medical Information

It is a term of your policy that we may access your medical record(s) and/or request a medical report from your treatment provider,'

It's not in dispute that Mr F first received a diagnosis of hip osteoporosis on 5 June 2024. That was the culmination of various clinical investigations to establish the root cause of his groin pain. However, looking at the policy wording above, it is clear that the policy also excludes conditions where symptoms were present prior to the inception of the policy, whether diagnosed or not.

Mr F says he first experienced symptoms of groin pain in November 2023. That may have been when the severe symptoms of groin, thigh and knee pain started. However, the available medical evidence shows earlier episodes of groin pain.

A urology clinic letter for an appointment on 1 June 2022 reports that he has groin pain. An oncology letter for a telephone consultation on 26 July 2022 records that he was seen by the urology team regarding groin pain and that he struggles with his usual activities. I'm aware however that this was mentioned in the context of being a possible side effect of hormone treatment.

GP notes for 11 May 2023 record:

'*History: Telephone encounter (9N31) spoken with pt he is having pain in his groin rt > lt, deep bruise, he mentioned that it is different from sciatica type pain he had it before, no pain raditing down the legs, not keen on analgesia and would like it to be investigated, ahd a fall in the [ast but doesn't think fracture, able to bear weight and walk. No shoulder pain. Diagnosis: Groin pain (XM091) Hip pain (X75rv)'*

Mr F then attended the GP surgery for a blood test on 15 May 2023. Whilst he's said that it was for a routine blood test, the GP notes record: '*Clinical information: Joint pain'*.

From Mr F's point of view, he says he has no recollection at all of the appointment he had with the locum GP in May 2023 (which I take to mean the telephone consultation on 11 May 2023 and the blood test on 15 May 2023) but says what was noted was a minor strain.

Furthermore, he says that he saw his oncologist the next day (after the blood test) who reported no mention of any discomfort until he was seen again in November 2023. He thinks that WPA has confused that appointment with the subsequent six-month check-up in November 2023. However, I'm not persuaded that's the case. I have seen the oncologist's clinic letter for 16 May 2023, which states:

'*The issue is that he has had pain in both groins – right greater than left – for the last few months. This is affecting his walking which is now reduced and he is also getting needing to use the hand rail to go up the stairs.'*

Mr F has provided copies of his personal diary entries for 15 and 16 May 2023. The entry for 15 May 2023 states that he went to the surgery for a blood test. However, this is disregarding that the blood test followed on from the telephone consultation he'd had on 11 May 2023. He says that, if he'd had symptoms of pain, groin or otherwise, during the appointment on 16 May 2023, the oncologist would have been concerned about possible metastases. But the clinic letter for that date goes on to say:

'*I think in the first instance as this is clearly a bothersome symptom, we will do a CT bone scan that should cover this area to exclude anything significant and I have suggested he take simple paracetamol to see if this will improve symptoms.*'

Mr F says he had been talking to his oncologist about his groin strain resulting from exercise and explains the symptoms away as due to over-exertion and weakness due to prostate treatment. However, it's clear that he'd been suffering from the groin strain for a few months prior to May 2023. As it was a symptom that was present in the year prior to taking out the policy, it should have been declared during the application process.

Mr F says his regular GP has confirmed that there is no mention of any hip pain in his medical records. He's also said that from buying the policy in September 2023 until June 2024, he saw GPs, a physiotherapist and two orthopaedic surgeons and nobody had any inkling that he had a hip problem. That may be the case but, as set out above, there is mention of groin pain, the cause of which was eventually diagnosed as hip osteoarthritis.

The question is, what would have happened had the groin pain been declared during the application process. WPA's position is that, had he declared the groin pain, it would have applied an exclusion for that and related conditions, particularly due to his age and the undiagnosed and ongoing nature of the condition. In fact, due to a number of other non-declared conditions that came to light after receiving the medical records, it said it wouldn't have offered cover at all. Having seen evidence of its underwriting criteria, I'm satisfied that is the case.

Mr F has suggested that his medical records contain errors. If he believes them to be inaccurate, he would need to take that up with his GP surgery in the first instance. When considering whether WPA has done anything wrong, I think it's reasonable for it to rely on the medical evidence as presented when assessing the claim.

I've thought very carefully about what Mr F has said and understand his strength of feeling about this issue. However, based on the available evidence, I'm satisfied that Mr F had pre-existing groin pain and that it was reasonable for WPA to assess this as being related to the hip osteoarthritis that was eventually diagnosed. Therefore, it was reasonable for it to decline the claim.

Mr F has said that WPA should have asked for sight of his medical records before agreeing to cover him. Insurers do not routinely ask for this documentation upfront but instead base their underwriting decisions on the information provided by policyholders during the application process.

Mr F also submitted claims for outpatient appointments that took place in advance of his hip replacement operation on 4 August 2024. However, WPA had not pre-authorised these treatments and so it was reasonable that it declined to pay for them.

It is the case that Mr F was given the final decision about the hip replacement not being covered on 31 July 2024, only a few days before the planned operation. WPA initially asked the GP to provide records in relation to osteoarthritis and any associated conditions from 2018, when what it actually wanted was his full medical records from 2018. In any event, the GP surgery initially only provided records dating back to August 2023. It wasn't until 30 July 2024 that the full records were received. It was fair that WPA delayed its decision to decline the claim until it had reviewed the medical records. On balance, I'm satisfied that WPA acted reasonably in this regard.

Based on the available evidence, I am unable to conclude that WPA has done anything significantly wrong in relation to its handling and declination of the claim. Therefore, whilst I know it will be disappointing to Mr F, I do not uphold that part of the complaint.

However, as previously mentioned, WPA offered a refund of premiums from inception and then rescinded that offer. Following further liaison with our investigator, it accepted that, as it wouldn't have offered cover had it known the full extent of Mr F's pre-existing medical conditions, a refund is appropriate.

I understand that Mr F's original payment card has expired and so WPA cannot make a refund back to it. WPA should contact Mr F to obtain his up-to-date details.

My final decision

For the reasons set out above, I do not uphold the part of the complaint about the claims handling or the claim being declined. However, Western Provident Association Limited (trading as WPA) should make a full refund of the premiums.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F to accept or reject my decision before 16 July 2025.

Carole Clark
Ombudsman