DRN-5450403

## The complaint

Mr N complains about how Western Provident Association Limited ('WPA') handled his private medical insurance claim.

## What happened

Mr N is insured under a group private medical insurance policy, provided by WPA.

WPA pre-authorised a claim for Mr N in early 2023. The medical condition claimed for was originally recorded by WPA as 'coronavirus infection'.

In October 2023, Mr N received a new neurological diagnosis and asked WPA to set up a new claim. WPA didn't set up a new claim and initially told Mr N that the existing claim would be extended to April 2024. However, in a letter dated 29 January 2024, WPA said it considered the coronavirus infection to be a chronic condition which it could provide cover for it until 29 February 2024, after which time the policy's chronic condition benefit limit would apply.

Unhappy, Mr N complained to WPA about various issues relating to this and another claim.

WPA acknowledged errors it had made in dealing with Mr N's claims and paid him £100 compensation, which Mr N returned before bringing the matter to the attention of our service.

In May 2024, WPA said it had reviewed additional evidence and its decision to categorize the claim (now recorded as 'peripheral nerve disease') as chronic remained unchanged. WPA said it would extend cover until 28 August 2024, after which time the chronic condition benefit limit would apply.

One of our investigators looked into what had happened. She issued a number of opinions, ultimately recommending that WPA should pay Mr N a total of £300 compensation for the distress and inconvenience he experienced. Mr N didn't agree with our investigator's opinions, so the complaint was referred to me. I made my provisional decision about Mr N's complaint in March 2025. In it, I said:

*'While I've set out only a brief summary of the background to this complaint, I want to assure both parties that I've read, understood and thought about all the evidence provided. In line with my remit and our service's role as an informal alternative to the courts, I'll be addressing only what I consider to be the key complaint points. I'm not obliged to address every complaint point raised.*

*For the avoidance of doubt, Mr N has confirmed that the other claim which he also complained to WPA about is no longer in dispute. So, I won't be considering or commenting on that other claim within this provisional decision.*

*Under the rules that govern us, the Financial Ombudsman Service has no power to consider a complaint issue unless the business involved has been given the opportunity to review the matter first. Generally speaking, this means I'd usually only be able to consider events which*

*occurred up until the date of a business' final response letter (in this case, 19 March 2024). However, WPA's consideration of Mr N's claim continued beyond that point, up until May 2024. WPA has commented on events up until May 2024 within its submissions to our service and I therefore think it's appropriate for me to consider and address these issues as part of my provisional findings.*

*WPA's decision about Mr N's claim*

*The terms and conditions of the policy which Mr N is insured under say that limited cover is provided for long-term (chronic) conditions. These are defined as:*

> *'…a symptom, disease, illness or injury that has one or more of the following characteristics:*
>
> *•It needs on-going or long-term monitoring or management through consultations, examinations, check-ups, and/or tests;*
> *• It needs on-going or long-term control or relief of symptoms;*
> *• It requires your rehabilitation or for you to be specifically trained to cope with it;*
> *• It continues indefinitely;*
> *• It has no known cure;*
> *• It comes back or is likely to come back'.*

*This definition refers to a 'symptom'. Mr N's symptoms have been ongoing since before this claim was first pre-authorised by WPA. The fact that Mr N received a new diagnosis doesn't mean that WPA is obliged to open a new claim or that WPA must 'restart the clock' in terms of providing cover. The medical evidence which I've seen suggests that Mr N's treatment is for the same ongoing symptoms, so I don't think it was unfair or unreasonable for WPA to consider the October 2023 diagnosis as a continuation of the existing claim and update the medical condition being claimed for rather than opening a new claim.*

*A form completed by Mr N's doctor (who I'll call 'Dr G') in April 2024 says Mr N's treatment plan is 'aimed for a curative outcome without recurrence', but 'scientific consensus'/'science agrees' that this will take between one and three years. I'm satisfied that it wasn't unfair or unreasonable for WPA to rely on this information and consider Mr N's symptoms as being chronic and requiring long-term management or control under the policy terms and conditions.*

*I don't think WPA was required to allow any set period of time for any new treatment of ongoing symptoms to work and, overall, I think WPA's ultimate decision to limit cover after August 2024 was fair and reasonable in the circumstances.*

*WPA's handling of Mr N's claim*

*Industry rules set out by the regulator (the Financial Conduct Authority) require WPA to handle claims promptly and fairly, and to provide appropriate information about the progress of a claim.*

*It's clear to me that WPA didn't handle Mr N's claim in line with industry rules.*
*I don't think WPA's decision to consider Mr N's claim as long-term (chronic) before May 2024 was fair or reasonable in the circumstances. I'm not satisfied that, prior to May 2024, WPA had sufficient medical information upon which to base this decision.*

*There were delays by WPA in recognising that Mr N had received a new diagnosis in October 2023, which were reflected in WPA's delays in updating its records about the medical condition being claimed for. And I think WPA could have explained much more*

*clearly to Mr N why it wouldn't be opening a new claim based on his new diagnosis.*

*WPA has acknowledged, amongst other errors, asking Mr N for information which he had already sent to it and failing to deal with correspondence within its own service standards, as well as administrative problems sending emails. In addition, WPA has told our service that it could have provided a better service to Mr N between issuing its final response letter and May 2024.*

*Of particular importance to Mr N is WPA's statement in its letter of 29 January 2024 that it had requested an update from Dr G, when this wasn't the case. WPA has explained to our service that this was poor wording on its part.*

*WPA told us it received Dr G's report dated October 2023 in January 2024 and it was this report which its letter was referring to. WPA has acknowledged that it should have referred specifically to the October 2023 report in the letter of January 2024 rather than giving Mr N the impression that it had requested further information from Dr G, when this hadn't happened.*

*I've reviewed WPA's claims records to check the accuracy of what WPA has told us. WPA's notes show it first received Dr G's report in early December 2023. WPA then mistakenly wrote to Mr N in January 2024 requesting the same report it already had, receiving another copy of this a few days prior to sending Mr N the letter in question.*

*WPA didn't handle this claim in the way I'd have expected it to, or in line with what I'd consider to be good industry practice, and I've had regard to the regulatory rules which Mr N has referenced. However, I've seen no evidence which would lead me to fairly conclude that WPA deliberately misled Mr N or took advantage of his illnesses. Nonetheless, it would undoubtedly have been helpful if WPA had carried out more thorough checks of its records when dealing with Mr N's claim and complaint, and if WPA had clarified the position in relation to the update from Dr G which it was referring to with Mr N directly as soon as the issue came to light.*

*Having said that, I don't agree with all of Mr N's submissions about how WPA handled matters. While WPA has acknowledged that it already had some of the answers to the questions it asked of Dr G in February 2024, I'm satisfied it wasn't unreasonable for WPA to ask for additional information at this point to help it make a fair decision about Mr N's claim. And I also can't fairly agree that WPA acted unreasonably by contacting Dr G to confirm whether an invoice had been paid by Mr N. I think this is a reasonable enquiry which an insurer is entitled to make in line with its own internal claims handling processes. It's not up to the insured to determine how the claims process runs.*

*But, overall, I'm satisfied that WPA's errors in this case caused Mr N more than the levels of frustration and annoyance which might reasonably be expected from dealing with an insurance claim, and there has been an impact on Mr N which is more than just minimal. I accept Mr N was inconvenienced by having to write multiple letters to WPA and also had telephone calls with WPA which were frustrating.*

*Having taken all the circumstances of this complaint into account, I think a total compensation payment of £300 would be fair and reasonable for the impact of the situation on Mr N. For the avoidance of doubt, this includes the £100 compensation which was already paid and returned.*

*I understand Mr N feels a compensation award of this level doesn't address failings in WPA's conduct but I have no power to punish or sanction a business for its actions through an award of compensation.*

*It's beyond my powers to tell WPA how it should act going forward, and any such direction wouldn't be legally enforceable. If Mr N is unhappy with any of WPA's actions in the future then he'd need to complain to WPA in the first instance before bringing a new complaint to the attention of our service.*

*I'm sorry if Mr N is disappointed with my provisional findings but I'm currently satisfied that a total award of £300 compensation is fair and reasonable in the circumstances.'*

WPA accepted my provisional decision. Mr N set out some additional comments but said he was prepared to accept the provisional 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 taken into account Mr N's response to my provisional decision.

Mr N asked us, in an email dated 31 May 2024, to consider events up until that date (including WPA's decision to limit cover from August 2024), so I'm satisfied that the eventual outcome did form part of this complaint.

WPA provided inaccurate information to our service about when it received Dr G's report, and I've clearly stated that I don't think WPA handled Mr N's claim in line with industry rules. While I appreciate Mr N may have wished for me to use stronger wording when describing WPA's actions, I must act within the limits of my statutory powers and remain independent and impartial. I've seen nothing which would lead me to conclude that WPA's actions were deliberate.

So, overall, I won't be changing my provisional decision.

**Putting things right**

Western Provident Association Limited must put things right by paying Mr N £300 compensation for the distress and inconvenience he experienced.

Western Provident Association Limited must pay the compensation within 28 days of the date on which we tell it Mr N accepts my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

**My final decision**

My final decision is that I'm upholding Mr N's complaint about Western Provident Association Limited, and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr N to accept or reject my decision before 30 April 2025.

Leah Nagle
**Ombudsman**