DRN-5472424

The complaint

Miss H and Mr P are unhappy that BUPA Insurance Limited (BUPA) declined their private medical insurance claims.

What happened

Miss H and Mr P had a group private medical insurance policy through Miss H's employer.

Miss H had left her employment in January 2024. The membership certificate shows cover started on 1 July 2024 and was due to end on 30 June 2025. Miss H's ex-employer ended the cover on 28 October 2024.

On 27 July 2024 and 2 September 2024, Miss H and Mr P contacted BUPA to request pre-authorisation for treatment. These were authorised for appointments/treatments which took place on 1 November 2024 and 13 November 2024.

On 15 November 2024, the treating facility informed Miss H said the treatments weren't covered under the policy as it was no longer in force when the treatments took place. Miss H says her ex-employer agreed for the policy to continue after she had left.

BUPA confirmed the pre-authorised treatments weren't covered as the policy cover had ended and it was Miss H's ex-employer's responsibility to inform her.

Miss H and Mr P made a complaint to BUPA. It maintained its decision to decline the claims.

Unhappy, they brought their complaint to this service. Our investigator didn't uphold the complaint. She didn't think BUPA had unfairly declined their claims.

Miss H and Mr P disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS').

ICOBS says that insurers should act honestly, fairly and professionally in accordance with the best interests of their customers, and that they should handle claims promptly and fairly. I've taken these rules into account when looking at this complaint.

It's not in dispute that Miss H and Mr P followed the correct process of obtaining pre-authorisation codes whilst they had cover. The issue in dispute is that they had treatments after the cover had ended.

I've started by looking at the terms and conditions of the policy as this forms the basis of the insurance contract.

On pages 49, under the heading: '*How your health insurance policy works'*, it states the policy is a group policy and that the contract of insurance is between BUPA and the sponsor (Miss H's ex-employer).

BUPA also explain on page 49 that the policy pays for treatment a member has on the date the treatment takes place while they are covered under the agreement. It doesn't cover any treatment that takes place after the date the cover ends even if BUPA has pre-authorised it.

And on page 51: '*When your cover starts and ends'*. This confirms that cover can be ended by the sponsor and it's their responsibility to inform their employee if the cover has ended.

The policy also states that if the cover ends, so does the cover for everyone else on the on the policy.

Having reviewed the policy terms and conditions, I'm not persuaded that BUPA has unfairly declined to cover Miss H and Mr P's claims. I'll explain why.

I've considered Miss H's comments. She said BUPA should have informed them the cover had ended. However, it's not BUPA's responsibility to inform them because the policyholder is Miss H's ex-employer and not Miss H herself. It's up to her ex-employer to have informed her when the cover had ended.

Miss H said her employer agreed that her policy would continue and that she received confirmation from BUPA of her new policy. I don't doubt this, and I understand she's unable to share the agreement she came to with her ex-employer. But there's no evidence to confirm the cover would indefinitely continue or that a date when cover would end had been agreed. Regardless of this, it's reasonable to assume Miss H would herself have known as this would have been in her agreement with her ex-employer. And even if she hadn't known, I don't think it was BUPA's responsibility to inform her when the cover ended. It's the ex-employer who decided to end the cover.

I note that Miss H has said her ex-colleague received notification from BUPA that cover had ended. However, BUPA says this was a marketing letter advertising another product rather than a letter informing her the cover had ended. BUPA said it cannot confirm why Miss H didn't receive the same letter. But bearing in mind the short time between the policy ending and Mr P's procedure, she would not have been able to make alternative arrangements even if she had received the letter. I don't necessarily agree with BUPA here as we can't be certain of this. But whether she received this letter, it's still not BUPA's responsibility to inform her. The onus was always on her ex-employer. As it stands, Miss H has said the ex-employer agreed to provide cover, but we have no evidence until when. So, on balance, I can't reasonably ask BUPA to pay the claims as it simply followed its processes as per the policy terms and conditions.

I note that BUPA confirmed to Miss H on 21 November 2024 and on 29 November 2024 that they may be able to continue their cover for the period of treatment for Mr P. It said Miss H and Mr P must transfer within three months of the date the scheme ended. And it provided a telephone number to call for advice regarding eligibility. This is also confirmed in the policy document on page 52. I think that was fair and reasonable as Miss H was entitled to continue with the policy on a personal basis.

I understand the ex-employer wouldn't have known of the treatments Miss H and Mr P had

scheduled. But the policy clearly states the contract of insurance is between BUPA and the sponsor, and it's the sponsor's responsibility to inform their employee when that cover was due to end.

Miss H's cover ended on 28 October 2024 and the appointments took place on 1 November 2024 and 13 November 2024. I fully appreciate the difficult situation Miss H and Mr P have found themselves in. And I realise that having to pay for the treatment has become a financial burden for them. However, taking everything into account, I can't reasonably hold BUPA responsible for this.

Overall, I'm satisfied BUPA declined the claims fairly and in line with the policy terms and conditions. I'm sorry to disappoint Miss H and Mr P but it follows that I don't require BUPA to do anything further.

My final decision

For the reasons given above, I don't uphold Miss H and Mr P's complaint about BUPA Insurance Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss H and Mr P to accept or reject my decision before 23 July 2025.

Nimisha Radia
Ombudsman