DRN-5489247

The complaint

Ms S has complained that Western Provident Association Limited ("WPA") declined her private medical insurance claim.

What happened

The background to this complaint is well known to the parties. In summary in October 2024 Ms S completed an application for private medical insurance. The application form asked whether she had had any joint or orthopaedic problems, including foot conditions like bunions. She answered "no".

In January 2025 Ms S contacted WPA to pre-authorise treatment for a bunion. Authorisation was given and Ms S had a consultation and an ultrasound scan. However the Consultant's report said that the condition had existed for ten years. WPA declined the claim and offered either policy cancellation from inception with a partial refund, or continuation with a personal exclusion. Unhappy with either of these options Ms S brought her complaint here. Our investigator didn't recommend that it be upheld. He didn't find that WPA had acted unfairly by declining Ms S' claim or that it had caused any unreasonable delays.

Ms S appealed. She said that she was born with the bunion and it had never been problematic. She said that although she went to her GP in 2014 for some pain she hadn't seen been seen by an orthopaedic doctor and it was only her GP's opinion that the pain might be coming from the bunion. Ms S explained that she had to stop working because she couldn't be on her feet because of the pain - she had an active job. As she was self-employed and couldn't earn she couldn't cover the cost of the operation herself.

Our investigator considered the further representations but remained of the view that it was fair for WPA to treat the bunion as a pre-existing condition.

As no agreement has been reached the matter has been referred to me to determine.

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.

Having done so, and although I'm very sorry to disappoint Ms S, I agree with the conclusion reached by our investigator. I'll explain why.

When considering complaints such as this, I need to consider the relevant law, rules and industry guidelines. The relevant rules, set 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 WPA acted in line with these requirements when it declined to settle Ms S' claim.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a

misrepresentation when taking out a consumer insurance contract (a policy). The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation the insurer has to show it would have offered the policy on different terms or not at all if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

WPA explained that Ms S's policy was fully medically underwritten which meant that it was designed to provide benefit for new symptoms or conditions that occurred after joining and are not related to or resulting from past medical history. When applying for the policy Ms S was asked:

Have you or any family member(s) applying for cover EVER had any orthopaedic surgery/therapeutic injection/ manipulation or treatment as a result of a bone or joint condition?

For example: • Arthroscopy, • Knee or hip disorders, • Joint replacement, • Cartilage/ligament/tendon problems, • Back neck shoulder problems, • Arthritis (osteoarthritis/ rheumatoid/inflammatory arthritis), • Foot disorders e.g. bunions • Fractures

Have you or any family member(s) applying for cover EVER been diagnosed with an orthopaedic condition but not received any treatment?

Ms S answered "no" to these questions. WPA says that based on the evidence received from Ms S' specialist this information was incorrect as Ms S did have a bunion for which she had been to her GP in 2014 and had been referred to Orthopaedics. Given it is not disputed that Ms S had a bunion when applying for the policy, I don't find that WPA wrongly concluded that she had failed to take reasonable care when answering the second question above.

WPA has provided evidence which shows that had Ms S answered the question correctly, a bilateral exclusion for bunions would have been placed on her policy. This means I'm satisfied that the misrepresentation was a qualifying one under CIDRA. WPA has treated the misrepresentation as careless – it has offered to add the exclusion it would have added or cancel the policy and refund the premium less the claim paid. I think this is fair and reflects the remedies available to WPA under the legislation.

It is for Ms S to decide what she would like to do and to let WPA know. But in all the circumstances I can't conclude that she has been treated unfairly or unreasonably by WPA.

I'm sorry my decision doesn't bring her welcome news.

My final decision

For the reasons given above my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms S to accept or reject my decision before 30 June 2025.

Lindsey Woloski
Ombudsman