DRN-5499973

The complaint

Mr M complains that BUPA Insurance Limited has turned down a claim he made on a group private medical insurance policy.

What happened

Mr M was insured under his employer's group private medical insurance policy. Cover under the contract began on 6 August 2023 and was provided on an underwritten basis.

In December 2023, Mr M made an online claim on the policy for mental health treatment. On the claim form, Mr M stated that his symptoms began in January 2012. The claim was therefore declined because BUPA concluded that Mr M's symptoms existed before the policy began.

Mr M later called BUPA to check whether the claim had been correctly turned down. During the call, he said that looking back, he'd had symptoms of the condition far back, but he hadn't recognised them until around two to three months earlier. And he said he hadn't seen a GP about his symptoms or had a diagnosis.

So BUPA asked Mr M to complete a 'Health Practitioner's Questionnaire' (HPQ) form which also required input from Mr M's GP.

However, while the HPQ reflected what Mr M had told BUPA, it maintained its decision to turn down the claim because it still felt his symptoms had existed before the policy began. Therefore, BUPA said Mr M's symptoms were specifically excluded by the terms of the contract.

Mr M was very unhappy with BUPA's decision and he asked us to look into his complaint. He felt that BUPA had discriminated against him due to prior mental health issues and against mental health conditions in general, as symptoms of such conditions often go unnoticed for some time.

Our investigator didn't think BUPA had treated Mr M unfairly. He thought it had been fair for BUPA to conclude that Mr M had likely been experiencing symptoms of a mental health condition before the policy began. So he didn't think it had been unfair for BUPA to find that Mr M's condition was pre-existing and excluded by the policy terms.

BUPA subsequently offered to reimburse Mr M for any medical costs he'd incurred in obtaining the HPQ, if he provided evidence of those costs and proof of payment.

Mr M disagreed with the investigator's findings and he turned down BUPA's offer. So the complaint's been passed to me to decide.

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, whilst I'm very sorry to disappoint Mr M, I don't think it was unfair for BUPA to turn down his claim and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think BUPA treated Mr M fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr M's employer and BUPA. The policy covers private medical treatment of eligible treatment. However, BUPA has also set out a list of risks it's chosen not to cover in a section called 'What is not covered'. One of those policy exclusions says:

'For underwritten members we do not pay for treatment of a pre-existing condition, or a disease, illness or injury that results from or is related to a pre-existing condition.'

Exception: For underwritten members we pay for eligible treatment of a pre-existing condition, or a disease, illness or injury which results from or is related to a pre-existing condition, if all the following requirements have been met:

- *you have been sent your membership certificate which lists the person with the pre-existing condition (whether this is you or one of your dependents)*
- *you gave us all the information we asked you for, before we sent you your first membership certificate listing the person with the pre-existing condition for their current continuous period of cover under the scheme.*
- *neither you nor the person with the pre-existing condition knew about it before we sent you your first membership certificate which lists the person with the pre-existing condition for their current continuous period of cover under the scheme, and*
- *we did not exclude cover (for example under a special condition) for the costs of the treatment, when we sent you your membership certificate and any confirmation of special conditions we send for anyone to whom a special condition applies. '*

BUPA has defined a 'pre-existing medical condition' as:

'any disease, illness or injury for which in the seven years before your effective underwriting date:

- *you have received medication, advice or treatment, or*
- *you have experienced symptoms*

whether the condition was diagnosed or not.'

In my view, the policy terms make it sufficiently clear that where BUPA has provided insurance on an underwritten basis, it won't cover any pre-existing medical conditions a policyholder is claiming for except in specific circumstances – including where a policyholder didn't know about their symptoms before BUPA sent their first membership certificate. BUPA concluded that Mr M had been experiencing symptoms of the condition he was claiming for in the seven years before cover under the policy began. And it concluded he was aware of those symptoms prior to the policy starting. So it considered his condition was a pre-existing medical condition and accordingly excluded from cover. I've therefore carefully reviewed all the available evidence to decide whether I think this was a fair conclusion for BUPA to draw.

Mr M completed an online claim form. On that form, he stated that his symptoms had begun on 1 January 2012. Given this would mean Mr M had clearly been experiencing symptoms within seven years of the policy beginning, I think it was reasonable for BUPA to conclude that his claim was caught by the pre-existing medical condition exclusion.

I note Mr M says he made a mistake when he filled out the form. I accept this is possible. So I've also listened to the claims call Mr M made later that day after his claim had initially been turned down.

During the call, Mr M told BUPA's call handler that he hadn't had a diagnosis or seen a GP. But that looking back, he could see symptoms far back and he alluded to the symptoms having gone on for a long time. I appreciate he said hadn't *recognised* the symptoms until two to three months earlier. And I appreciate that Mr M may not have necessarily known he had symptoms of a potential condition. I've borne this in mind carefully.

But I must weigh up the evidence in the round. Given Mr M originally said he'd been suffering with symptoms since January 2012, as I've said, I think it was fair for BUPA to place some weight on this. Mr M's subsequent description of symptom onset being potentially later was after BUPA had initially declined the claim. And it seems Mr M had been aware of some symptoms, even if he didn't know what they meant. So, on balance, I don't think it was unreasonable for BUPA to conclude that Mr M most likely had been experiencing symptoms of the condition he was claiming for in the seven years before the policy began. And I don't think it was unfair for BUPA to consider that Mr M hadn't met all the exception criteria I've outlined above. Nor do I think the information the GP included on the HPQ form negated BUPA's conclusions on this point.

It seems that Mr M is no longer covered by the policy. And it isn't clear that he incurred any medical costs for the condition while the policy was in force. As cover's ended, BUPA isn't liable for any costs Mr M might later go on to incur. With that said, if Mr M did incur treatment costs while the policy was active and he has further medical evidence he'd like BUPA to consider which gives further information about his symptoms and their onset, it's open to him to send it on to BUPA for its consideration. I'd expect BUPA to assess any new medical evidence in line with its regulatory obligations.

I do appreciate how frustrating BUPA's decision must be for Mr M. But terms excluding cover for pre-existing medical conditions are very common in private medical insurance policies and BUPA's definition of a pre-existing condition is very similar to the definition applied by other insurers in the market.

This means then that I don't think BUPA acted unfairly or unreasonably when it concluded that Mr M was claiming for treatment of a pre-existing medical condition in line with the policy definition. And so, while I sympathise with Mr M's position, it follows that I don't think it was unfair for BUPA to conclude that Mr M's claim wasn't covered by the policy terms.

Nonetheless, I think BUPA has made a fair offer to reimburse Mr M for any costs he incurred because of his GP completing the HPQ form, subject to proof Mr M incurred the fee and proof of payment. I understand Mr M doesn't feel this fairly resolves his complaint but I think it's a reasonable and proportionate offer in these circumstances.

I understand that Mr M has real concerns that BUPA has discriminated against him and against those with mental health conditions in general.

It's not our role to say whether a business has acted unlawfully or not – that's a matter for the Courts. Our role is to decide what's fair and reasonable in all the circumstances. In order to decide that, however, we have to take a number of things into account including relevant

law and what we consider to have been good industry practice at the time.

In this case, I've already explained to Mr M why, having considered everything, I don't think BUPA acted unfairly or unreasonably. So I hope it reassures him to know that someone independent and impartial has considered his concerns.

My final decision

For the reasons I've given above, my final decision is that BUPA Insurance Limited didn't act unfairly or unreasonably when it turned down Mr M's claim.

But I direct BUPA Insurance Limited to reimburse Mr M for any GP fee he incurred as a result of its request to complete the HPQ form, subject to Mr M providing it with proof of that cost and proof of payment.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 28 May 2025.

Lisa Barham
Ombudsman