DRN-5564186

The complaint

Miss C has complained that AWP P&C S.A. declined a claim she made on a private medical insurance policy.

What happened

The start date of the policy was 12 March 2024. It included a moratorium for pre-existing medical conditions, meaning that any condition that Miss C had in the last five years would be excluded from cover.

On 22 May 2024 Miss C registered a claim for an eye condition. She then met with a consultant and underwent some tests, for which she requested reimbursement from AWP. Upon receiving the consultant's clinic letter, AWP declined the claim on the basis that the condition was pre-existing. It did then say that it would cover the costs incurred so far, although that was later rescinded.

Our investigator thought that AWP had acted reasonably, in line with the policy terms and conditions. Miss C disagrees and so 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 AWP by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for AWP to handle claims promptly and fairly, and to not unreasonably decline a claim.

The complaint involves the actions of the claim administrators, acting on behalf of AWP. To be clear, when referring to AWP in this decision I am also referring to any other entities acting on its behalf.

As mentioned above, Miss C rang AWP to set up the claim on 22 May 2024. The symptom she wanted investigating was a blind spot in one eye. She said she had a referral from her GP and a report from her optician, and she was asked to send both of those in. She then sent in the GP referral but not the optician report, for which AWP chased her on 28 May 2024.

Miss C went ahead and met with a consultant ophthalmologist on 6 June 2024. She then had further tests done on 11 June and 13 June 2024.

Although she says that AWP had fully approved the claim, that's not quite the case at this point as it was still assessing the claim and awaiting documentation to do so. Whilst the claim was registered and she was given a claim reference number, she had not received any pre-approval for treatment.

Miss C says its common practice on the part of AWP for policyholders to pay the costs up front and for it then to provide reimbursement. That may be the case, but only if the treatment has been pre-approved or the claim is ultimately accepted. She says herself in her complaint form to this service that she was told *if* the claim was approved afterwards, she would be reimbursed.

It wasn't until 26 June 2024 that Miss C provided a copy of the optician report. It was dated from 16 May 2023 and recorded that she: "*Feels like LE has a 'larger blind spot' – been noticing this for a year – not constant.*" Therefore, it's clear from this that she'd been experiencing this symptom since at least May 2022.

Unfortunately, AWP made a mistake at this point. It should have assessed the optician report to conclude that the condition was pre-existing and therefore declined the claim. However, it instead responded on 27 June 2024, approving the claim and saying it was happy to cover an initial assessment, standard tests and a follow up appointment. It's important to note however, that Miss C did not undertake treatment and incur those medical costs because of this mistake – she'd already taken the decision herself to embark on treatment before this point, in advance of receiving approval.

Later on 27 June 2024 Miss C forwarded AWP the consultant's clinic letter from her appointment on 6 June 2024. It was upon reviewing this letter that AWP realised its mistake. The consultant reports that Miss C had been experiencing the blind spot for about 12 months, so this is when AWP recognised the condition as pre-existing prior to the start of the policy. It emailed Miss C on 28 June 2024 to say that it had overturned its decision to cover the claim.

As I understand it, Miss C isn't disputing that her condition was pre-existing and that therefore it is not covered under the policy terms. Her argument is that AWP accepted the claim having received the optician letter. The consultant's letter contains no material new information, so it shouldn't be able to rely on that to reverse its decision.

When a business makes a mistake, we wouldn't necessarily expect it to honour what it had said in error. An important consideration is the impact that error had on the consumer. In this case, Miss C had already undergone an initial consultation and tests. She was told on 27 June 2024 that those costs would be covered and then she was told the next morning that they wouldn't be. She suffered some loss of expectation that the costs would be reimbursed. However, that expectation was fairly short-lived.

When Miss C objected and pointed out that the information about the symptom being pre-existing was present in the optician report, the claims adviser responded that AWP would cover the claim as previously agreed (so the initial assessment, standard tests and a follow up) but that the claim would not be extended beyond that point.

Miss C's original complaint was therefore actually about any ongoing claim not being covered. AWP has said that the adviser was not authorised to make that offer, which should have been a management decision. It therefore rescinded the offer, although that was not made explicit in its complaint final response letter (FRL) of 31 July 2024.

When considering a complaint and deciding whether it would be appropriate to award redress, I look at what did happen in comparison to what should have happened, and if there has been any detriment as a result.

Looking at the circumstances of this case, there are a number of things that should perhaps have happened differently.

I've listened to the phone call of 22 May 2024 in which Miss C calls to register the claim. She says she has a blind spot out of one eye which she only noticed recently. The adviser asks her how long she'd had the symptoms for and she says that it started at the beginning of April 2024. Given the contents of the optician report from May 2023, it's clear that the symptoms had begun much earlier, even if they weren't constant. A couple of weeks later she told the consultant that she'd had the symptoms for about 12 months. Had she accurately declared that to AWP, I consider it would have told here then and there that the claim would not be covered.

Miss C was asked for the optician report during this call. Had she provided that at the first time of asking, there is a possibility that the pre-existing nature of the condition would have been identified at that point and therefore the claim would have been declined then. Also, Miss C didn't wait for the claim to be assessed and treatment pre-approved, before undergoing treatment.

When the optician report was eventually provided on 27 June 2024, AWP should have reviewed its contents to conclude that the claim would not be covered.

During the complaints process, AWP identified that the claim adviser's offer to cover the initial costs was made in error and it therefore rescinded that offer. Whilst I'm satisfied that the outcome of the FRL was that none of the claim would be covered, it failed to make that sufficiently clear. Therefore, Miss C had a second loss of expectation when she later found that out.

Disregarding Miss C's non-disclosure of the pre-existing condition, if things had happened as they should, the claim would have been declined on 27 June 2024 and she also would have understood that none of the claim was being paid. Although that didn't happen, it doesn't necessarily follow that the claim should now be paid.

She arranged the initial consultation and tests without any guarantee that they would be covered. So, I consider that she would have gone ahead and incurred those costs anyway. Therefore, the position she's in now is the same as she would have been in had the errors not occurred and the claim declined on 27 June 2024.

I've thought very carefully about what Miss C has said and have some sympathy with some of her arguments. Whilst acknowledging that her claim and complaint weren't dealt with as well as they could have been, on balance, I'm unable to conclude that AWP did anything significantly wrong. Overall, I consider it was reasonable for it to decline the claim in its entirety. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss C to accept or reject my decision before 18 July 2025.

Carole Clark
Ombudsman