

The complaint

Mr S is unhappy with how Vitality Health Limited (Vitality) has handled his private medical insurance claim.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Mr S has a private medical insurance policy which he took out in June 2024. The policy is underwritten by Vitality and was set up on a moratorium underwriting basis. This means that no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required. And any pre-existing conditions from the previous five years of starting the plan are excluded which can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

Mr S contacted Vitality on 6 November 2024. He uploaded a private GP referral form for treatment under his policy. Vitality reviewed the information and because it wasn't sufficient, it asked for Mr S's GP medical records so it could assess the claim.

Mr S made a complaint to Vitality. It said Mr S's medical records are required from his GP to progress the claim.

Unhappy, Mr S brought his complaint to this service. Our investigator didn't uphold the complaint. She didn't think Vitality had treated Mr S unfairly.

Mr S 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 relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of this policy and the circumstances of Mr S's claim, to decide whether Vitality treated him fairly.

The starting place on this complaint is the policy terms and conditions. I've considered the relevant sections that apply to this complaint.

The policy was set up on a moratorium basis. So, no medical underwriting took place. As such when a claim is made, medical records are required for review and assessment by Vitality. Vitality said the claim was also made a few months after the policy was taken out. Therefore, there is a requirement for the GP to provide Mr S's full medical information and

for a form to be completed where specific questions are asked.

Mr S's private GP referral form on 10 November 2024 stated that he was experiencing breathing issues. The GP referred Mr S to a cardiologist. As the policy was a moratorium one and the referral form said past medical history was missing, I don't think it was unfair for Vitality to request access to Mr S's medical records to progress and validate the claim.

Whilst Mr S said the email he received on 13 November 2024 was confusing, I don't agree. This email was sent to Mr S so he could provide his consent for Vitality to contact his NHS GP and to request his medical records. The email is clear and it states that information is required from a GP who has Mr S's full medical records.

Mr S said a central part of his complaint relates to the misleading information presented on Vitality's online dashboard. This instructed him to access outpatient treatment and led him to believe cover had been confirmed. He incurred consultation costs but then the claim was declined due to incomplete underwriting. As far as I can see, Vitality hasn't declined Mr S's claim. It's simply asked for Mr S's full medical records which it is entitled to see, under the policy terms and conditions, before making a decision on the claim. Mr S went ahead with the consultation, but I can't see that Vitality had confirmed the claim had been approved.

Mr S also said that he didn't receive the Docusign link which he needed to complete to consent the release of his medical records. Whilst I understand that he might not have received the link, I can see emails were sent to Mr S which referred to the link being sent. I understand Mr S did inform Vitality he hadn't received the link and it sent him another link. If Mr S still hadn't received it then I would have expected him to let Vitality know. It's not unusual for insurers to ask for consent from a policyholder before medical records are accessed so I don't think Vitality did anything wrong but it followed the claims process.

Mr S said he provided his medical history through his NHS patient access system. I note this was a summary of his past and present medical information. However, Vitality said this information wasn't sufficient for it to assess the claim and therefore required Mr S's GP to provide his full medical records. I don't think Vitality needs to justify why it required the full medical records. The policy terms and conditions state that Vitality may require information as necessary to validate a claim. Additionally, as the policy is set up on a moratorium basis, I'm satisfied Vitality didn't act unfairly or unreasonably here as these needed to be reviewed.

I don't think Vitality specifically stated that it needed a referral form from a private or NHS GP. But it is a requirement, under the policy terms, that a GP referral must be completed by a GP who holds a policyholder's full medical records – whether that is a private GP or an NHS GP is regardless. What is relevant is that it has to be a GP who has the policyholder's full medical records.

Overall, I'm satisfied that Vitality has followed its process when handling Mr S's claim. I don't think it's treated Mr S unfairly or outside the terms and conditions of his policy. I understand Mr S was frustrated by the process and from his perspective, he'd sent Vitality the GP referral form and his medical records which he could access from his NHS patient information. However, this wasn't enough in the circumstances here. The policy terms and conditions are clear in what information will be needed when a claim is made. And having looked at everything, I don't think Vitality provided misleading information or treated Mr S unfairly.

Vitality said it requires Mr S's medical records from his GP to progress and assess the claim. Unless Mr S provides this, it can't proceed with the claim. This seems fair and reasonable. If Mr S wishes to therefore progress his claim, he should contact Vitality directly.

My final decision

For the reasons given above, I don't uphold Mr S's complaint about Vitality Health Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 26 September 2025.

Nimisha Radia
Ombudsman