DRN-5574316

The complaint

Mrs O is unhappy that Vitality Health Limited (Vitality) declined her private medical insurance claim and applied a retrospective exclusion.

Mrs O is being represented by her husband, Mr O, on this complaint.

What happened

Mrs O took out a private medical insurance policy with Vitality in May 2023 on a '*Continued Personal Medical Exclusions*' (CPME) underwriting basis. She switched from her existing provider.

In September 2023, Mrs O submitted a claim to Vitality as she was experiencing back pain and wanted to see a specialist.

Vitality declined the claim and added a retrospective exclusion. It said Mrs O failed to disclose that she had lumbar spinal stenosis and had treatment for this, when she took out the policy. And if she had disclosed this, an exclusion would have been applied on the policy.

Unhappy, Mrs O brought the complaint to this service. Our investigator upheld the complaint. He didn't think Vitality showed sufficient evidence of misrepresentation by Mrs O when she took out the policy. He recommended that Vitality deals with the claim subject to the remaining policy terms and conditions and add 8% interest. And as Vitality accepted there were delays in providing its final response and offered £150, the investigator thought this was fair and reasonable.

Mrs O disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me.

I issued a provisional decision to both parties on 14 May 2025. I said the following:

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

There are two aspects to this complaint. The first one is non-disclosure and the second is customer service. I'll separate these below.

Non-disclosure

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 must 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.

I've gone on to think about this when looking at Mrs O's complaint and her individual circumstances. Vitality has said Mrs O failed to take reasonable care not to make a misrepresentation when she didn't disclose all the medical information she should have when the policy was taken out.

Vitality said Mrs O was required to answer the following question:

> *'In the last 3 years, have you or any other person to be insured:*
>
> *• Experienced symptoms;*
>
> *• Received any advice from a healthcare professional;*
>
> *• Received treatment or have treatment planned or expected;*
>
> *for any physical, mental health, psychiatric or behavioural problems?'*

The application form explained that 'treatment' meant:

> *'medical care (including diagnostics and tests), investigations, surgery, medication (including over the counter), therapy or advice, provided for an illness, disease, injury or ailment?'*

I think the question was clear and was answered 'No' by the Vitality advisor. As the answer was 'No', further questions didn't follow.

Vitality required medical information from Mrs O's GP so requested a claim information request form (CIR) to be completed. The GP said Mrs O's symptoms first started in July 2017 and she was diagnosed with spinal stenosis in 2019 when she had an injection. She had a further injection in January 2023. And in regard to the recent episode relating to the claim, Mrs O said in her claim form that symptoms were first noticed in October 2022 and the doctor was consulted about this in June 2022. So, Vitality said Mrs O had experienced symptoms in her back in the three years before the policy started in May 2023. Based on this information, I don't think it was unreasonable for Vitality to say that Mrs O should have disclosed her condition in her application.

Having reviewed the above medical question that was asked, as I've said, I think it was clear. And I don't think it was unreasonable for Vitality to have expected Mrs O to have answered this accurately. And based on the answer provided and the completed claim from by the GP, I'm satisfied the medical question wasn't answered accurately.

I've considered what happened when the policy was taken out. A quotation and a 'Record of meeting' form was sent to Mrs O on 1 June 2023. The advisor asked Mr O (as he was dealing with the application on Mrs O's behalf) to review the information on these and to confirm back that they agreed with the proposed and wanted to proceed with the application.

The medical question (mentioned above) on the application was shown as answered 'No'. Vitality said this question was answered as such based on the information provided by Mr O

that Mrs O had no medical condition or treatment in the previous three years. The advisor drew Mr O's attention to the underwriting requirements and the customer declaration to ensure that they understood the information and that it was full and honest.

Mr O checked his understanding on 1 June 2023 before accepting the quotation. Mr O asked:

> *'To be clear in my mind, I understand that by accepting the quote, I am obtaining cover for exactly the same medical conditions as are covered in my present Bupa policy. I do not need to complete the medical conditions section of the Record of Meeting, as there are no conditions excluded.'*

The advisor confirmed this was correct (based on the telephone discussion he had with Mr O). The advisor said Mr O had said Mrs O hadn't any medical conditions or treatment in the previous three years. And that was why Mr O didn't need to complete any further medical information as the answer was 'No' to the question already asked.

Mr O confirmed that they wanted the policy switch from the previous provider to go ahead. I understand there's a dispute about the medical condition and the discussion that took place. I'll address this further below. But it was also Mr O's responsibility to check the medical question was accurately completed and whilst I understand he sent an email to check his understanding to the advisor, it's clear that he had read both documents and specifically mentioned the medical conditions section. The question was clear, and the expectation would have been for Mr O to check the information provided was accurate. The quotation confirmed the medical question was answered as 'No'. And the medical conditions section was left blank by the advisor on the 'Record of meeting' form. This was because of the previous discussion with Mr O in which he'd confirmed to the advisor that there were no conditions or treatment in the previous three years before taking out a policy. I can see Mrs O had an injection for her back pain in 2023 and even if Mr O hadn't remembered what happened in 2017 and in 2019, it's highly likely he would have known about the most recent injection. Mrs O has also said in her claim form that symptoms started in 2022.

In terms of non-disclosure of the medical condition, I've gone on to think about whether failing to take reasonable care makes a difference in this case.

Vitality has shown if Mrs O had declared her medical condition and treatment accurately, an exclusion would have been applied on the policy. Under CIDRA, Vitality has classified this as a qualifying misrepresentation and for this to have been careless. Vitality is entitled to do this. I agree with Vitality that the misrepresentation was careless, as I appreciate that Mrs O was not attempting to deliberately mislead Vitality. And I'm satisfied this is fair and reasonable.

The remedy available to Vitality under CIDRA is that it can apply the exclusion retrospectively to the policy, as it has done. It follows that it was appropriate for Vitality to decline the claim, as this fell under the exclusion.

<u>Distress and inconvenience</u>

Mr O says Mrs O's back condition was never discussed with the advisor. Vitality says Mr O informed the advisor about the medical condition, but he said Mrs O had no symptoms or treatment in the previous three years. So, the advisor answered the medical question as 'No'.

Because there is no call recording, I have to determine what I think most likely happened based on the evidence available.

There's no dispute the quotation and the 'Record of meeting' was received by Mr O and Mrs O as subsequent emails between Mr O and the advisor refer to these.

I've considered that even if Mr O wasn't clear in the telephone discussion about the information he was required to provide, they did read the application form and the 'Record of meeting' form. There was nothing unclear or ambiguous – the medical question was clear, and it was answered as 'No'. I've considered that even if Mr O was confused in the telephone discussion about the information he was required to provide, he did read the documents. However, I also think Vitality could have communicated this more clearly to Mr O. He reached out to Vitality for some guidance in completing the application form. Whilst I understand that Mr O was in receipt of the application form and a copy of the 'Record of meeting' form, based on what happened, I don't think the advisor clearly explained to Mr O that he'd been informed Mrs O's back condition happened more than three years prior to the policy start date. It's evident there was confusion in the communication. And in the absence of the call recordings, I think the advisor could have communicated better and recorded the discussion about the medical condition and why the medical question was answered as 'No'. There was a separate section on the 'Record of meeting' form for notes but there's no further information there either.

Overall, I do understand that the whole situation has been frustrating for Mrs O and the situation has impacted her. I think ultimately the claim has been declined fairly based on the terms and conditions of the policy. And while Mr O could have declared the medical condition accurately as there were opportunities for him to have corrected this, I think Vitality could have communicated and recorded the discussion better. The situation has caused Mrs O additional stress and inconvenience that hasn't been taken into account in the circumstances here. I therefore think an additional compensation award of £150 (making it a total of £300) is fair and reasonable in the circumstances of this complaint.

I'm minded to direct Vitality to do as I've set out below.

I now invite both parties to provide any further comments to me by 28 May 2025.

Vitality responded and said it had no further comments to add.

Mr O replied on Mrs O's behalf and provided some comments. I'll address these in the section below.

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.

Mr O, in summary, said:

- They are disappointed with the provisional decision.
- They were comparing what they thought was like for like alternatives and there was no intention to misrepresent.
- They were fully aware the application requested further information and that was why Mr O contacted the advisor on the telephone and also finally by email to ask if he should be filling in the medical section. So based on the answer the advisor provided that Mr O's understanding was correct, they went ahead with the policy. This understanding was confirmed again.
- Mr O requested the reassurance in writing as he would never have taken out the cover had he known Mrs O wouldn't have been covered.
- They have had to pay for treatment for Mrs O's back and any new policy has

removed the possibility of cover for her back.

Firstly, I am sorry to disappoint Mrs O and Mr O. I realise that the situation has been stressful, and they have had to pay for treatment for Mrs O's back for which they thought had cover.

However, I must decide based on the evidence available and on the balance of probabilities. In my provisional decision, I've taken into account that there were telephone discussions and emails between Mr O and the advisor. And further to those, paperwork was sent to Mr O. The questions asked on the application form and recorded on the *'Record of meeting'* form were clear. Whilst they were answered '*No*' by the advisor, I think it's more likely this was because a discussion took place on the telephone about Mrs O's medical conditions which confirmed there was no conditions in the previous three years. It didn't help that there was no call recording.

But even if this conversation didn't take place in the way Vitality has said, I would have expected Mr O (on Mrs O's behalf) to highlight that the question hadn't been answered accurately. I understand that he asked if cover was being provided for the same medical conditions as their previous policy, but that isn't the same. They were aware that Mrs O had an injection and had a diagnosis, and the most recent injection was in January 2023 – just a few months before taking out the policy. So, it was clear in asking for the reassurance that Mr O had read the question and the answer to this.

CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). The standard of care required is that of a reasonable consumer. So, it would have been reasonable for Mr O to raise the issue and provide an answer that was accurate at the time of the application.

I do appreciate that the misrepresentation wasn't intentional and that is why, under CIDRA, it has been classified as careless. I think this is fair and reasonable.

I also understand the impact of this situation is that they have had to pay for Mrs O's treatment for her back. And any future policies will potentially remove the possibility of cover for this condition. Again, I'm sorry for this. But not all insurance policies cover for every eventuality and with this policy, Mrs O had a pre-existing medical condition which would not have been covered if it was declared accurately at the start. I can't comment on what would have happened if Mrs O had remained with their previous provider. But in the circumstances here, I don't think the claim was declined unfairly or that Vitality unfairly added an exclusion retrospectively.

And overall, I think there was a failing in Vitality's communication, so I think £300 total compensation is fair and reasonable for what happened.

Putting things right

I direct Vitality to put things right by:

- Paying Mrs O £300 total compensation for the distress and inconvenience caused in its poor communication.

My final decision

For the reasons given above, my final decision is that I partly uphold Mrs O's complaint about Vitality Health Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs O to accept or reject my decision before 19 June 2025.

Nimisha Radia
Ombudsman