

The complaint

Mr O complains about Vitality Health Limited's decision to avoid his private medical insurance policy due to misrepresentation and turn down his claim because of this.

What happened

Mr O held private medical insurance cover with an insurer (that I'll call Insurer A) which had been taken out on a moratorium underwriting basis.

In March 2024, Mr O switched to a policy with Vitality. The underwriting type for the Vitality policy was 'continued personal medical exclusions'. This meant that his moratorium with Insurer A transferred to his Vitality policy, as well as any exclusions.

A few months later, Mr O was sadly diagnosed with cancer. He made a claim under the Vitality policy for surgery that had been arranged for early June 2024. Vitality assessed the claim, but hadn't made a claim decision by the time Mr O's surgery took place. Mr O complained to Vitality about the time taken to assess his claim.

Vitality issued its first final response to the complaint on 27 June 2024. It explained the actions it had taken to assess the claim, but said it still wanted more information before it could make a decision on the claim.

Further correspondence took place between the parties. After receiving a further complaint about its handling of the claim, Vitality issued a second final response on 3 September 2024. It set out what had happened since its previous response. It then let Mr O know that it had decided to turn down his claim, as it thought he had misrepresented information about his health when applying for the policy. Though Vitality accepted there had been some avoidable delays in it considering its position and it offered Mr O £300 compensation for this.

Vitality sent Mr O a separate letter, also on 3 September 2024, confirming that his policy had been avoided due to misrepresentation and that his claim had been turned down. Vitality said it thought Mr O's misrepresentation had been deliberate and so it wouldn't be returning the premiums he'd paid.

Unhappy with Vitality's responses, Mr O brought a complaint to this service. Mr O explained that he hadn't immediately cancelled his cover with Insurer A when he took out his policy with Vitality, and therefore the cost of his surgery had been covered by Insurer A. He had cancelled his policy with Insurer A on 12 June 2024. He thought Vitality's handling of the matter had prevented him from continuing his cover with Insurer A.

Our investigator recommended the complaint be partly upheld. She agreed with Vitality that Mr O had misrepresented information about his health when taking out the policy, but she thought this had been careless rather than deliberate. She recommended that Vitality return the premiums Mr O had paid, plus interest. She thought the £300 compensation Vitality had previously offered for claim delays was fair.

Mr O accepted our investigator's recommendations, though Vitality did not. Therefore, the matter 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.

As Vitality says that Mr O failed to tell it relevant information about his health when taking out the policy, I need to consider the matter in accordance with the principles set out under the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA), which concerns misrepresentation.

Under CIDRA, there's a duty on a consumer to take reasonable care not to make a misrepresentation to an insurer, and if a qualifying misrepresentation is made, it sets out the remedies that are available to the insurer.

Vitality says that Mr O deliberately misrepresented information about his health when taking out the policy, as he didn't tell it about an abnormal result following a blood test he had in February 2024, which led to a referral to a specialist. And that he also failed to tell it that he had a knee condition.

Mr O took out the policy with Vitality via a broker. I note that Vitality has continually referred to two questions (one that related to the applicant's previous 12 months of health, and another that asked if the applicant had ever had any joint disorders) throughout its correspondence with Mr O as well as this service. I've established with Vitality that these questions weren't asked.

Instead, Mr O was asked the below questions when applying for the policy:

'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?'

Mr O answered 'yes'. This led to the following being asked:

'When did you or any other person to be insured last experience symptoms, receive advice from a healthcare professional, or receive any treatment (including prescribed or over the counter medication) relating to the following?

...

(Please advise us of the most recent time period for each condition i.e. if you have treatment or advice planned, anticipated or expected and you also had treatment 1-3 years ago, please select "treatment or advice planned, anticipated or expected")'

The answer options available to Mr O were:

- Not in the last three years or never
- Between one and three years ago
- Within the last year
- Currently experiencing symptoms, or treatment or advice is planned or expected

Mr O was then asked about various medical condition groups, including 'Cancer' and 'Arthritis, joint pain or injury'. In response to both of these, he answered 'Not in the last three years or never'.

Under a final section for 'Any other condition not declared above', Mr O answered 'Within the last year'. He wasn't asked any further questions relating to this disclosure.

I've considered the medical information to decide if Mr O misrepresented information about his health when answering the above.

Mr O had a history of osteoarthritis in his left knee. He had an osteotomy for this in 2019 which was complicated by infection. He remained in pain and so had a partial knee replacement in November 2023. In response to the medical condition group 'Arthritis, joint pain or injury' I think Mr O should have answered 'Within the last year', as the policy was taken out in March 2024. So, I agree with Vitality there was misrepresentation regarding his knee condition.

Mr O saw a private physician for some blood tests (that he describes as routine) on 13 February 2024 and was subsequently referred to a specialist. The GP referral letter said Mr O's latest CEA cancer marker was elevated. Mr O saw that specialist shortly after the policy had started.

Vitality thinks that Mr O was aware his raised CEA marker could mean he had cancer, as the referral letter mentioned cancer, and Mr O had provided a copy of the referral letter to Vitality. It has told this service that Mr O ought to have disclosed his elevated CEA level under the medical condition group of 'cancer' in the application form, despite previously telling Mr O that it accepted he had answered the 'cancer' section correctly.

Although Mr O sent a copy of the referral letter to Vitality, he only did so after he made his claim (on 29 May 2024). I haven't seen any evidence to show that he was provided with a copy of the referral letter by his GP before he took out the policy with Vitality and therefore ought to have known that his raised CEA level might indicate cancer. So, I don't agree with Vitality that Mr O ought to have made a disclosure under the 'cancer' section.

However, when the policy was taken out, Mr O was aware he'd had a blood test and had been referred to a specialist where he would likely have investigations and receive advice. Mr O denies knowing that it was anything to do with cancer at the time, and explains he thought it was because the blood test showed he had anaemia. Nonetheless, I agree with Vitality that in response to the medical condition group 'Any other condition not declared above' Mr O ought to have selected the response 'Currently experiencing symptoms, or treatment or advice is planned or expected'.

Vitality has shown me that if Mr O had answered the relevant sections in the way that I've said above, he would have been asked for more information about the conditions. If he'd disclosed his knee problem and blood test as I think he ought to have done, then Vitality has shown that this would have led to referrals to its underwriter. I'm satisfied Vitality would have therefore learnt of Mr O's partial knee replacement in 2023 and that he had an elevated CEA level in February 2024.

Therefore, I agree with Vitality there was misrepresentation in respect of both Mr O's knee condition and his blood test.

I've also considered whether Vitality has shown that the misrepresentation was qualifying, according to CIDRA. In other words, if Vitality has shown that, without the misrepresentation,

it wouldn't have entered into the contract with Mr O at all or would have only done so on different terms.

Vitality has provided evidence to show that if it had known that Mr O had undergone a partial knee replacement in 2023, it would have applied an exclusion for '*partial left knee replacement and related conditions, including any repeats/revisions*'.

Vitality has also shown that if it had known of Mr O's elevated CEA level, it would have either refused to provide cover at all, or would have waited to make a decision until the investigations were complete and he had a diagnosis. Vitality has said that its approach to decline/delay the underwriting in situations such as this is to reduce its risk associated with a potential future diagnosis of cancer. It has confirmed that if it had delayed making a decision rather than declining the application at the outset, because Mr O was then diagnosed with cancer, it would have refused to provide cover at that point.

So, I'm satisfied the misrepresentation was qualifying, according to CIDRA.

The next point for me to consider is whether Mr O's misrepresentation was careless, or deliberate/reckless. Vitality considers it to be deliberate/reckless, which is why it kept the premiums Mr O paid rather than returning these to him. Under CIDRA, when a misrepresentation is deliberate/reckless, an insurer can avoid the policy and retain the premiums paid.

CIDRA says:

'(2) A qualifying misrepresentation is deliberate or reckless if the consumer—

- (a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and*
- (b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.*

(3) A qualifying misrepresentation is careless if it is not deliberate or reckless.

(4) It is for the insurer to show that a qualifying misrepresentation was deliberate or reckless.'

In response to the section '*Any other condition not declared above*' Mr O did declare that he'd experienced symptoms/received advice or treatment in the last year. We've asked Mr O for more information about this. He's unsure why he'd answered in this way, but said the only other thing he had was a partial knee replacement. Vitality has shown that Mr O answering this particular section in this way didn't prompt it to ask him any further questions. Though of course Mr O couldn't have known that Vitality wouldn't want to know more information about his declaration.

It therefore seems to me that Mr O did take some care over his answers, even though I've found he ought to have disclosed his knee problem under a different condition group.

Mr O has further explained that he understood the policy would be transferring across his previous moratorium terms from Insurer A, and therefore he was aware he wouldn't have any cover for his knee condition (as it fell under the moratorium with Insurer A). So, he didn't think the information relating to his knee condition was relevant. Taking all this into account, I'm minded to agree with our investigator that the misrepresentation in respect of Mr O's knee problem was careless rather than deliberate.

Regarding the elevated CEA level, Mr O has explained that he didn't think of this when he answered Vitality's questions. He says he thought his referral to the specialist was taking place because he was anaemic and wasn't anything serious that needed to be disclosed. I note from his medical records that his blood test did show iron deficiency anaemia as well as the slightly raised CEA.

Vitality says it thinks Mr O deliberately misrepresented his symptoms and history in respect of the blood test in order to obtain cover for a possible claim. I don't agree with Vitality here. I think Mr O's explanation supports that whilst he was careless in his answer, he wasn't intentionally trying to deceive Vitality in order to obtain cover for cancer. Also, Mr O already held cover with Insurer A. Mr O says if he had the slightest idea his raised CEA level might mean he had cancer, he wouldn't have switched his cover and would have remained with Insurer A. On balance, I don't think Vitality has shown that Mr O's misrepresentation in respect of the blood test was deliberate or reckless.

So, I find that the misrepresentation for both the knee condition and the elevated CEA marker was careless.

CIDRA explains that when a misrepresentation is careless, the remedy available to the insurer is based on what it would have done if there hadn't been a misrepresentation. And if the insurer wouldn't have entered into the contract at all, it may avoid the policy and refuse all claims but must return the premiums paid.

As I'm satisfied that Vitality wouldn't have offered Mr O cover at all had it known about his raised CEA marker (or it would have delayed making a decision on this until his diagnosis was known, and then refused to provide cover), I find that it was entitled to turn down his claim and avoid his policy. But it should return the premiums paid, plus interest.

Mr O's wife was also covered under the policy. I understand Vitality offered to continue her cover separately (though she didn't accept). But the only option under CIDRA was for Vitality to avoid the whole policy. That means it should refund all the premiums paid.

Our investigator thought it would be reasonable for Vitality to pay interest on the refund of premiums from 5 August 2024 to the date of reimbursement, as she thought Vitality ought to have made a decision by this date. That seems reasonable to me.

Vitality says that Mr O had altered his medical records before it had received the unedited version from his GP. But it hasn't provided any evidence of that to this service, despite our investigator asking for this.

Vitality has already accepted there were some avoidable delays in its handling of the policy avoidance and claim. As our investigator has pointed out, when an insurer has reason to consider that a misrepresentation has been made, it's appropriate for it to investigate this. Having said that, it seems it took Vitality around six weeks to make a decision after it received Mr O's GP records in late July 2024. I think this was too long, but I'm satisfied the £300 compensation Vitality offered Mr O to recognise the impact of this delay was reasonable.

Vitality let Mr O know that it had concerns about misrepresentation in late May 2024. Its Medical Affairs team reviewed the information held at that point, and on 6 June 2024 it was thought cover would have been withheld if it had known of his elevated CEA level. Though its Medical Affairs team also wanted to carry out a further review. Vitality therefore obtained further medical information before making a decision on this.

Mr O is unhappy that Vitality didn't tell him on 6 June 2024 that it wouldn't have offered him cover if it had known about his elevated CEA level. His policy with Insurer A was still in place at this time, and so he explains he wouldn't have cancelled that policy in mid-June 2024 if he had known that Vitality would be avoiding his policy.

Whilst I can understand Mr O's frustration with the timing of events, I don't think Vitality did anything wrong here. Vitality thought there may have been misrepresentation on Mr O's part, but this was based solely on the GP referral letter. It wanted further medical information before making a decision on this. I think that was reasonable.

When Vitality avoided Mr O's policy and turned down his claim, it also referred to the fraud condition under the policy. Though it did then refer to CIDRA in the same letter, so it seems its decision to avoid the policy was based on its view there had been deliberate misrepresentation (based on CIDRA) rather than a conclusion that Mr O had been fraudulent. In any event, I've found that Mr O's misrepresentation was careless rather than deliberate. So, I don't think there was deliberate misrepresentation or that he fraudulently tried to deceive Vitality. Therefore, if Vitality has placed any fraud markers against Mr O's name either internally or externally, it should remove these.

My final decision

My final decision is that I partly uphold this complaint. I require Vitality Health Limited to do the following:

- Refund the premiums. Interest at the rate of 8% simple per annum should be added to this amount from 5 August 2024 to the date of reimbursement*
- If Vitality hasn't already done so, it should pay Mr O the £300 compensation it previously offered him**
- Remove any internal or external fraud markers against Mr O's name.

* If Vitality considers that it's required by HM Revenue & Customs to take off income tax from that interest, it should tell Mr O how much it's taken off. It should also give Mr O a certificate showing this if he asks for one, so he can reclaim the tax from HM Revenue & Customs if appropriate.

**Vitality must pay the compensation within 28 days of the date on which we tell it Mr O accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr O to accept or reject my decision before 5 November 2025.

Chantelle Hurn-Ryan
Ombudsman