

The complaint

Mr J complains that Vitality Health Limited has turned down a cash benefit claim he made on a personal private medical insurance policy.

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 main events.

On 30 April 2023, Mr J took out a personal private medical insurance policy. Vitality offered insurance on moratorium terms, which meant it wouldn't cover any pre-existing conditions a policyholder had had in the five years before the policy began.

Unfortunately, in August 2023, Mr J was diagnosed with prostate cancer. And in January 2024, he made a claim for NHS cash benefit after he'd undergone cancer treatment through the NHS.

Vitality asked for medical evidence so it could assess Mr J's claim. Mr J and his GP sent it evidence which stated that Mr J's symptoms had begun in May and June 2023. But Vitality noted that on 5 June 2023, Mr J had made an online consultation request due to weak urinary flow for a couple of months. And a GP letter said that Mr J had been seen on 27 June 2023 with urinary symptoms of a few months' duration. So Vitality concluded Mr J had been experiencing symptoms of prostate cancer before he took out the policy. And that it was therefore a pre-existing medical condition which was excluded under the terms of the moratorium. It turned down Mr J's claim.

However, Vitality acknowledged there'd been some delays in its handling of Mr J's claim and it paid him £250 compensation.

Mr J was very unhappy with Vitality's decision and he asked us to look into his complaint.

Vitality also subsequently told Mr J that he'd benefited from a moratorium discount he hadn't been entitled to, so it offered him the option to cancel the policy or to pay an additional premium to bring the policy up to date. Mr J opted to cancel the contract from February 2025.

Our investigator thought Mr J's complaint should be upheld. She didn't think there was enough medical evidence to show Mr J had been experiencing symptoms of the condition which had led to the claim before the policy began. So she recommended that Vitality should reinstate the policy and reconsider Mr J's claim. She also recommended that Vitality should pay Mr J an additional £400 compensation.

Vitality disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 23 June 2025 which explained the reasons why I didn't think it was unfair for Vitality to turn down Mr J's claim. I said:

'First, I'd like to say how sorry I was to hear about Mr J's diagnosis. It's clear this has been a very worrying and upsetting time for him and for his family.

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 medical evidence, to decide whether I think Vitality handled Mr J's claim fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr J and Vitality. Mr J took out cover on moratorium underwriting terms. Page 30 explains how the moratorium works. It says:

'We don't pay claims for the treatment of any medical condition or related condition, which, in the five years before your cover started:

- You have received medical treatment for, or*
- **Had symptoms of**, or*
- Had advice on, or*
- To the best of your knowledge and belief, were aware existed.*

This is called a pre-existing medical condition.' (My emphasis added).

I think the policy terms make it clear how the moratorium works and what it considers to be a pre-existing medical condition. A policyholder doesn't need to have been given a formal diagnosis in order for Vitality to classify a condition as pre-existing. And I also think the policy makes it clear that a policyholder doesn't need to meet every 'limb' of the list I've set out above in order for a condition to be classed as pre-existing. This term isn't unusual and, in my experience, most moratorium terms are drafted in a very similar way.

Vitality concluded that Mr J's claim was caught by the moratorium because it believed he had symptoms of prostate cancer before the policy began, which he was aware of. So I've looked at the available medical evidence to decide whether I think this was a fair conclusion for Vitality to reach.

Mr J's original claim form stated that his symptoms had first started on 1 June 2023 and that he'd completed an online referral form. His GP completed a statement which said that Mr J's symptoms had been poor urinary flow and urgency, with his symptoms beginning in May 2023. The GP said that Mr J had first presented on 27 June 2023, following an online triage on 5 June 2023. The GP said that they believed Mr J was first aware of symptoms 'a few weeks before presentation'. They also stated: 'I believe there were no symptoms or signs to [sic] the stated condition prior to the initial presentation'.

It seems then that there was some confusion on the paperwork as to when Mr J had first experienced symptoms of poor urinary flow (which was the trigger for the referral for investigations leading to Mr J's subsequent diagnosis with prostate cancer).

I've seen a copy of Mr J's original e-consult online request to his GP. Mr J said that he'd been 'experiencing a weak urine flow' and that the duration of his symptoms was 'about a couple of months'. This would indicate that Mr J's symptoms had been present since around early April 2023 – before the policy began. Mr J stated his 'ideas and concerns' were 'any suspicious cause rather than age.'

And in a letter to Vitality dated 14 July 2023, Mr J's GP noted the following:

'5 June 2023 – online consultation received declaring change in urinary flow of a few months

duration.

27 June 2023 – seen in surgery with urinary symptoms of ‘a few months’ duration.’

Again, the GP’s letter would suggest that Mr J had been experiencing symptoms of weak urinary flow for ‘a few months’ before he made the online consultation request and before he was seen by the GP. I don’t think it was unreasonable then for Vitality to rely on the medical evidence to conclude that Mr J had been experiencing symptoms of the condition he was later diagnosed with only very shortly before the policy began.

Mr J’s GP was supportive of Mr J’s claim. They wrote to Vitality stating that ‘patients are often vague about the onset of the symptoms and this should reasonably be taken into account. The maximum variability based on the wording might be a few weeks, but this is not a significant enough length of time to warrant...the increased distress this could cause the patient in delaying his claim.’

I’ve weighed up all of the available evidence. There’s no suggestion that Mr J was aware he had prostate cancer when he took out the policy. I don’t doubt how shocking and upsetting Mr J’s diagnosis was. But the online consultation request and GP notes do indicate, on balance, that by 5 June 2023, Mr J had been experiencing urinary flow symptoms for at least a couple of months. And that he was sufficiently worried about a potentially more serious cause that he sought medical advice. So I don’t think it was unfair or unreasonable for Vitality to conclude that Mr J’s symptoms had most likely started before the policy began – and likely by early April 2023. This means I don’t currently think Vitality acted unfairly when it decided that Mr J’s condition was pre-existing and that the claim was therefore excluded by the moratorium. And so, I don’t think it was unreasonable for Vitality to turn down Mr J’s claim.

It seems that some months later, Vitality reviewed Mr J’s policy and concluded that he hadn’t been eligible for a moratorium discount. It asked Mr J to either pay an additional premium for cover or to cancel the policy at the point it was paid up to. It seems that Mr J took up the second option. However, I don’t think it would be appropriate for me to make any finding on whether it was fair for Vitality to have retrospectively increased Mr J’s premium. That’s because it isn’t clear to me that Mr J has complained to Vitality about this issue; that it’s had a chance to look into it or that it’s issued a final response to that particular complaint point. Under our rules, a financial business must be given eight weeks to investigate and respond to a complaint before we can potentially help with it. So Mr J would need to make a new complaint to Vitality about that issue alone should he wish to.

Nevertheless, Vitality accepts that it didn’t handle Mr J’s claim as well as it should have done and that it had caused unreasonable delays in the assessment of his claim. It paid Mr J £250 compensation to reflect the effect of its claims handling on him at a difficult time. Given I don’t currently think Vitality acted unfairly when it turned down Mr J’s claim, and taking into account the delays I think Vitality was responsible for, I think the compensation it’s already paid Mr J is fair, reasonable and proportionate to reflect the impact of those delays on Mr J. So I don’t think it needs to pay him anything more.

Overall, whilst I’m sorry to cause Mr J further upset at an already very worrying time for him, I’m not planning to tell Vitality to do anything more.’

I asked both parties to send me any further evidence or comments they wanted me to consider.

Mr J didn’t accept my provisional decision, and I’ve summarised what he’s said. He felt my provisional decision was based on symptoms rather than awareness of symptoms. He stated

that he wasn't aware of symptoms before the start date of the policy. He didn't agree that Vitality had relied on medical evidence that he was displaying symptoms of the condition causing the claim – instead, it had relied on his GP notes and the referral. He felt the medical evidence started when his GP gave Vitality their opinion on more than one occasion. He considered awareness of symptoms must be a major factor – he felt a stand-alone application of 'had symptoms of' in the definition of a pre-existing medical condition was too wide. He didn't feel Vitality had provided any evidence to show he was aware of symptoms before the policy began. And he also felt his situation was similar to a scenario Vitality had included in the contract where a claim wasn't excluded by the moratorium.

Vitality didn't respond by the deadline I gave.

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 J, my final decision is the same as my provisional decision and for the same reasons. I'll go on to address Mr J's further submissions, although I'll focus on what I consider to be the key points.

As I set out in my provisional decision, Vitality has clearly set out how it defines a pre-existing medical condition. This definition includes when a policyholder has symptoms of that condition before the policy began – even if they aren't aware of an actual diagnosis. In my experience, most, if not all, private medical insurance policies include similar definitions. And I don't generally think the definition is inherently unfair.

I appreciate Mr J doesn't believe the GP records and referral letters to be medical evidence which Vitality's entitled to rely on. However, I think this is relevant medical evidence which sets out the symptoms Mr J was experiencing when he got in touch with the GP and how long they'd been going on. And that evidence does indicate, on balance, that Mr J had been experiencing symptoms of weak urinary flow for a 'few months' – likely since around early April 2023. It also seems Mr J was aware of that symptom and concerned enough about it to contact his GP.

So, it's still the case that I think Vitality was reasonably entitled to rely on this medical evidence when it assessed the claim. I've taken into account Mr J's GP's later correspondence with Vitality. But overall, I think it was reasonable for Vitality to conclude - based on the contemporaneous GP notes and referrals from the time - that Mr J had been experiencing a symptom of prostate cancer, before the policy began, even though he wasn't aware of an actual diagnosis at that point.

Mr J has referred to a scenario in the contract which he feels is similar to his own and in which Vitality would accept a claim. However, in the scenario Mr J has referred to, the policyholder wasn't aware of any symptoms of their condition before the policy began. In Mr J's case, the available evidence indicates he was most likely aware of a symptom of prostate cancer (even though he didn't know what the ultimate diagnosis would be) before the policy began. So I don't think Vitality has made a decision which is inconsistent with the contract terms.

Overall then, despite my natural sympathy with Mr J's position, I still don't think Vitality acted unfairly when it turned down his claim. And I'm still satisfied that Vitality's already paid him fair compensation for its errors. This means that I'm not telling Vitality to do anything more.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr J to accept or reject my decision before 6 August 2025.

Lisa Barham
Ombudsman