DRN-5687339

The complaint

Mr M is unhappy that Vitality Health Limited didn't follow through on its agreement to reinstate his private medical insurance policy.

What happened

Mr M had private medical insurance with Vitality and began experiencing payment issues from June 2024. In September 2024, Vitality decided to cancel his policy as Mr M hadn't made a payment since July. Once Mr M realised this, he discussed the issue with Vitality in October and was told his plan would be reinstated and his direct debit amended to recover the arrears and bring his plan back up to date.

Mr M said he realised this didn't happen in February 2025 and that he was being pursued for unpaid medical bills for treatment that was authorised in July 2024. He said Vitality didn't try hard enough to contact him and let him know there was an issue with the agreement made in October 2024.

Mr M said he's been left in a difficult position where he has no private medical insurance cover because Vitality have asked that he pay his annual premium in advance. He also has unpaid medical bills and is unable to find cover elsewhere because of his pre-existing medical conditions.

Vitality acknowledged it'd made a mistake in telling Mr M it'd reinstate his direct debit to pay the monthly premium. It said because of Mr M's poor payment history, this was no longer an option available to him and that the adviser he spoke to in October hadn't realised that. Vitality said it tried to contact Mr M the following day and left him a voicemail and that he didn't return its call. It also said it's Mr M's responsibility to ensure the premiums are paid on time. Vitality said it sent Mr M a small food gift by way of apology.

Our investigator didn't uphold this complaint. She said that whilst she acknowledged Vitality had made an error, she considered it had treated Mr M fairly overall because it continued to pay his treatment costs, despite Mr M not paying the policy premiums.

Mr M, unhappy with this, asked for an ombudsman to consider his complaint. In summary, he said he had no reason to think the policy hadn't been reinstated as agreed in October 2024; that the investigator incorrectly stated that Vitality's offer of reinstating the policy had been withdrawn; and that Vitality's decision to pay his treatment costs shouldn't be a reason not to award him compensation for the error and the impact that's caused. And so, it's now for me to make a final 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.

Having done so, I've decided not to uphold it. My reasons for doing so are similar to those given by our investigator. I agree Vitality made a mistake here, but Mr M must also shoulder

some responsibility as he must make sure the premiums are paid on time. And so, whilst I accept Mr M was given incorrect information in October 2024, I'm not persuaded this negates his responsibility to pay the policy premiums on time. I'll explain why.

The relevant rule that applies in this case comes from the Insurance Conduct of Business Sourcebook (ICOBS) and is set by the Financial Conduct Authority. ICOBS says Vitality must handle claims promptly and fairly and not unreasonably reject or avoid a claim.

The policy terms say about payment of premiums;

"What we expect from you (the planholder) You must:
• ensure all premiums are paid when due, in accordance with the invoice we send you."

For clarity, I should explain this complaint spans two separate policy years. Mr M's policy period runs from 13 September – 12 September.

- Policy A is between 13 September 2023 – 12 September 2024 and
- Policy B is between 13 September 2024 - 12 September 2025.

Mr M missed several payments during policy A. This happened shortly after the policy's inception as Mr M didn't pay his premiums for October, November, December and January 2024. Vitality had actually cancelled the plan due to non-payment of premiums. However, Mr M asked that the plan be reinstated, and Vitality agreed. Mr M made a manual payment in February 2024 to bring the plan back up to date. But a few months later in June 2024, Mr M missed a premium again.

Mr M called Vitality and paid June's premium in July, however, July's premium went unpaid. There was also no premium paid in August or September 2024. This was following an agreement with Mr M in September that Vitality would attempt to reinstate his direct debit and collect payment three days later. Policy A was then cancelled due to non-payment of premiums.

In October 2024 Mr M asked Vitality to reinstate Policy A, which it agreed to do, however, because of Mr M's previous payment history, this wasn't possible unless he paid the arrears he owed, bringing Policy A up to date. The adviser Mr M discussed this with on 2 October 2024 agreed to arrange collection of the arrears by direct debit, which it later transpired, was agreed in error.

Vitality explained Mr M had a history of missing payments and so it would no longer allow him to pay his premiums through monthly direct debit. Vitality said it tried to call Mr M back the following day on 3 October 2024 to explain this and that it didn't hear back from him until four months later in February 2025. During this time, Policy B also remained unpaid for these reasons.

Whilst I accept Mr M's argument that Vitality should have tried harder to contact him to explain this situation, I also think he had a responsibility to ensure payments were being made. I think it reasonable to expect that he checked with his bank the payments were being made at the time. And Mr M ought reasonably to have been aware he wasn't making any payments during this period.

Vitality offered to reinstate Mr M's policy, provided he paid the arrears on Policy A and paid the upfront cost of Policy B – which I think is fair. I note Mr M continued to receive treatment throughout the period he'd not paid his premiums for Policy A and that Vitality continued to meet those costs. These were significant costs of more than £2,000. Mr M said these were

treatments that were approved by Vitality and so they should have been paid. However, these were costs that were approved upon the basis Mr M continued to pay his premiums. And so, because he didn't do that, I don't think Vitality was obligated to have paid those treatment costs.

Our investigator cited this as the main reason she didn't recommend compensation for the error Vitality made in October 2024. She thought Mr M had benefited by having his treatment covered, despite not paying for the policy in July, August and September 2024. Mr M disagreed with that and said it was unfair to consider this as compensation in the circumstances. I've thought carefully about that, and I agree with what our investigator said and for the same reasons. I also recognise Vitality sent Mr M a small food gift by way of an apology to acknowledge the mistake.

Whilst I accept an error occurred, I cannot ignore that Mr M has benefited significantly by receiving treatment, paid for by Vitality, that it was otherwise entitled to decline due to the non-payment of premiums at the time. The role of the ombudsman is to put consumers back in the position they would otherwise be in had the insurer's mistake not occurred.

The error here was Vitality hadn't told Mr M he was unable to pay his premiums by direct debit and didn't make enough effort to tell him about that change. And so, to correct that, Mr M would still need to bring his policies back up to date and then all treatment would be considered for payment. The evidence I've seen persuades me Vitality offered him the opportunity to do that at the time, but he didn't make those payments.

Mr M said this was an unreasonable position for Vitality to take as most people couldn't afford to pay those costs and pay the upfront cost of the new policy. But Mr M was given the opportunity to pay monthly before this issue and still didn't do that. And so, I think Vitality's position here is reasonable as it has legitimate concerns about Mr M's ability to pay his premiums on time. In this case, it's decided Mr M presents a risk of missing payments in the future and so is entitled to exercise its commercial discretion in the way that it has in these particular circumstances.

I should say that had Vitality decided to pursue Mr M for the other treatment costs it'd paid in error, I wouldn't have said that was unreasonable. I note Vitality gave that serious consideration at the time and that it decided not to ask for the costs to be repaid, because of the miscommunication it had with Mr M in October 2024.

As I've explained, I agree with Mr M's argument that Vitality should have tried harder to contact him after October 2024, but I also think Mr M had a responsibility to ensure his premiums were being paid. In any event, I don't think it's fair to award compensation for this error because having taken everything into account, I don't think Mr M has lost out overall.

Mr M said he's being pursued for unpaid medical bills for treatment that was authorised during the Policy A year. But given my position on this complaint, I don't think it's fair that Vitality pays those costs, because Mr M didn't adhere to the agreement by paying his premiums. Therefore, as there was no longer a policy in place, I can't fairly say Vitality should pay Mr M's treatment costs.

My final decision

I'm not upholding this complaint because I think Vitality had already done enough to put things right by giving Mr M a food gift, and not clawing back the costs it paid for treatment he had during the period he'd not paid his premiums.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or

reject my decision before 26 November 2025.

Scott Slade
Ombudsman