DRN-5723924

The complaint

Mr B is unhappy Vitality Health Limited (Vitality) declined his claim.

What happened

Mr B held a group private medical insurance from 31 October 2024. The policy was underwritten by Vitality on a 'moratorium' basis.

He contacted Vitality to make a claim on 26 December 2024. Vitality authorised a consultation and diagnostic tests whilst they requested Mr B's medical records to review. They also agreed to the initial investigations with a consultant on 7 February 2025.

On 5 March 2025 Vitality declined any further cover under the moratorium terms of the policy. They said the evidence from Mr B's attendance at Accident & Emergency (A&E) on 30 November 2024 indicated there had been a three month history of symptoms, which was before the policy was taken out.

Mr B was unhappy because his planned operation had to be cancelled when Vitality withdrew cover. He complained and has since had to pay for the treatment himself.

Our investigator looked at what had happened and said, based on the evidence available to Vitality at the time, she thought it was reasonable for them to decline cover.

Mr B disagreed. In summary he said:

- The report from A&E was incorrect and he wanted to get this changed
- He has only had three previous episodes of heart palpitations. The first of which occurred on 29 November 2024 - his GP and both consultants confirm this
- The investigator has taken a single unverified note from an A&E junior clinician and elevated it above multiple formal assessments from specialist consultants and a GP
- The fact that he has now developed atrial fibrillation isn't evidence he had it for months prior
- No evidence has been presented of symptoms prior to 29 November 2024

He also provided new medical evidence to support his position.

So the case has been passed to me to decide.

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 rules and industry guidelines say that Vitality has a responsibility to handle claims promptly and fairly. And they shouldn't reject a claim unreasonably.

Mr B's policy is underwritten on a 'moratorium' basis. The policy states:

[Vitality] 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*

• *asked advice on, or*

• *to the best of your knowledge and belief, were aware existed.*

This is called a pre-existing medical condition.

This means if Mr B's claim relates to symptoms that existed in the five years before his policy started on 31 October 2024, his claim wouldn't be covered.

Before cover started, Mr B didn't have to answer any questions about his health on his application. Instead, with this type of policy, if necessary, his medical history is assessed at the time he submits a claim.

Based on the length of the time the policy had been in place, and the medical information they had at the time I think Vitality acted fairly in covering the invoices before they withdrew cover. And it was reasonable for them to obtain further information about Mr B's medical history in the meantime.

I've carefully reviewed the available medical evidence and agree there is a discrepancy in the information provided regarding the date Mr B's symptoms started.

Mr S has said his symptoms didn't begin until November 2024. He has explained he has three previous episodes of heart palpitations being:

- Friday 29th November
- Thursday 26 December
- Sunday 5th January

However, the report from Mr B's visit to A&E on 29 November recorded that Mr B said at that time:

"*for the last 3 months he had a sensation of a racing heart but had attended A&E* ***as this time*** *the symptoms were prolonged*".

I don't think it was unreasonable for Vitality to rely on the timeline reported in this evidence and conclude Mr B was suffering from symptoms of a racing heart before the policy started.

Mr B has highlighted the letter from his appointment with his consultant cariologist on 20 January 2024 which says he has only had three episodes, and they have gone on for some hours. It also says Mr B hasn't been unwell previously.

Mr B argues that if he'd been experiencing severe and debilitating symptoms three months earlier, it would be reported by his cardiologist here. But I'm not persuaded by that. The terms don't just exclude cover for people suffering severe and deliberating pre-existing symptoms. It excludes cover for any level of symptoms – even if not severe or long lasting. And for the reasons I've explained above I think it was reasonable for Vitality to conclude Mr B had suffered milder symptoms before the policy began.

I acknowledge that there wasn't any diagnosis of atrial fibrillation until a later date. But the exclusion for pre-existing conditions doesn't require a diagnosis of a condition – just the presence of symptoms. And I think it was reasonable for Vitality to conclude a racing heart

during resting (even for a short period of time) was likely a symptom of Mr B's condition he is now claiming for.

Mr B has said there would be evidence from his GP records if he'd been suffering from any heart related symptoms prior to the policy inception. But I'm persuaded Mr B still could've experienced symptoms of a racing heart, but as it wasn't for a prolonged period, it wasn't something he may have felt he needed medical assistance for in the past.

I don't dispute Mr B's argument that he only suffered three severe episodes of heart palpitations that went on for a prolonged period of time. But the test I must apply is when any related symptoms began, and I think it was reasonable for Vitality to link a racing heart (even for a short period) whilst resting, with the condition Mr B is claiming for.

Mr B has provided supporting letters from his GP and treating consultants that agree his symptoms didn't start until after the policy was in place. But I'm mindful these opinions are based on a timeline Mr B has self-reported because these medical professionals didn't have any contact with Mr B in the months leading up to the policy inception. So I still think it was fair for Vitality to place more weight on the A&E record as it's a detailed report of everything Mr P said at the time in November 2024 about how he was feeling and what led to his visit to A&E on that day. It's a reliable source of evidence from that time.

I appreciate this will be disappointing for Mr B and I'm sorry to hear he is still unable to work and may require further surgery. But I think IPA were fair to conclude the evidence suggests Mr B's symptoms started before 31 October 2024. As such, any claims for this condition would be excluded under his policy.

Mr B has said he has further new evidence to support his claim. This would need to be sent to Vitality for their consideration in the first instance to see if it changes their decision on the claim. It hasn't formed part of this complaint.

My final decision

I'm not upholding this complaint for the reasons I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B to accept or reject my decision before 24 October 2025.

Georgina Gill
Ombudsman