

The complaint

Ms M is unhappy with the way Vitality Health Limited handled a request to add her to a group private medical insurance policy ('the policy').

What happened

In March 2024, Ms M's employer contacted Vitality about Ms M being interested in joining the policy. They requested a quote from Vitality to enable her to decide what to do. There were subsequent communications between Ms M, her employer and Vitality about this.

In early April 2024, Ms M requested to be added to the policy. She had the benefit of a medical insurance policy her husband benefitted from which was due to end.

In early June 2024, Vitality's representative told Ms M by email that she'd been added to the policy on a medical history disregarded (MHD) underwriting basis. However, that was incorrect.

In October 2024, Ms M contacted Vitality to enquire whether it would be possible to add one or two dependants to the policy, and if so, the cost. She also said she hadn't received her membership details yet and requested these.

It was then discovered that, despite earlier assurances, she hadn't been added to the policy. Ms M asked to be added on 24 October 2024 and received the following email in reply:

We can add you as of today with new start Moratorium terms meaning that previous conditions (if any) would not be covered for at least [sic] years.

Or we could possibly back date the cover start date with ongoing cover terms which would enable continued cover for previous treated conditions.

If you do not require cover to be continuous, I will add you to the plan today.
Could you please clarify which option is preferred.

Ms M responded:

For the 2nd option, would the continued cover be for the previous treated conditions since I joined [employer name] or from even before then (i.e. all previous treated conditions, if any)?...

Vitality replied:

It's from the start date of the cover when you joined [employer name] – unless you had cover in place and transferred that to [the policy].

Ms M replied:

...please just add me to the Moratorium terms.

I had cover with Vitality through my husband's company, but this was cancelled when I joined [employer name]. I wasn't made aware of the option to transfer at the time and I assume it's too late now.

Vitality then replied confirming that cover (on a moratorium basis) was now live.

Subsequently, Ms M made a claim on the policy. I understand that Vitality declined to cover the claim relying on the moratorium clause in the policy terms.

Ms M / her employer then raised concerns about how Vitality handled the request to add her to the policy and cover not continuing on a MHD underwriting basis, as originally requested. Vitality concluded that Ms M had ultimately asked to be added to the policy on moratorium underwriting basis in October 2024, so it wouldn't look to amend the underwriting to MHD. However, it offered £100 compensation to Ms M for being told (wrongly) in June 2024 that she'd been added to the policy.

Unhappy, Ms M brought a complaint to the Financial Ombudsman Service. Our investigator looked into what happened and partially upheld her complaint. He recommended that Vitality pay Ms M total compensation in the sum of £200.

Ms M disagreed and raised points in reply. These didn't change our investigator's opinion. So, this complaint has been passed to me to consider afresh.

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.

That includes all submissions made to the Financial Ombudsman Service. Whilst I've considered these in detail (along with all the other evidence) I won't be responding to each point made. I hope the parties understand that no discourtesy is intended by this. Instead, I've focussed on what I think are the key issues here. The rules that govern the Financial Ombudsman Service allow me to do this as we are an informal dispute resolution service. If there's something I've not mentioned, it isn't because I've overlooked it. I haven't. I'm satisfied I don't need to comment on every point to fulfil my statutory remit.

I have a lot of empathy for Ms M's situation. Vitality accepts that it incorrectly told her that she'd been added to the policy when she hadn't. Whilst I accept that it would've, of course, been surprising and frustrating for Ms M to discover this in October 2024 (and that she had no cover in place for around five months), looking at the email correspondence from the time, she didn't seem to be too disappointed with this. Her response was:

I think I was supposed to have been added in June, but I guess it doesn't matter now. Thankfully, no reason to claim...

I also accept that Vitality's initial error meant that she was put to the unnecessary inconvenience of having to correspond further with Vitality about this issue.

Overall, I don't think £100 compensation offered by Vitality does fairly reflect the impact its error had on Ms M. I'm satisfied that a total of £200 compensation more fairly reflects the distress and inconvenience she experienced.

I've also thought very carefully about whether it would be fair and reasonable for Vitality to provide the cover under the policy that Ms M originally requested and been told she had in

June 2024 (continued cover on MHD underwriting). In the circumstances of this particular complaint, I'm not persuaded that this does lead to a fair and reasonable outcome.

I'm satisfied that the email correspondence between Vitality's representative and Ms M in October 2024 could've been clearer. For example, the moratorium clause could've been better explained and although it's said that previous conditions (if any) wouldn't be covered for years; the email didn't elaborate on the number of years and how the moratorium worked. Further, Ms M did say that she'd benefitted from health insurance with Vitality through her husband's company, but this was cancelled when she joined her employer. She said she wasn't made aware of the option to transfer cover at the time and that she'd assumed it was too late now.

Vitality's representative didn't respond to this point directly. However, I think it's reasonable to assume that they didn't do so because they had been discussing the MHD underwriting which relates to continuing cover in the emails leading up to this. I'm satisfied that Ms M was categoric in her answer that she wanted to proceed on the basis of a moratorium underwriting in October 2024.

There's nothing to suggest that Ms M didn't understand how the moratorium operated. If she had any questions, I would've reasonably expected her to have raised these then rather than agreeing for cover to be underwritten on a moratorium basis.

Ms M asked to proceed on the basis that cover would be underwritten on a moratorium basis. Therefore, on the balance of probabilities, I'm satisfied that even if Vitality had provided further clarity about cover continuing on MHD underwriting at that stage, I think she would've continued with the moratorium. When making this finding, I've taken into account what she's said about having no reason to claim between June and October 2024 and that the premium (and corresponding tax liability for a benefit in kind) would've been lower than cover on a MHD underwriting basis.

Putting things right

I direct Vitality to pay Ms M £200 compensation for distress and inconvenience. It can deduct the sum of £100 it's offered, if already paid to her.

My final decision

I partially uphold this complaint and direct Vitality Health Limited to put things right as set out above. Under the rules of the Financial Ombudsman Service, I'm required to ask Ms M to accept or reject my decision before 13 February 2026.

David Curtis-Johnson
Ombudsman