

The complaint

Mr M is unhappy with the way Vitality Health Limited handled a claim made on a group private medical insurance policy which he was a member of ('the policy').

What happened

The details of this complaint are well known to both parties, so I won't repeat them again here. I'll focus on giving the reasons for my 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.

That includes all submissions made by Mr M to the Financial Ombudsman Service. Whilst I've considered these in detail (along with all other evidence) I won't be responding to each point made.

I hope Mr M understands 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.

So that everyone is clear, I've only considered issues up to the date of Vitality's final response letter dated 15 July 2025. If Mr M has any concerns about Vitality from after this date, he can raise another complaint with Vitality in the first instance.

I can see that Mr M feels very strongly that Vitality hasn't acted fairly here. He made a claim under the policy because he was experiencing very bad headaches and sinus issues. Vitality authorised treatment up to diagnosis (that included up to two consultant's appointment, pathology and a MRI or CT scan).

However, upon diagnosis, Vitality wouldn't confirm cover for surgery which the consultant had arranged for Mr M. Vitality wanted more information from Mr M's GP to consider whether the surgery needed was for a pre-existing medical condition.

Mr M says this is unfair and he was forced to delay surgery. As a result, he's explained that his life has been severely impacted, and he's been in significant discomfort. I have a lot of empathy for his situation. However, I've focused on whether Vitality has acted fairly and reasonably by wanting further information from his GP and not confirming cover for his operation. And I'm satisfied it has. I'll explain why.

Vitality has a regulatory obligation to handle insurance claims fairly and promptly. And it mustn't unreasonably decline a claim.

Mr M joined the policy in July 2023 and on a 'moratorium' basis.

The policy terms and conditions explain the moratorium as:

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
- asked advice on, or
- to the best of your knowledge and belief, were aware existed

The policy terms refer to this as a pre-existing condition.

A related condition is defined as:

any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It could be deemed to be an underlying cause of, or directly caused by, another medical condition.

However, under the policy, pre-existing medical conditions can become eligible for cover providing:

you have not:

- consulted anyone (eg a GP, dental practitioner, optician or therapist, or anyone acting in such capacity) for medical treatment or advice (including check-ups), or
- taken medication (including prescription or over the counter drugs, medicines or injections)

for that pre-existing medical condition or any related condition for two continuous years after your cover start date.

The consultant's letters from June 2025 reflect that Mr M had been experiencing symptoms of nasal congestion with facial discomfort and headaches with hyposmia and rhinorrhoea over the past three months. This was greatly affecting his quality of life. A CT scan revealed a septal deviation. Surgery was recommended and subsequently booked for 7 July 2025.

Vitality has provided an internal note which shows that a previous claim made under the policy for 'acute sinusitis' had been declined as it was considered to be pre-existing. It was noted at the time that Mr M had septoplasty in 2022. This isn't disputed by Mr M (although he says this isn't related to the surgery he needed in July 2025).

Based on the medical information provided by the consultant (and the more limited information it had relating to his medical history), I'm satisfied that Vitality acted fairly and reasonably by wanting to obtain further medical information to assess whether the surgery was related to a pre-existing medical condition as defined by the policy terms.

I can, of course, understand Mr M's disappointment that the surgery ended up being cancelled, particularly given what he says about his symptoms and how they were impacting him.

However, the surgery hadn't been pre-authorised by Vitality, and the terms say:

Before you have any treatment

...Contact us so we can authorise your treatment...we will not pay for treatment we have not authorised in advance...

Mr M was aware of this as he contacted Vitality over a few days in the short period between Vitality receiving the correspondence from the consultant and the intended date of the operation.

I'm satisfied Vitality promptly reviewed the information received from the consultant and reasonably requested more information from the consultant about the condition, to consider whether surgery was related to a pre-existing medical condition. I've looked at the questions it asked the consultant and I'm satisfied that they're relevant.

In its final response letter, Vitality accepts that it should've proactively told Mr M that it had gone back to the consultant for more information. So, I accept that Mr M should've been kept better up to date, and this would've prevented him from having to contact Vitality again.

Vitality apologised for this and offered Mr M £30 to reflect the impact. I'm satisfied this sum fairly reflects the distress and inconvenience Mr M experience because of this communication issue.

Having received the consultant's answers on 4 July 2025, I'm satisfied Vitality reasonably promptly reviewed the response. Given the information it already had on its records (and in light of all the information received from the consultant), I'm satisfied that it was reasonable for Vitality to want to obtain further information from Mr M's GP when assessing whether the surgery would be covered under the policy. I'm satisfied Vitality reasonably concluded that the information received from the consultant didn't provide much insight into Mr M's past relevant medical history.

I appreciate that it can take time for medical records to be obtained from a GP surgery. However, that's outside of Vitality's control. Given the circumstances, I'm persuaded that Vitality suggested to Mr M that he can contact his GP surgery to chase them for this information. I think that's fair and reasonable in the circumstances.

Mr M also says that he has now been urgently referred for the same surgery through the NHS. I'm not convinced that Vitality was, in any way, doubting the severity of Mr M's symptoms or the consultant's medical opinion that surgery was needed. However, in the circumstances of this case and for reasons set out above, I'm satisfied Vitality acted fairly by wanting more information to assess whether surgery was for a condition that was pre-existing as defined by the policy terms.

My final decision

Vitality Health Limited has already made an offer to pay Mr M £30 compensation. I find this offer to be fair in all the circumstances.

So, my final decision is that Vitality Health Limited should pay £30 compensation to Mr M for distress and inconvenience.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 10 November 2025.

David Curtis-Johnson

Ombudsman