DRN-5883767

The complaint

Mr S complains about the way BUPA Insurance Limited has handled a claim he made on a 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 key events.

On 21 May 2025, Mr S took out a private medical insurance policy with BUPA on a fully underwritten basis. On the following day, Mr S spoke with BUPA's GP service, due to symptoms he was experiencing, including a rash. It seems the GP diagnosed Mr S with urticaria and suggested that he take antihistamines, as well suggesting that he be referred to a specialist. Mr S made a claim on the policy to allow him to see a consultant.

Given Mr S was seeking authorisation for a claim only the day after the policy began, BUPA told him it would need more information from his GP before it could consider the claim further.

However, Mr S flew abroad for a planned trip. A few days later, he was diagnosed with a serious medical condition and required hospitalisation and treatment abroad. He made a further claim on the policy.

BUPA told Mr S he'd need to obtain medical evidence from his GP before it could assess his claim. It also told Mr S it didn't cover the costs of medical treatment abroad. And it said he'd need to ensure his medical reports were translated.

Mr S was very unhappy with BUPA's position and he complained. BUPA acknowledged that it could and should have translated the medical reports for Mr S and so it paid him £200 compensation.

Remaining unhappy with BUPA's position, Mr S asked us to look into his complaint.

Our investigator didn't think Mr S' complaint should be upheld. In summary, she thought it had been reasonable for BUPA to ask for medical evidence to allow it to consider whether Mr S' referral was covered. She also felt the policy terms made it clear that BUPA didn't cover the costs of medical treatment abroad. She considered that BUPA ought to have had the medical reports translated, rather than asking Mr S to facilitate this. But she thought the compensation BUPA had already paid Mr S was fair and reasonable in the circumstances.

Mr S disagreed and I've summarised his detailed responses to our investigator:

- He questioned the advice he'd been given at the outset by the GP;
- He felt BUPA had failed to meet its regulatory obligations when dealing with his claim;
- He considered it had been unreasonable for BUPA to offload its administrative work onto him;

- He believed we should direct BUPA to liaise directly with his GP to obtain medical information and provide clear timescales for assessing claims;
- He considered compensation of £5000 would be more appropriate, given the impact BUPA's claims handling had had on him.

The complaint's 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.

Having done so, whilst I'm very sorry to disappoint Mr S, I'm satisfied that BUPA has already settled his complaint fairly and I'll explain why.

First, I'd like to say how sorry I was to hear about Mr S' serious diagnosis and the impact this has had on him. It's clear this has been a very difficult time for Mr S. I'd also like to reassure Mr S that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't commented on each point that's been made and nor am I required to under our rules. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly and that they mustn't reject claims unreasonably. They must also provide reasonable guidance to help a policyholder make a claim. I've taken those rules into account, amongst other relevant considerations, such as regulatory principles, the policy terms and the available evidence, to decide whether I think BUPA treated Mr S fairly.

Was it fair for BUPA to require Mr S to provide medical evidence in support of his urticaria claim?

Both parties agree that Mr S took out the policy on 21 May 2025 on a fully medically underwritten basis. On the following day, Mr S made a claim for referral to a specialist following his appointment with the GP.

I've carefully considered the policy terms and conditions, as these form the basis of the contract between Mr S and BUPA. Page 12 of the policy explains how full medical underwriting works. It includes the following term:

'Depending on your symptoms and how long you've been covered, when you contact us to make a claim, we may need to check that your symptoms or condition started after your cover started. We may also ask your doctor for more information, and they may charge for this. We'll let you know if your policy covers some of the cost. If not, you'll need to pay for it yourself.'

In my view, the contract makes it clear that in certain circumstances, BUPA will require further medical evidence before it agrees to pay a claim and that such evidence may be at a policyholder's own cost. In this case, given the very short time between Mr S taking out the policy and making a claim, I don't find it was unfair or unreasonable for BUPA to require medical evidence from his GP ahead of agreeing to cover a claim. Nor do I think such a request was in breach of BUPA's regulatory obligations. And I don't think BUPA unfairly delayed its assessment of this claim.

I can understand why Mr S wanted to receive medical care ahead of travelling abroad. But the policy isn't intended to cover emergency medical treatment, so if Mr S felt he needed

urgent care ahead of travel, it was open to him to seek advice and treatment on the NHS.

Has BUPA handled Mr S' subsequent claim fairly?

From Mr S' account, he was diagnosed with a very serious condition 26 May 2025 – five days after the policy began and he required hospitalisation abroad. At that point, he was found to have a tumour and I understand urgent treatment was required.

Page 35 of the contract states that BUPA won't pay for treatment a policyholder has abroad, unless that treatment isn't available in the UK. I haven't seen any persuasive evidence that the treatment Mr S needed wasn't available in the UK and so I don't think I could fairly direct BUPA to pay any treatment costs he incurred abroad.

With that said, I would expect BUPA to reasonably assess whether it will cover treatment of Mr S' condition should he receive that treatment in the UK. As I've said though, the policy terms make it clear that in certain circumstances, BUPA will require further medical evidence before it accepts a claim. And again, Mr S needed treatment abroad only a few days after cover began. So I think BUPA was reasonably entitled to ask for medical evidence to allow it to decide whether Mr S' claim was covered.

As Mr S has been undergoing treatment abroad, his medical reports have naturally been written in the local language. BUPA wrongly told Mr S that he'd need to get evidence translated into English before it could assess his claim – despite this being something BUPA had the capacity to do. So I don't doubt that asking Mr S to arrange such a translation when he was already in such a very worrying situation caused him unnecessary, additional frustration. And I think it was reasonable and appropriate for BUPA to pay Mr S compensation to reflect the additional upset this error caused him. I'm satisfied that the £200 compensation BUPA has already paid Mr S is a reasonable and proportionate award in the circumstances for this mistake.

It seems that following BUPA's translation of the medical report, it let Mr S know that it needed further information, in the form of a healthcare practitioner's questionnaire. It's provided evidence that it sent Mr S a text to that effect in late August 2025 – but it seems that, to date, no further medical information has been provided. As I've set out above, I don't think it's unreasonable for BUPA to require medical evidence to allow it to assess whether or not this claim is covered. It's open to Mr S to provide BUPA with the evidence it's asked for and I'd expect BUPA to review that evidence in line with the policy terms and its regulatory obligations.

Mr S has raised concerns about the diagnosis reached by the virtual GP. However, the virtual GP is independent of BUPA and BUPA isn't responsible for any of its clinical decision making. So if Mr S is unhappy with the way the virtual GP assessed his condition, he'll need to complain directly to the GP service about that issue.

Overall, I'm not persuaded that BUPA has handled Mr S' claims unfairly. Nor do I think it's made unreasonable requests for medical information. And I find it's already paid Mr S fair compensation for its mistake in failing to arrange translation of the medical report at the outset. Therefore, I'm not directing BUPA to do anything more.

My final decision

For the reasons I've given above, 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 S to accept or reject my decision before 22 December 2025.

Lisa Barham
Ombudsman