DRN-5970383

The complaint

Mr A is unhappy with the service he received from Vitality Health Limited (Vitality) in relation to a claim he made on his 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.

Mr A took out a private medical insurance policy through his employer in October 2024. The policy ended in June 2025 when Mr A left the employer. Vitality was the underwriter of the policy which was set up on a moratorium underwriting basis.

This means that no medical underwriting takes place at the start of the policy. Instead, claims are assessed based on information the policyholder provides and any medical information that's required. And any pre-existing conditions from the previous five years of starting the plan are excluded which can become eligible for cover if the policyholder has been symptom free for two continuous years after the start of the plan.

Mr A was experiencing back pain. So, on 18 March 2025, he attended a GP appointment through Vitality. A claim form was completed by Mr A and the GP which was sent to Vitality on 21 March 2025.

On 25 March 2025, Vitality requested further information from Mr A's NHS GP to satisfy the moratorium requirements of the policy.

Mr A called Vitality several times for updates between 9 April 2025 and 30 April 2025 as he hadn't heard anything further about his claim. He was told the information was being assessed.

On 25 April 2025, Vitality explained to Mr A what it needed from the NHS GP. Mr A said he would obtain this and send this to Vitality.

On 30 April 2025, Vitality received the information from Mr A which he had got from his NHS GP. The advisor on the phone confirmed authorisation for an initial consultation, X-rays, blood tests, an MRI scan and a follow-up consultation. A claim reference was provided. Mr A asked whether the specialist he was recommended by his GP was covered under the policy. The advisor said the specialist was covered.

50about wasn't available under the hip and knee network. So alternative specialist names were provided to Mr A.

On 17 June 2025, Mr A left his employment and the policy terminated as a result.

On 18 June 2025, Mr A had his treatment.

Mr A made a complaint to Vitality about the overall poor service he received. It responded and said it needed the information from the NHS GP, and it was waiting for this. Vitality said

it hadn't done anything wrong.

Unhappy, Mr A brought his complaint to this service. When the complaint was brought to this service, Vitality offered Mr A £100 compensation. Our investigator didn't uphold the complaint. She thought the £100 compensation was fair and reasonable in the circumstances of this complaint.

Mr A disagreed and asked for the complaint to be referred to an ombudsman. So, it was passed to me.

I issued a provisional decision to both parties on 24 November 2025. I said the following:

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations, such as industry principles and rules, the policy terms and the available evidence, to decide whether I think Vitality handled Mr A's claim fairly.

The key issue in dispute here is the amount of compensation that's been offered by Vitality.

Mr A says Vitality failed to progress the claim within a reasonable timeframe and caused a delay. This pushed his treatment just beyond the period of cover on the policy. He says had Vitality acted with due care and followed up with his NHS GP in a timely and organised manner, his treatment would have taken place while the policy was still valid.

I've reviewed the information provided by both parties and listened to the call recordings. Having done so, I'm minded to direct Vitality to pay a total of £250 for the distress and inconvenience caused to Mr A. I'll explain why.

Mr A made several calls between 25 March 2025 and 30 April 2025 to get updates on his claim. I note that he was promised callbacks but didn't receive them. When Mr A asked for updates, they were not meaningful.

- *It wasn't until 25 April 2025 that Vitality explained what it needed from the NHS GP even though the further medical evidence had been requested by it on 25 March 2025.*

- *Meanwhile, I can see Mr A made a complaint to Vitality as he was unhappy with the service he was receiving. When Vitality looked into Mr A's complaint, it had the opportunity to put things right. But I don't think it looked at what happened fairly and reasonably. And when the complaint was brought to this service, Vitality offered £100 compensation.*

- *I fully appreciate that the GP might not have responded sooner than 30 April 2025. But the issue is that Vitality failed to communicate clearly and failed to provide Mr A with meaningful updates. I note that as soon as Mr A was informed what information Vitality was awaiting, he chased his NHS GP and sent in the information to Vitality. So, it's possible that the information from the NHS GP could have been received earlier than 30 April 2025.*

- *I'm not persuaded that Vitality treated Mr A fairly and reasonably. If Mr A had received meaningful updates, Mr A could potentially have had his treatment sooner*

and the claim might have been valid before the policy ended. But I can't be certain of this and my reasons for awarding the compensation here therefore relates to the service Mr A received from Vitality – both while he sought authorisation and in how the complaint itself was investigated.

- *There was an impact on Mr A as he was claiming for back pain and required authorisation before he could have the treatment. Whilst I understand it's not unusual for insurers to request further medical information as required, I'm not persuaded Vitality provided the level of service Mr A should have expected. Vitality also had the opportunity to investigate Mr A's concerns and put things right when he made the complaint. In the circumstances, I don't think it did this sufficiently.*

- *I've looked at the service provided by Vitality, Overall, I think Vitality could have provided better service. Therefore, my intention is to direct Vitality to pay £250 compensation for the distress and inconvenience caused to Mr A.*

Putting things right

My intention is to direct Vitality Health Limited to pay Mr A £250 total compensation (this includes the £100 already offered) for the distress and inconvenience caused to him.

Both parties now have until 18 November 2025 to provide any further comments to me. After this date, I will make my final decision.

Mr A and Vitality responded to my provisional 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.

Mr A says the award of £250 doesn't reflect the full extent of the financial and practical impact caused by Vitality's failings.

Mr A says he was forced to proceed with the treatment privately after the policy ended which he had to pay for, he spent many hours making calls, chasing for updates and he received promises for callbacks which weren't received. This caused him material stress and anxiety, and Mr A believes an award in the range of £1,000 to £1,250 more accurately reflects the true impact caused by Vitality.

Vitality said it advised Mr A on 15 April 2025 what information it needed. It doesn't agree with my comment that it didn't do this until 25 April 2025 and therefore the compensation recommended in the provisional decision should be reduced.

I appreciate Mr A and Vitality taking the time to provide us with a response.

Having thought carefully about everything, I consider that £250 is fair and reasonable for what happened.

I have a great deal of sympathy for Mr A and I can understand why he believes he should receive a more significant amount for the distress and inconvenience he has suffered. However, as an alternative dispute resolution service, our awards are lower than he might expect and probably less than a court might award.

Vitality sent Mr A an email on 2 May 2025 which confirmed he had authorisation for the

treatment and provided consultants names who were on the hip and knee network. The email explained that the consultant Mr A had named wasn't on the network and wouldn't be eligible. So, whilst I think Vitality caused a delay and could have handled the claim better, Mr A had authorisation for his treatment on 2 May 2025 – before his employment ended.

And in response to Vitality's further comments, whilst Mr A may have been informed on 15 April 2025, I think he was provided clearer information on 25 April 2025. I therefore don't agree that the compensation should be reduced. There was a delay in Mr A's claim handling, and I don't think Vitality sufficiently investigated his concerns when he made the complaint.

Mr A's complaint is about the service Vitality provided when he made a claim. Having looked at this issue, I think overall £250 is fair and reasonable for the distress and inconvenience caused to him.

Putting things right

I direct Vitality Health Limited to pay Mr A £250 total compensation (including the £100 already offered) for the failings in the overall service provided to him.

My final decision

For the reasons given above, I uphold Mr A's complaint about Vitality Health Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 22 December 2025.

Nimisha Radia
Ombudsman