DRN-5990098

The complaint

Mr M complains about how WESTFIELD CONTRIBUTORY HEALTH SCHEME trading as Westfield Health handled a claim under his health cash plan policy.

What happened

Mr M took out a health cash plan policy with Westfield Health with a start date on 1 April 2024. He submitted a claim for chiropractic treatment that took place on 9 April 2024, and a claim for osteopathy treatment on 13 April 2024. Westfield Health told Mr M on 11 April 2024 that it needed his GP to complete a form for it to assess the claim. It explained this was because the policy didn't cover pre-existing conditions, and it needed to check the treatment had been recommended by a GP. Mr M's GP completed the form on 1 May 2024, and Westfield Health told Mr M his claims were covered on 10 May 2024.

However, the GP had charged Mr M £50 to complete the form. Mr M first emailed Westfield Health on 3 May 2024 about this, and he asked it to reimburse the fee. When Mr M didn't receive a response, he sent a chaser on 18 May, and again on 28 May 2024. Westfield Health responded on 4 June 2024 and explained the policy terms stated that if it made a reasonable request for additional information, this must be provided at Mr M's own expense.

Unhappy with this, Mr M raised a complaint. Westfield said it would respond within eight weeks, and it sent its final response on 16 July 2024. It said that Mr M's email on 3 May 2024 was sent to an incorrect email address. And when he sent this to a correct email address on 18 May 2024, Westfield Health responded on 4 June 2024 to explain why the GP fee wasn't covered. Mr M remained unhappy about how Westfield Health had handled everything, and that it hadn't refunded the GP fee. So, he brought a complaint to this service.

One of our investigators reviewed the complaint. Having done so, she didn't think Westfield Health had acted unfairly or unreasonably in the circumstances of Mr M's complaint. In short, she thought it had declined to reimburse the GP fee in line with the terms and conditions of Mr M's policy. She also noted that Mr M's first email to Westfield Health querying this initially was sent to a wrong email address.

Mr M didn't agree with the investigator's findings. He thought that the point about emailing the wrong department was a smokescreen. Ultimately, he emailed Westfield Health, and the email was accepted. As no agreement was reached, the complaint 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.

Industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. I've taken these rules, and other industry guidance, into account when deciding what I think is fair and reasonable in the circumstances of this complaint.

Mr M made two claims within the first month of his policy. Both chiropractic and osteopathic treatment come under Therapy Treatments in the policy terms. The terms make it clear that the policy doesn't cover Therapy Treatments for pre-existing conditions:

> *"You […] will not be entitled to claim the following benefits for any pre-existing medical conditions:*
> *[…] Therapy Treatments."*

The policy terms also state that a benefit is payable for Therapy Treatments in the following circumstances:

> *"When…*
> - *your GP or Consultant Physician/Consultant Surgeon recommends that you receive treatment. If requested at any time, you must provide us with written evidence of this recommendation at your own expense […]"*

And under the "How to claim" section of the policy terms it says the following:

> *"If we make a reasonable request for additional information, this must be provided at your own expense.*
>
> *In order for us to verify a claim it may be necessary for us to request a medical report from your GP […]"*

Finally, under the "Exclusions" section of the policy terms it says the following is not covered:

> *"any charges that a hospital/treatment centre, practitioner or any other organisation makes for filling in a claim form or providing any information we ask for relating to a claim"*

As Mr M made claims for Therapy Treatments within the first month of the start date of his policy, I think Westfield Health acted fairly and reasonably when it asked information from Mr M's GP to confirm that these didn't relate to pre-existing conditions. I say this because he wouldn't have been entitled to a benefit under the policy if this was the case. I think it also acted fairly and reasonably when it asked information from his GP to confirm they recommended the treatment, as this was a condition for a successful claim in line with the policy terms.

The policy terms, as I've set out above, also make it clear that Mr M needed to provide evidence to support his claim at his own expense. The policy also included a specific exclusion for any charge in filling in a claim form, which is what the GP charged Mr M. So, I think Westfield Health acted in line with the terms and conditions of the policy when it declined to reimburse Mr M the GP fee.

For completeness, it's a fundamental principle of insurance that it's for a policyholder to show they have a valid claim. So, in addition to what I've explained above, I see no fair or reasonable grounds for me to ask Westfield Health to refund Mr M the GP fee he was charged. This is because he needed to provide this to show he had a valid claim under the policy terms.

It's not clear if Westfield Health received Mr M's email dated 3 May 2024 when he first queried the GP fee. But he chased for a response on 18 and 28 May 2024, and Westfield Health did receive these emails. It responded on 4 June 2024 to explain its position on this fee. Overall, I don't think Westfield Health caused any significant unnecessary distress or inconvenience in the delay in clarifying its position on this fee. I say this because even when it did respond, Mr M remained unhappy. Westfield Health then issued its final response within eight weeks, as it was required to do.

Having considered everything, I don't think Westfield Health acted unfairly or unreasonably in all the circumstances of Mr M's complaint.

My final decision

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 M to accept or reject my decision before 1 January 2026.

Renja Anderson
Ombudsman