DRN-6069479

The complaint

Miss S has complained about the way Vitality Health Limited handled a claim she made on a private medical insurance policy.

What happened

Miss S is a member of a group insurance scheme provided by her employer. She made a request for treatment on 26 March 2025 and has complained about delay and poor customer service.

Vitality partly upheld her complaint. It originally offered her £75 compensation plus reimbursement of the £40 fee she'd paid for a medical report, being £115 in total. Miss S accepted this and, as I understand it, this amount has been paid to her.

Miss S subsequently referred her complaint to this service, at which point Vitality increased the compensation element of the offer to £150, meaning that it would pay her a further £75. Miss S didn't accept this.

Our investigator thought that Vitality's revised offer was reasonable and that the £150 compensation was in line with our redress guidelines. Miss S disagrees with the investigator's opinion and so the complaint has been passed to me for a 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.

I've carefully considered the obligations placed on Vitality by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Vitality to handle claims promptly and fairly, and to not unreasonably decline a claim.

Miss S has talked about ensuring that Vitality improves its processes. It's important to make clear that we're not the industry regulator. We have no power to regulate the financial businesses we cover, nor to direct them to change their processes or procedures. Our role is to investigate individual complaints made by consumers to decide whether, in the specific circumstances of that complaint, a financial business has done something wrong which it needs to put right.

Miss S submitted the care request on 26 March 2025, and the claim was finally authorised on 6 May 2025, so that's a period of about six weeks.

Whilst she feels that a second referral to the GP was unnecessary, I consider it was reasonable for Vitality to make further enquiries based on the initial medical information it received.

However, looking at the available evidence, I can see that there were some avoidable delays. In particular, it took a week for the initial claims assessment to be done following

receipt of the self-declaration and GP referral letter. And there was then a delay in the underwriters having access to the second GP report, meaning they took longer than they should have to confirm that the claim could be assessed as normal. Vitality has itself accepted that the claim could probably have been authorised by 1 May 2025.

Miss S believes that the delay would have been even greater if it hadn't been for the intervention of the insurance broker. It's difficult to say what difference it made, if any. It might have had some marginal impact, but I'm unable to conclude that a decision would have taken much longer without it, as the claim was already progressing. Nevertheless, Miss S did have to go to the trouble of contacting her work HR department to see if they could do anything to move things forward.

There were also some communication issues. Miss S was promised updates by certain times, which then didn't happen. She was also promised a call back from a manager within 48 hours which then didn't happen for five days.

Miss S had to spend a good deal of time on the phone, chasing Vitality. I appreciate this was a very stressful time for her as she was concerned about her health and was seeking an outcome to her claim as a matter of urgency. I can therefore appreciate why she feels she should be entitled to a higher amount of compensation. However, as an alternative dispute resolution service, our awards are more modest than she might expect and likely less than a court might award.

I would say that Vitality's original offer of £75 was insufficient to compensate her for the distress and inconvenience caused. So, in that sense, I am upholding the compliant. However, matters moved on after the complaint came to us, with Vitality making a revised offer to try and reach a resolution.

I have every sympathy with Miss S, however, on balance, I consider the £150 revised offered by Vitality to be appropriate compensation for the distress and inconvenience caused as a result of the service failings.

My final decision

For the reasons set out above, I'm satisfied the offer of £150 compensation is fair and reasonable. Vitality Health Limited should pay Miss S the additional £75 compensation now if it hasn't already done so.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss S to accept or reject my decision before 4 March 2026.

Carole Clark
Ombudsman