

The complaint

Mr and Mrs S have complained that BUPA Insurance Limited declined a claim they made on a private medical insurance policy.

What happened

Mr and Mrs S bought the policy in July 2024. In February 2025, Mrs S made a claim which Bupa declined on the basis that the condition being claimed for was pre-existing.

Our investigator thought that Bupa had acted reasonably in declining the claim, in line with the policy terms and conditions. Mr and Mrs S disagree 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 Bupa by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Bupa to handle claims promptly and fairly, and to not unreasonably decline a claim.

Mr and Mrs S have held Bupa-underwritten medical insurance since around 2013.

Mrs S began to have some trouble with her hand in February 2024. Upon consulting her GP, she was told she'd need a referral to a consultant, followed probably by an operation. She was told that, whilst there would be a wait on the NHS, the condition was unlikely to deteriorate during that time. They therefore decided not to make a claim on their existing policy at that time.

The cost of renewing their existing policy had risen quite significantly in June 2024, so they looked around for alternative cover. They were attracted to a policy they found online, via a different intermediary, because it was still underwritten by Bupa.

They assumed initially that, because Bupa was the underwriter, they would have continuing cover on the same basis as previously. Bupa was not responsible for the sale and so I cannot deal with any dissatisfaction they have about the sale here. In this decision I am only looking at whether it was fair and reasonable for Bupa, as the underwriter, to decline the claim.

The new policy was offered on a moratorium basis. That means that any medical conditions that Mr and Mrs S had in the three years prior to taking out the policy would only be covered after a two-year trouble-free period.

Mr and Mrs S now accept that they bought a new, different, policy and that it was sold on a moratorium basis. However, because Mrs S's symptoms began when they still held the

previous policy, they feel that, ethically, Bupa should cover the claim. I appreciate their argument, however, I'm afraid I'm not persuaded by it.

As established, they now have a new policy – and at the point of purchase they entered into a new contract with Bupa, with both them and Bupa agreeing to its conditions. They agreed to the less favourable terms of this new cover – being subject to the moratorium clause – in return for a cheaper premium. That was their decision and it was their responsibility to ensure that the new policy met their needs. I can't agree that, because they were long-standing customers of Bupa, that it should act outside the terms of the current policy to cover the claim.

I am sympathetic to their situation. They have missed out on having full cover and have paid for Mrs S's treatment themselves. However, the matter at hand is whether Bupa has done anything wrong – and I'm unable to conclude that it has. It was reasonable for it to decline the claim, in line with the policy terms and conditions. It follows that I do not uphold the complaint.

My final decision

For the reasons set out above, I do not uphold the complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S and Mr S to accept or reject my decision before 23 March 2026.

Carole Clark
Ombudsman