

The complaint

Mrs B is unhappy that Western Provident Association Limited (WPA) declined her private medical insurance claim.

Mrs B is being represented on this complaint by her husband, Mr B.

What happened

In April 2024, Mrs B switched into a group private medical insurance policy, which is underwritten by WPA. She joined the policy on a continued personal medical exclusions (CPME) underwriting.

In March 2025, Mrs B submitted a claim for surgery to her right hip. WPA declined the claim as it said Mrs B didn't disclose her hip condition (osteoarthritis) when she applied for the policy. As a result, WPA applied an exclusion to the condition.

Unhappy, Mr B made a complaint to WPA. He said Mrs B wasn't diagnosed with arthritis when she applied for the policy and therefore didn't need to disclose any hip condition. WPA maintained its decision to decline the claim.

Unhappy, Mrs B brought her complaint to this service. Our investigator partially upheld the complaint. She said WPA didn't have sufficient evidence to conclude that Mrs B had been diagnosed with osteoarthritis prior to completing the policy application form. She recommended for WPA to pay £150 compensation for the distress and inconvenience caused to Mrs B.

WPA disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

In summary, WPA said the following:

- The referral letter from the GP says that Mrs B presented with right hip pain, is known to have osteoarthritis, and that her condition is worsening. WPA said, at the very least, her symptoms should have been declared on the application form.
- When Mrs B set the claim up on 24 March 2025, she reported that symptoms had been present for two years. This information provided by Mrs B provides sufficient evidence. WPA says there was no need to request further information relating to the symptom history.
- Mrs B made a personal judgement on what information to disclose rather than answering the specific question. Her subsequent explanation that the hip was not causing issues and that no diagnosis had been received prior to the transfer are inconsistent and differs from the information provided to WPA.
- Given the referral letter, prior investigations and the statements made by Mrs B, WPA believes there is sufficient evidence to confirm osteoarthritis was a known and

material condition at the time Mrs B completed the application form. Therefore, this should have been disclosed.

I issued a provisional decision to both parties on 4 February 2026. 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 law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation the insurer must show it would have offered the policy on different terms or not at all if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

I've gone on to think about this when looking at Mrs B's complaint and her individual circumstances. WPA has said Mrs B failed to disclose the medical information when the policy was switched in April 2024.

WPA said Mrs B was required to answer a number of underwriting questions on the application form.

On page 4 of the application form, under section 2. Switch Continued Personal Medical Exclusions (CPME), it states:

'Please note: When you complete this form, no medical examination is required. We rely on you to answer all questions honestly and accurately; if you do not, any claim may be delayed or may not be paid.'

Mrs B was asked:

'Please tell us if any person to be covered by this application has:

2) In the last 2 years, had any back, spinal, knee, hip or shoulder conditions or arthritis?'

Mr B answered the question on behalf of Mrs B. The question was answered as 'No'.

I think this question was clear. WPA said, based on the information it received (the GP referral letter and the telephone conversations with Mrs B when the claim was made), the question wasn't answered accurately. WPA therefore applied an exclusion retrospectively and declined the claim.

Mrs B had two telephone calls with WPA about her claim. I've listened to both calls. I've also considered the GP referral letter.

On 24 March 2025, Mrs B called WPA to make a claim. She said she wanted to get authorisation to see a consultant about her hip. Mrs B explained it was her right hip and her

symptoms first started about two years ago. She said she had seen a consultant previously, but she wasn't happy with him, the symptoms had come on progressively. She explained that she hadn't seen a GP because she knew what it was, so didn't need to see him. WPA asked Mrs B to provide a GP referral letter but to help speed up the process, it provided Mrs B with a telephone number for a remote GP.

Mrs B provided the GP referral letter to WPA. It states the following:

'She presented with right hip pain. She is known to have osteoarthritis...

Hip pain and OA in right hip

Right hip is very pain full is getting worse [sic]

Had x-ray and MRI 18 months ago.'

The second call was to inform Mrs B that the claim wouldn't be covered and that a personal exclusion would be added for arthritis on the policy. Mrs B said the following in the call:

- She didn't understand because the reason she had the MRI scan was because of the arthritis.*
- She did have symptoms of arthritis two years ago as this shows in the scan.*
- She didn't understand why she wouldn't be covered for arthritis as she was paying for this in the policy. She thought she would be covered as she had arthritis 18 months ago, so it's obvious she would still have arthritis as it doesn't just clear up.*
- She asked about the application form she completed. She said she didn't remember completing the form. The advisor explained an exclusion would have been applied at the start had she completed the question accurately. Mrs B was unhappy as she said had the policy not been switched, she would have had the cover.*

WPA had a subsequent telephone conversation with Mr B. I've listened to this call also. Mr B explained that arthritis wasn't disclosed on the application as Mrs B hadn't been diagnosed with arthritis or any hip condition.

As I've said above, I think the underwriting question was clear. And I don't think it was unreasonable for WPA to have expected Mrs B (or Mr B on her behalf) to have answered this question accurately. Having looked at all the information - the application form, the GP referral letter and Mrs B's telephone calls, I'm satisfied the underwriting question wasn't answered accurately.

WPA has provided evidence to show if Mrs B had declared her medical condition accurately, an exclusion would have been applied on the policy. I understand WPA applied an exclusion subsequently for 'Osteoarthritis of hip (Bilateral)'. A revised policy certificate was sent to Mrs B to confirm this in June 2025. I've taken regard of the underwriting evidence, and I'm satisfied that this shows an exclusion would have been applied.

Under CIDRA, WPA has applied this as a qualifying misrepresentation and for this to have been careless. WPA is entitled to do this. Having looked at everything, I'm satisfied the misrepresentation has been applied fairly.

The remedy available to WPA under CIDRA is that it can apply the exclusion retrospectively to the policy. As it has done. It follows also that it was appropriate for WPA to decline the

claim, as this fell under the exclusion. I'm not persuaded that WPA has acted unfairly or unreasonably.

Overall, I understand the whole situation has been frustrating for Mrs B. Ultimately, however, I think the claim has been declined fairly and I'm satisfied that it was fair to apply the exclusion to the policy retrospectively.

I'm sorry to disappoint Mrs B but I'm not intending to ask WPA to do anything further.

I now invite both parties to provide any further comments to me by 18 February 2026.

Both parties responded to my provisional decision.

WPA said it accepts the provisional decision and had no further comments to add.

Mr B responded on behalf of Mrs B. In summary he said the following:

- Mrs B was told by the doctor 12 months before switching into the policy that arthritis is prevalent in most people over 50 years old and no further action was recommended or required at that time.
- They expected WPA to access Mrs B's medical records at the switchover and had she stayed on her original policy, cover would not have been an issue.
- Mrs B is not a new customer but a long-term existing customer who has been let down and has been mis-sold the policy. She wasn't advised better when the policy was switched by the broker.
- At no point did Mrs B or Mr B try to mis-lead WPA.

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 thought about Mr B's comments in response to my provisional decision. I don't think these comments are new and which I haven't already considered. However, for completeness, I have provided a further explanation.

Mr B talks about the advice he received from the broker when the policy was switched. I'm not considering the sale/switch of the policy on this complaint. I'm only considering whether it was fair for WPA to decline Mrs B's claim and whether the exclusion was applied fairly. I can't therefore comment on what happened when the switch was made.

Mr B also says that Mrs B's medical records should have been obtained when the policy was switched as this could have established that there may have been an issue. To confirm, Mrs B switched policies on a 'Switch Continued Personal Medical Exclusions' (CPME) basis. To add to what I've explained in my provisional decision about this underwriting method, this means that Mrs B would not be able to claim for any personal exclusions shown on her certificate of insurance. She wouldn't be able to claim for any pre-existing conditions that fell within the application questions unless these were properly declared and formally accepted by WPA in writing. In other words, WPA relied on Mrs B to answer the medical questions on the application form accurately.

The information available is sufficient to show that Mrs B was aware she had a hip condition

and that she was aware of her osteoarthritis at the time the policy switch was made. WPA said the medical question that was asked on the application wasn't accurately completed. Had Mrs B declared her condition at the time, WPA would have been applied an exclusion for the condition.

I understand it wasn't Mrs B's or Mr B's intention to mis-lead WPA. But overall, having re-reviewed all the available information provided by both parties, I'm satisfied that WPA fairly declined the claim and fairly applied the retrospective exclusion to her policy. I'm sorry to disappoint Mrs B, but it follows that I don't require WPA to do anything further.

My final decision

For the reasons given above, my final decision is that I don't uphold Mrs B's complaint about Western Provident Association Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 16 March 2026.

Nimisha Radia
Ombudsman