

## The complaint

Mrs P has complained that Exeter Friendly Society Limited (trading as The Exeter) declined a claim she made on a private medical insurance policy and added two exclusions.

## What happened

Mrs P purchased the policy in November 2024 via a broker. She then registered a claim in January 2025 for a referral to a cardiologist.

Exeter declined the claim on the basis that the circumstances are not covered under the policy terms. It said that Mrs P hadn't declared a pre-existing medical condition (PEMC) at the time of purchasing the policy and that, had she done so, it would have excluded cover for heart palpitations and shortness of breath. It then declined the claim and added those exclusions to the policy, with effect from the start date.

Our investigator thought that Exeter's actions had been fair and reasonable. Mrs P disagrees 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 Exeter by the Financial Conduct Authority (FCA). Its 'Insurance: Conduct of Business Sourcebook' (ICOBS) includes the requirement for Exeter to handle claims promptly and fairly, and to not unreasonably decline a claim.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract.

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 has to show it would have offered the policy on different terms - or not at all - if the consumer hadn't made the misrepresentation.

Exeter thinks Mrs P was careless when not declaring a PEMC. So, it has applied the exclusion that it would have applied had the misrepresentation not happened. When considering whether someone has taken reasonable care, I need to consider how clear and specific the questions asked were.

During the application process, Mrs P was asked the following questions:

*'Have you had any consultations, investigations, symptoms (whether diagnosed or not) or treatment in the last 12 months (NHS or Private)?'*

And:

*'Have you been treated for, diagnosed with, or advised that you have any of the following in the last 5 years?*

### *3.1 Heart condition?*

Mrs P answered 'No' to both of these questions.

In assessing the claim, Exeter received a medical information form (MIF) from her GP. This showed that she'd had an ECG in August 2023. She was again referred for NHS cardiology advice in relation to breathlessness associated with palpitations in October 2023, although she cancelled that referral.

In relation to an episode on 26 December 2024, for which she saw her GP on 31 December 2024, the MIF says that she'd first had symptoms three months prior.

Mrs P says she's had Supraventricular Tachycardia (SVT) for over 40 years. She says this presents in short bouts of a faster heartbeat and slight breathlessness, brought about by caffeine and anxiety. Her GP had offered her a referral in October 2023 for peace of mind. However, as she had herself concluded that it was stress-related, she didn't feel that she needed to pursue it further. As I understand it, she hasn't ever received a formal diagnosis from a medical professional.

When she saw the GP on 31 December 2024, he thought she might have angina and so suggested that she use her private medical insurance to see a cardiologist. She says that particular GP didn't know her and the answer she gave him about her symptoms related to her SVT during the previous three months and not the new symptoms she'd experienced on Boxing Day 2024.

Looking at the first question above, it asks about *any* symptoms in the last 12 months. So, it's not asking about relevant symptoms, or giving the option to someone to use their discretion to not disclose what they consider to be minor or irrelevant symptoms. By Mrs P's own admission, she'd had palpitations and breathlessness during that period. She says she disclosed her historic benign palpitations honestly when asked by the GP. The point is, she should also have disclosed them to Exeter by answering 'Yes' to that question.

Contrary to what Mrs P has said, the second question doesn't ask about heart disease. It asks about heart conditions. SVT is a medical condition that affects the heart. She'd had treatment for it within the previous five years, including referrals from her GP to a cardiologist. Therefore, she should also have answered 'Yes' to that question.

She says that the application form didn't ask about benign symptoms, only diagnosed conditions. However, that is not the case. She will see from the above wording that it asks about symptoms, whether diagnosed or not. She says that, if Exeter is seeking to rely on benign symptoms when underwriting policies, it needs to specifically ask about them. However, in asking someone to declare *any* symptoms, benign symptoms would be picked up at that point if someone answers 'Yes' to the question.

Mrs P says that the cardiologist subsequently confirmed that there were no major issues with her heart and there was no relationship between her recent symptoms and her SVT. Her GP also confirmed that she had no previous symptoms of angina. She therefore feels that Exeter is being unreasonable in refusing to remove the exclusion. However, what happened subsequent to inception of the policy is not a relevant consideration here. The crux of this matter is what Exeter would have done at the point of sale if Mrs P had correctly answered 'Yes' to the above questions.

Overall, I consider it was reasonable for Exeter to conclude that she didn't take reasonable care when applying for the policy. CIDRA says that an insurer is entitled to apply cover as if it had all of the information it wanted to know at the outset.

Exeter had provided underwriting evidence that it would have applied the following two exclusions:

*'Any investigation or treatment as a consequence of palpitations and their underlying cause.'*

And:

*'Any treatment or investigations as a consequence of shortness of breath (dyspnoea) and any underlying cause.'*

Based on the available evidence, I'm satisfied that it was entitled to add these exclusions and backdate them to the start date of the policy. As such, it follows that it was reasonable for it to decline the claim for referral to a cardiologist for her breathlessness symptoms.

I'm sympathetic to Mrs P's situation and understand how strongly she feels about the issue, including her concerns about what it means for any future claims. However, I'm unable to conclude that Exeter has done anything significantly wrong. Overall, I'm satisfied that it has now correctly applied the exclusions that it would have applied had she taken reasonable care when taking out the policy. 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 P to accept or reject my decision before 15 April 2026.

Carole Clark  
**Ombudsman**