complaint

Mr P is unhappy that Western Provident Association Limited did not tell him directly about its decision to exclude certain medical conditions from his policy.

background

Mr P's wife works for an organisation that offers a group scheme medical insurance. In January last year, she added Mr P to her group scheme policy as a family member. Mr P brings his complaint in his capacity as a group scheme beneficiary. This also means his continued enrolment is contingent upon his wife's continued participation with her employer and membership of the group scheme. She must elect for him to be and remain insured.

Mr P said WPA decided to exclude certain medical conditions from his policy, but did not tell him about this directly. Around six months later, in June, Mr P was suffering with chest pains and was referred to see a cardiologist. Mr P paid for some diagnostic tests and would like WPA to reimburse his costs.

WPA said Mr P had suffered with increased blood pressure before he joined and so it listed hypertension, as well as other related conditions, as a pre-existing medical condition. It said that because Mr P was then referred to a cardiologist it could fairly rely on the exclusion. WPA also said it wrote to the group scheme member, Mr P's wife, to inform them of the exclusion as part of its offer of insurance, as is its standard practice. It offered Mr P £100 compensation as a gesture of goodwill and took on board feedback from Mr P that it could perhaps share this information with group scheme beneficiaries via its online portal.

Our investigator thought this was fair. She was satisfied WPA had sent a revised certificate of registration to Mr P's wife and that this clearly listed the exclusions to his cover.

Mr P did not agree that this was fair for mainly the same reasons as before. In addition, he said he had his own policy prior to taking out this one and highlighted he'd have been covered had he not had cancelled it to go ahead with WPA's cover.

And so it's for me to make a final decision.

my findings

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint. Having done so, I won't be asking WPA to do anything more than it has already. The reason I say this is because I've not seen any evidence that persuades me it's made a mistake. I'd like to explain why.

Mr P had his own cover with another provider and in January 2018, decided to join WPA as a family member of his wife's policy. So although Mr P has his own policy terms and exclusions, his wife is the main policy holder. This means any changes to the policy terms or the cover provided will be communicated to her directly, rather than Mr P. This is similar to the way in which Mr P's cover was initiated as it was Mrs P who originally sourced the policy and completed the application for Mr P. I note WPA initially asked Mrs P more questions pertaining to Mr P's health as he was subject to full medical underwriting – which she provided detailed answers to. Some of the answers she gave led to the exclusions being added to the cover.

So although I take on board Mr P's argument that WPA should have corresponded with him directly, this was not something it did to begin with and is not necessarily something it's obligated to do moving forward – because he is not a member of the group scheme, rather, he is a beneficiary. Further, I think it reasonable for WPA to expect Mrs P to share information with Mr P in the way she did when it asked her to gather further information about Mr P's health during the application process.

WPA offered to provide cover for Mr P in its revised certificate of registration in February 2018. The certificate listed exclusions as;

"[Mr P] has hypertension which is associated with an increased risk of developing several diseases/disorders and as a result is not eligible for any investigations or treatment that are for, resulting from, or related to the following condition(s):

- *Hypertension*
- *Peripheral vascular disease*
- *Ischaemic heart disease*
- *Aortic valve regurgitation*
- *Hypertensive renal disease*
- *Stroke (CVA)*
- *Cerebral arterial aneurysm*

A related condition is where a current UK body of reasonable medical opinion considers another symptom/disease, illness or injury to be associated with the excluded condition"

And so based on this, I think WPA acted fairly in declining cover for the cardiologist's diagnostic tests. I say this because it's considered investigative treatment that's related to one or more of the conditions listed above. WPA added the exclusions because Mr P had suffered with high blood pressure in the past and so I'm satisfied they were applied fairly.

Mr P has since highlighted that had he not have accepted the cover offered by WPA then he would have likely been covered under his existing policy. This may well be the case, but I've not seen any information about Mr P's previous policy. In addition, this was a non-advised sale of insurance, meaning it was not WPA's responsibility to ensure the policy met Mr P's individual needs. And I think Mrs P was provided with clear information about what the policy did or didn't cover. So I don't think it fair to place any responsibility on WPA here. However I note WPA did what it could to make sure Mr P and his wife fully understood the cover on offer and stated during the application process;

"please check all WPA documents before cancelling any other Private Medical Insurance you already have. It is important that you understand what the group scheme provides benefit for and that it meets your needs"

Mr P confirmed during a conversation with WPA that he and Mrs P had received the revised certificate of insurance and that they'd not read it until he needed to make a claim, which is when they first realised the exclusions. But I think WPA took reasonable steps to make the exclusions clear and so I make no further recommendation here either as it was for Mr P to make sure the cover was suitable for his needs.

my final decision

I do not uphold Mr P's complaint for the reasons I've explained.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr P to accept or reject my decision before 11 February 2019.

Scott Slade
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