DRN-4587345

The complaint

Mr L complains about the way Vitality Health Limited handled a claim he made on a personal private medical insurance policy.

What happened

Mr L took out a personal private medical insurance policy with Vitality in January 2023. The policy was taken out on a moratorium underwriting basis.

Unfortunately, in June 2023, Mr L was diagnosed with cancer whilst in hospital. He contacted Vitality to make a claim in early July 2023. Vitality told Mr L he'd need to ask his GP to complete a Condition Information Request (CIR) form before it could accept his claim.

Mr L was unhappy with Vitality's request. He felt his medical records were available through the hospital. He said it would take him months to obtain a GP appointment. And he considered Vitality was trying to avoid paying private medical bills. He was concerned that this had caused a delay to the treatment he needed.

Vitality treated Mr L's concerns as a complaint and issued a final response letter on 10 July 2023. It maintained that it would need a CIR from Mr L's GP before it could authorise treatment.

Mr L remained very unhappy with the way Vitality had handled his claim and his complaint. So in August 2023, Vitality issued a second final response letter. It said that while it required a completed CIR from Mr L's GP, it ought to have let him know that he might not need a face-to-face appointment to obtain one. It said it would cover any charges he incurred in obtaining this information. And it said it could have previously given Mr L information about private consultants who could offer him care, even if his claim was ultimately turned down and he'd needed to cover the treatment costs himself. So it offered Mr L £50 compensation.

Remaining dissatisfied with Vitality's handling of his claim, Mr L asked us to look into his complaint.

Our investigator thought Vitality had made a fair offer to settle Mr L's complaint. She thought Vitality had been entitled to require a completed CIR from Mr L's GP before it would agree to accept his claim. And she thought the £50 compensation it had already offered was fair and reasonable to reflect the impact of its failure to tell Mr L that he might not need a face-to-face GP appointment and its failure to discuss his complaint with him ahead of issuing its first final response letter. So she didn't think Vitality needed to do anything more.

Mr L disagreed. In summary, he felt Vitality had tried to avoid the substantial costs it would incur if he'd undergone treatment privately. He noted it had accepted that it ought to have handled the situation differently by putting him in touch with private consultants. He considered that Vitality hadn't acted in his best interests and had followed a strategy of doing the bare minimum it was entitled to do under the terms of the contract. He didn't think it had acted with compassion. And he considered the compensation offered to be meaningless and derisory.

The complaint's been passed to me to decide.

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.

Having done so, whilst I'm sorry to disappoint Mr L, I think Vitality has already made a fair offer to settle his complaint and I'll explain why.

It's clear Mr L has been through a very worrying and distressing time. I understand Vitality has now accepted his claim and I do hope his treatment is progressing well. I'd like to reassure Mr L that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules and guidance say that insurers must handle claims promptly and fairly. And that they must pay due regard to the interests of their customers and treat them fairly. So I've taken these rules and guidance into account, amongst other things, when deciding whether I think Vitality treated Mr L fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Mr L and Vitality. Mr L took out the policy on a moratorium basis. This means that Vitality won't pay claims for any pre-existing conditions a policyholder had in the five years before a policy began. In this case, Mr L took out the policy in January 2023 and made a claim in early July 2023. The policy says:

'Sometimes, particularly if you claim in the first one or two years after joining us, we may need you to send us a fully completed claim form to help us assess your claim. We will normally ask for details of your medical history for at least the previous five years, with sections for both you and your GP to complete. We will not pay fees charged by a medical practitioner for completing a claim form, and we will be unable to assess the claim or pay for any treatment before we receive the claim form.'

In this case, Mr L's diagnosis was made around six months after he took out the policy. So I don't think it was unreasonable for Vitality to rely on the contract terms and require a completed CIR before it agreed to accept Mr L's claim. That was so it could be satisfied that Mr L's claim wasn't caught by the moratorium. It isn't unusual for a medical insurer to require medical evidence from an insurer before it will agree to accept and pay a claim. And while I appreciate Mr L's treating hospital had information about his diagnosis, I don't think it was unreasonable for Vitality to request a CIR from Mr L's GP, who had access to his medical records. I'd add too that I'm satisfied Vitality made Mr L aware of the need for a completed CIR very promptly and so I don't think it caused any unreasonable delays in the handling of this claim. Nor do I think there's persuasive evidence that Vitality sought to avoid accepting or paying Mr L's claim.

Nonetheless, Vitality accepts it could have done some things differently. It's clear that Mr L was concerned about the time it might take him to book a GP appointment. So I agree that Vitality could have told him upfront that he likely wouldn't need an in-person appointment in order to get the CIR filled-out. And Vitality accepts too that it could have given Mr L details of private consultants, even if Mr L had had to ultimately pay his own costs. Additionally, Vitality felt it could have done more ahead of issuing its initial final response letter. So I've considered what I think fair compensation for these errors should be.

As the investigator explained, because Mr L expressed dissatisfaction with Vitality's claims handling process at an early stage, it was required by the regulator to deal with his concerns as a complaint. But I agree it would have been helpful for Vitality to discuss Mr L's concerns with him ahead of the first final response being issued. And to let him know both that he could request the CIR in writing and to provide him with details of private consultants. I don't think Mr L has provided persuasive medical evidence to show that its failure to do either of these things though caused delays in him being able to access treatment.

I think that Vitality's offer to pay for the completed CIR was fair in the circumstances, especially given the policy explicitly states that it won't be liable for such costs. And it's offered Mr L £50 to reflect the inconvenience its service errors caused him. In my view, this is a fair, reasonable and proportionate award to reflect the material distress and inconvenience I think Mr L has been caused. So I'm not telling Vitality to pay anything more.

In his submissions to us, Mr L referred to Vitality's obligations under the Consumer Duty. But this was introduced on 31 July 2023 and isn't retrospective. So it doesn't apply to his complaint, as the event he is complaining about (the requirement for a completed CIR) happened before the Consumer Duty was introduced. However, I have considered the rules and standards that were in place at the time, as set out above.

My final decision

For the reasons I've given above, my final decision is that Vitality has already made a fair offer to settle Mr L's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 6 March 2024.

Lisa Barham
Ombudsman