DRN-4615932

The complaint

Mr A complains that Personal Assurance Plc (PA) hasn't settled a claim he made on a personal hospital plan.

What happened

The background to this complaint is well-known to both parties. So I've set out a summary of what I think are the key events.

Mr A held a personal hospital plan, which provided cover for a nightly benefit payment if he was hospitalised as an inpatient – both in the UK and abroad. In mid-March 2023, Mr A increased the benefit level available under his plan.

In May 2023, Mr A made a claim on the plan. He said he'd been admitted to hospital abroad between the end of March 2023 and 14 April 2023, suffering from Covid-19. He provided evidence of positive Covid-19 tests and stamped documents from the hospital.

And Mr A also claimed for a further period of inpatient admission, at another hospital, between 23 April and 15 May 2023. The relevant paperwork said that Mr A had been treated for typhoid fever.

PA looked into Mr A's claim and it decided it needed further information in order to validate it. So it appointed an overseas agent to look into things. The agent's report found that:

- While the documentation provided for the first hospital appeared to be genuine, the ward manager could find no evidence that Mr A had been admitted to either the medical or surgical wards;
- Upon checking the reference number given for Mr A on the documents, the ward manager found details of a different patient;
- A medical technician responsible for Covid-19 tests in the area stated that the Covid-19 test results were fake;
- At the second hospital, the doctor stated that their son had provided Mr A with the medical reports relating to his first admission. The doctor said they themselves had provided Mr A with the paperwork for the second admission and that Mr A had suffered from typhoid fever. But the doctor had said they had a relationship with Mr A's family. And they had been unable to provide medical records showing the treatment Mr A had undergone, because the doctor said the hospital didn't keep records of that nature.

Having considered the agent's report, PA felt there were discrepancies in the claim and so it asked Mr A for an explanation. Mr A maintained that his claim was genuine and that he had no knowledge of a relationship with the doctor at the second hospital.

But PA concluded that it couldn't validate Mr A's claim and it wasn't persuaded that the

hospital documentation he'd provided was genuine. So it didn't agree to pay Mr A's claim. Mr A cancelled the plans at the end of July 2023 – although PA wrote to him to tell him that it would have withdrawn cover in any event and that he wouldn't be permitted to take out any new products with it either.

Unhappy with PA's position, Mr A asked us to look into his complaint.

Our investigator felt PA had acted fairly. She thought it had been reasonable for PA to rely on the agent's conclusions to turn down Mr A's claim.

Mr A disagreed and so 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 A, I don't think PA treated him unfairly and I'll explain why.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of Mr A's plan and the available evidence, to decide whether I think PA treated Mr A fairly.

I've first considered the plan terms and conditions, as these form the basis of Mr A's contract with PA. The plan provides hospital inpatient benefit if a plan-holder is hospitalised as an inpatient up to a limit of 730 days.

It's a general principle of insurance that it's for a policyholder to provide enough evidence to show they have a valid claim on their policy. I'm conscious that Mr A has provided stamped evidence from the hospitals abroad which state that he was an inpatient for the periods for which he's claimed. One of the doctors who said they treated Mr A verified that Mr A had undergone typhoid treatment. And Mr A's provided PA with testimony in support of his claim.

On the other hand, it isn't unusual for insurers to appoint agents to investigate claims on their behalf. I don't think it was unreasonable for PA to do so in this case, given the high value nature of the claim.

The agent's report found that there were a number of concerns regarding Mr A's claim. In particular, that a medical technician had stated the Covid-19 tests weren't genuine; that there were no admission records for Mr A in the first hospital or records of his treatment in the second hospital; and that the second doctor indicated there was a relationship between them and Mr A's family.

In my view, it wasn't unfair for PA to rely on the agent's report to conclude that there were unresolved questions about the claim and to seek further information from Mr A. Not least because I think PA is entitled to have concerns about whether Mr A was treated in the hospitals as he said and if so, for what conditions. I've looked carefully at the answers Mr A gave PA. However, I think these lacked detail and focused on the evidence Mr A had already sent PA. So I don't think it was unfair for PA to consider that Mr A still hadn't shown that he had a valid claim on the policy. Nor do I think it was unreasonable for PA to decide that Mr A's responses didn't satisfy its concerns about the claim.

So, while I sympathise with Mr A's position, I don't think it was unfair or unreasonable for PA

not to pay his claim based on the available evidence. I must make it clear that I make no finding as to the veracity of Mr A's claim. Instead, my role here is to consider whether I think PA was reasonably entitled to request further information in support of Mr A's claim. Based on the evidence I've seen; I think it was.

Mr A chose to cancel the plan ahead of PA choosing to do so. This means he no longer has cover in place. It does remain open to him to obtain more evidence in support of his claim, should he wish to, and send this to PA for its review.

Overall though, based on the available evidence, I don't think PA acted unfairly or unreasonably when it concluded that Mr A hadn't shown he had a valid claim on the policy or that he'd been an inpatient as he'd claimed. So I'm not directing PA to do anything more.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 29 March 2024.

Lisa Barham
Ombudsman