DRN-4645757

The complaint

Miss R is unhappy with the way Vitality Life Limited has handled a claim made on her personal protection plan, which includes serious illness cover ('the policy').

What happened

Miss R took out the policy in early 2023. And in August 2023, she made a claim for the serious illness benefit under the policy in respect of a medical condition she'd been diagnosed with. She subsequently provided some medical information in support of her claim.

At the end of September 2023, Vitality Life informed Miss R that the medical information she'd submitted needed to be verified and it wanted to write to her GP and consultant.

Around mid-October 2023, Miss R consented to Vitality Life contacting her GP to ask five questions. She subsequently withdrew her consent to her GP sharing that information with Vitality Life directly.

Miss R was unhappy with the way Vitality Life was handling her claim. That included requesting medical information which it already had been provided by her. She was also unhappy with the delays.

Vitality Life issued a final response letter dated 23 October 2023 accepting that it had caused some delays and that Miss R hadn't received updates within the timescales she'd been given. It apologised, said feedback had been given to its claims team and offered £100 compensation.

By this stage, Miss R had already brought a complaint to the Financial Ombudsman Service which she wished to continue. Our Investigator looked into what happened and didn't think Vitality Life had to do anything more to put things right.

He said that it was fair and reasonable for Vitality Life to want to hear directly from her GP and consultant and to ask them questions. He felt that £100 fairly compensated her for the impact of the service failings she'd experienced.

Miss R disagreed and requested an Ombudsman's decision. So, her complaint has been passed to me to consider everything afresh to determine.

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.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), has set out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says that insurers should act honestly, fairly and professionally in accordance with

the best interests of their customers. It also says they should handle insurance claims promptly and fairly.

Just so everyone is clear, I confirm I've only considered the issues up to the date of Vitality Life's final response letter dated 23 October 2023. I know Vitality Life has very recently declined the claim (in mid-February 2024) in light of GP information which was provided after the date of the final response letter.

Vitality Life's recent decision to decline the claim doesn't form part of the complaint I'm determining. As Miss R is unhappy with that decision, she'll need to continue with her appeal/complaint she's recently raised with Vitality Life about that decision. If she's unhappy with the response she receives, she may then be able to bring a further, separate complaint to the Financial Ombudsman Service to investigate.

Did Vitality act fairly and reasonably by requesting further medical information?

After receiving notification of Miss R's claim, I'm satisfied that Vitality Life promptly sent her forms to agree to including access to medical reports and letter of authority. It also sent her a treating specialist report to provide to her consultant if she was happy to give that document to the consultant herself to complete.

I'm satisfied that Miss R then provided Vitality Life an overview from her GP and consultant along with the treating specialist report, which she had completed based on medical information she'd provided to Vitality Life around the time of making her claim, referring back to those documents.

I don't think Vitality Life acted unreasonably by not accepting the claim based on the medical information Miss R had provided directly to it as at the date of the final response letter. I'm satisfied that Vitality Life's ultimate decision that it required the consultant to complete and sign the treating specialist form and request further information from Miss R's GP directly was fair and reasonable.

The policy terms allow it to do this. It says under the heading: "medical evidence":

> We will ask your General Practitioner, and any specialists who are treating you, for medical evidence. We will need different types of information for different types of illness…our Chief Medical Officer will use this evidence to determine whether your claim is valid and, if appropriate, which severity level applies to your condition

Further, it's standard industry practice, when a claim is made for critical illness, for insurers to want to validate medical information directly with the treating specialist and GP. I don't think by doing so, Vitality is insinuating that Miss R made a fraudulent claim or has treated her unfairly.

I have listened to a call Miss R had with one of Vitality's representatives in early October 2023. The representative does say that due to Miss R's profession she'll have access to her medical records and that's put forward as one of the reasons why Vitality Life needs to validate the information. I can hear that Miss R got very upset about being told this. But I'm satisfied that the representative quickly and reasonably sought to clarify any misunderstanding and, on many occasions, said she wasn't accusing Miss R of making a fraudulent claim but her medical information needed to be verified, as was normal procedure. I think that clarification was enough to put things right.

I also think it's likely Vitality Life would've acted similarly regardless of her profession. I'm satisfied asking questions and seeking answers directly from the specialist and GP ensures

that Vitality Life is taking into account all relevant information so that it's able to properly assess the claim. That includes whether Miss R had been diagnosed with a serious illness covered under the policy and whether it meets the specific policy definition of that condition.

Further, it's common for insurers to want to ensure that the person claiming under the policy answered questions about medical history and lifestyle when applying for the policy. Because if they didn't, this can sometimes impact whether the claim is paid, or paid in full.

As at 23 October 2023, the date of Vitality Life's final response letter, it had requested the treating consultant complete its form (which at that time was still awaited) and the GP had been asked five questions to answer. However, Miss R had withdrawn her consent to the GP providing answers directly to Vitality Life. So, I'm satisfied that having yet to receive all the medical information it had requested, Vitality Life wasn't able to continue its assessment of Miss R's claim.

I know, at the time, Miss R was also concerned that once in receipt of the medical information requested, Vitality Life may request more medical information, further delaying the assessment of her claim. However, I don't think Vitality Life's position as set out in its email dated 18 October 2023 was unreasonable. It's said:

> Once we receive the GP report, it will be assessed. I can't confirm if we will or will not require anything further as it depends on what information the assessor finds in it. If there is new information that we were unaware of at application, she may immediately send it to our underwriting department to review the terms or she may request further information from the GP.

I think it's reasonable that Vitality Life couldn't provide any assurances about whether further medical information may be needed when it hadn't received or been able to assess the initial medical information requested. It might have needed to make reasonable follow up queries.

The service provided by Vitality Life

Vitality Life has apologised for delays incurred up until the date of the final response letter and accepts that there were times when Miss R didn't receive updates within the timeframes she was promised.

I'm also satisfied that it took over a month for Vitality Life to assess the medical information Miss R initially provided before confirming to her that it requires information directly from the treating consultant and for her GP to answer some questions. I think that's too long in the circumstances here.

I'm satisfied this impacted Miss R. When she didn't receive the updates as requested, she went to the trouble of having to contact Vitality Life for the updates. I'm also satisfied that she would've been upset and frustrated by the time taken to review the information she'd provided. I'm satisfied that £100 fairly compensates her for this.

When making that finding, I think it's likely that even if the decision that Vitality Life required further medical information from her GP and consultant had been communicated to her a bit sooner, Miss R would've still been disappointed and unhappy about that. However, for reasons set out above, I'm satisfied that, in principle, the position taken by Vitality up to the date of the final response letter was fair and reasonable.

Putting things right

As it's already agreed to do in its final response letter dated October 2023 (and if it hasn't already done so), I direct Vitality Life to pay Miss R compensation in the sum of £100 for distress and inconvenience.

My final decision

Vitality Life Limited has already made an offer to settle the complaint, as set out above. I think that's fair in all the circumstances.

My final decision is that Vitality Life Limited should put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss R to accept or reject my decision before 25 March 2024.

David Curtis-Johnson
Ombudsman