DRN-4680279

The complaint

C complains that when buying a new company medical policy HEALTH AND PROTECTION SOLUTIONS LIMITED (HP) gave him misleading information, which has led to a claim being refused by the companies' insurer.

What happened

C held a medical insurance policy that covered the cost of various medical treatment for its named employees. HP is C's insurance intermediary or broker, and searches the market to find suitable policies for C.

When the policy was due for renewal, C discovered the premium had increased substantially, and HP tried firstly to get this reduced. When that failed HP looked at other insurers who could provide similar cover at a lower price. C agreed to transfer its business to new provider, and to do that completed a "switch declaration" which included several questions about pre-existing conditions and/or ongoing treatment for various types of illness.

C discussed the implications of answering these questions with HP and said they'd check whether one member had received treatment for a particular condition listed in the declaration within the previous 6 months. Subsequently C signed the declaration to say no treatment had been received, and the policy was set up with the new insurer.

A few months later the member in question made a claim for the same condition, and the insurer refused to meet it. It based that decision on the fact that the member had in fact received treatment within the relevant 6 month period. C paid for the most recent treatment, but has complained that they were misled by HP during the sales process, leading to them innocently make an incorrect declaration. C wants HP to compensate it – that is pay for the treatment – and change its working practices so this can't happen again.

HP responded to say that its staff had acted appropriately during the sale process and that C had been representing itself and policy members when it signed the declaration. It didn't think it had done anything to lead C to believe it need not declare that treatment had been received in the relevant time period.

C asked us to review the complaint. Our investigator thought HP had acted as it should have and need do no more. C says this is clearly unfair, and I've been asked to decide this complaint.

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'm not going to uphold this complaint, for much the same reasons as our investigator gave. I've limited my comments to the main issue, and may not comment on everything I've seen, although I have considered all the information. In particular this decision is about what happened at the time C was renewing their policy, as that's the point at which the mistake

was made on the declaration.

C bought the insurance through HP, which was advising it about renewing an existing policy or changing to a new provider. HP was obliged to check C's circumstances and only recommend a policy that met C's requirements.

I've listened to the relevant phone call between C and HP about this. It took place shortly before C completed the switch declaration. During the call HP explained that C needed to be able to answer the declaration questions "no" if the new insurer were to provide cover in line with the quote they were looking at. In particular, C and HP discussed how C might answer a question about whether any member had received treatment for a back problem within the previous 6 months. C was aware that a claim had previously been made for this issue because that was a factor in the price increase at renewal. C asked, and HP explained, that "treatment" included any follow up appointments that might have occurred in the relevant time period. HP said it didn't need C to provide medical records, nor did it need to know the detail of any claim, but that C would be answering the question to the best of their knowledge. HP emphasised that if a question was answered "yes" then cover might not be provided for the condition. I'm satisfied that HP explained the importance of answering the question correctly and I'm also satisfied that C understood this. That's underlined by the fact that C was to check dates with the member concerned.

C says it was only required to answer to the best of its knowledge, and HPs statements that it need not obtain medical records led to the mistake. I'm not persuaded by that argument. Instead it appears that a mistake was made by C when completing the declaration. I say that because an email from C suggests the member who'd made the previous claim said they'd had no treatment during the relevant six month period. That was later found to be incorrect. As I said above, I'm satisfied C was aware how important answering the question correctly was, Whilst I can see how a genuine mistake arose, and I'm sorry about the impact this has had for C financially, I can't say that was because of anything HP did or didn't do. I can see HP tried to help C appeal the insurers decision when a claim was refused, but that doesn't impact upon what happened when the declaration was made, and doesn't affect my conclusions.

My final decision

Taking everything into account my decision is that I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask C to accept or reject my decision before 2 August 2024.
Susan Peters
Ombudsman