DRN-4686550

The complaint

Mr W complains that Western Provident Association Limited (WPA) has unfairly refused to meet two claims made on his medical insurance policy.

What happened

Mr W has a private medical policy with WPA, that he took out in early 2023. It covers the cost of various treatments and tests, but excludes cover (in the first two years) for any conditions Mr W or other policy members had in the five years before he bought the policy.

Mr W made a claim in mid-2023 for some tests he needed, and whist WPA agreed to cover some of them, it won't cover other costs because it says it appears that Mr W's condition existed before he took out the policy.

Mr W complained about this, and WPA agreed to reconsider its position if he provided his medical record for the five years before he bought the policy. Mr W has provided some information and given authority for WPA to obtain further records if it so wishes.

WPA says the record isn't complete so it won't take the claim further.

Mr W also complained that a claim for his son has also been refused on the grounds that his condition was pre-existing.

When Mr W asked us to review his complaint, our investigator said he thought the medical record he'd seen didn't cover all of Mr W's medical history, so he couldn't ask WPA to do more than it has. And he said that a complaint about his son's claim would need to be made separately before it could be considered by this service.

Mr W says WPA does have enough information and that as his consultant says his condition isn't pre-existing, that should be enough for WPA to meet the claim.

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.

When an insurer considers a claim, it must do so in line with the terms and conditions contained in the policy. In Mr W's case, he can't claim for treatment of pre-existing conditions. More specifically, that's any condition for which he's had symptoms, sought advice or had treatment in the five years prior to the policy starting. The moratorium lifts if he has no treatment etc for the first two years of holding the policy.

The evidence provided by Mr W suggests that he has an ongoing condition, in that the letter from his consultant mentions linked conditions, some of which he's had for years. It seems

reasonable to me that WPA should ask to see Mr W's full medical history for the five years before agreeing whether it should meet the claim. I appreciate Mr W's consultant doesn't think his condition is pre-existing. But I haven't seen anything that suggests the consultant has seen Mr W's medical record for previous years, and I'm persuaded it's fair that WPA should want to check this.

I appreciate that Mr W has given WPA permission to ask his GP for his medical record. But the terms and conditions don't say this is WPAs responsibility. Instead they say that Mr W must provide any requested information. That's a common requirement in most insurance policies, so I can't say Mr W is being disadvantaged by this term. I also don't think Mr W's requirement to provide information is over-ridden simply because WPA *could* ask for information if it needed to.

It follows that I think that until Mr W provides the required record I wouldn't expect WPA to do more than it already has.

I also agree with the comments made by our investigator about Mr W's son's claim. Until WPA has had a chance to consider a complaint about that claim, I and this service can't review the complaint. That means I've taken no account of anything said about the other claim in this decision.

My final decision

My decision is that I do not uphold this complaint.

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

Susan Peters
Ombudsman