DRN-4810649

The complaint

Mr H complains because Vitality Health Limited declined a claim for treatment and applied a retrospective exclusion to his private medical insurance policy.

What happened

Mr H held a private medical insurance policy, underwritten by Vitality.

The policy was taken out in August 2021 through an independent broker, on a 'continued personal medical exclusions' basis. This means that Mr H provided a copy of his previous insurance certificate so that any existing personal medical exclusions could be carried over to the Vitality policy. Mr H was also asked questions about his health so that Vitality could decide if any additional personal medical exclusions would be added to his cover. No personal medical exclusions were applied to the Vitality policy when it was sold to Mr H.

In June 2023, Mr H contacted Vitality to make a claim relating to his heart. Vitality said the claim wasn't covered because Mr H hadn't told it about the full details of his medical history when he took out the policy. Vitality said, if Mr H had done this, it would have added an exclusion relating to the cardiovascular system to his policy. Vitality therefore retrospectively added this exclusion to Mr H's policy and declined his claim.

Unhappy, Mr H complained to Vitality and then brought the matter to the attention of our service. One of our investigators looked into what had happened and said she didn't think Vitality had acted unfairly.

Mr H didn't agree with our investigator's opinion so the complaint was referred to me. I made my provisional decision about Mr H's complaint earlier this month. In it, I said:

"I'm sorry to hear that Mr H has been unwell, and that he experienced additional stress as a result of this situation at what was already a worrying time. I understand Mr H ended up paying for the treatment he needed himself, at significant cost and has since taken out an alternative private medical insurance policy which is subject to a similar exclusion to the one which Vitality retrospectively applied here.

The broker who sold this policy to Mr H is a separate and distinct business entity, independent of Vitality. Vitality isn't responsible for the broker's actions. If Mr H is unhappy with the type of policy sold to him, or with how this policy was sold, then he'd need to direct these concerns to the broker in the first instance before our service would have the power to consider a complaint about these matters. When making my decision about this complaint, I can only consider the regulated activities which Vitality is responsible for; these are Vitality's decision to apply a retrospective exclusion to Mr H's policy and decline his claim, as well as Vitality's handling of Mr H's claim.

Our investigator, when setting out her opinion to Mr H, didn't outline the relevant considerations, such as the law, which our service must take into account when dealing with a complaint like this.

The applicable law in this case is The Consumer Insurance (Disclosures and Representations) Act 2012 ('CIDRA'). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out an insurance policy. The standard of care required is that of a reasonable consumer. If a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is – what CIDRA describes as – a 'qualifying misrepresentation'. For a misrepresentation to be a qualifying one, the insurer must show it would have offered the policy on different terms, or not at all, if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether a consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

Vitality thinks Mr H failed to take reasonable care not to make a misrepresentation because of how he answered the questions which were asked on the policy application form in August 2021. The questions asked were as follows:

> *'In the last three years, have you or any other person to be insured:*
>
> - *Experienced symptoms;*
> - *Received any advice from a healthcare professional;*
> - *Received treatment or have treatment planned or expected;*
>
> *for any physical, mental health or psychiatric condition?'*

and

> *'When did you or any other person to be insured last experience symptoms, receive advice from a healthcare professional, or receive any treatment (including prescribed or over the counter medication) relating to the following?*
>
> *(Please advise us of the most recent time period for each condition i.e., if you have treatment or advice planned, anticipated or expected and you also had treatment 1-3 years ago, please select "treatment or advice planned, anticipated or expected").*
>
> *…*
>
> *Heart conditions*
>
> *You do not need to tell us about: High blood pressure and/or high cholesterol that has never required you to see anyone other than your GP.*
>
> *…*
>
> *Any other condition not declared above.'*

I'm satisfied that these questions asked by Vitality were clear and specific.

In response to these questions, Mr H declared that he had been diagnosed with a bicuspid aortic valve in 2002 and was having annual checks with a cardiologist as a result. In addition to this, Mr H declared glaucoma. But Vitality thinks Mr H should also have told it about moderate aortic stenosis, aortic regurgitation and atypical chest pain/pericarditis.

Mr H's medical records within the three years prior to applying for this policy show that he saw a consultant cardiologist on 27 September 2019, who referred to Mr H as having moderate aortic stenosis. A letter from a cardiology registrar dated 25 November 2020 also refers to Mr H as having moderate aortic stenosis, as well as trivial aortic regurgitation. A letter dated 16 December 2020 again refers to aortic stenosis (although this letter says the stenosis is 'mild to moderate'). Finally, a letter dated 4 January 2021 refers to Mr H as having experienced atypical chest pain which was treated as pericarditis.

Mr H didn't provide this information to Vitality in response to the questions he was asked, so I don't think he took reasonable care not to make a misrepresentation about his medical history.

Vitality has provided confidential underwriting evidence to our service which I've considered carefully and I'm satisfied this demonstrates that it would have applied an exclusion to Mr H's policy if it had been told about his aortic stenosis and aortic regurgitation. This exclusion would have removed cover for 'any disease or disorder of the cardiovascular system and related conditions', which is the exclusion which Vitality retrospectively applied to Mr H's policy before making the decision to decline his claim.

Vitality hasn't provided any evidence to show what – if anything – it would have done differently if Mr H had declared atypical chest pain/pericarditis. I don't think it's necessary for me to make a finding about whether I think Mr H should have declared these issues. This is because Vitality has shown me that it would have entered into the contract on different terms if Mr H had told it about his aortic stenosis and aortic regurgitation, which I think he should have.

So, I'm satisfied that Vitality has demonstrated that Mr H made a qualifying misrepresentation under CIDRA. Vitality has treated Mr H's qualifying misrepresentation as a careless one and is therefore entitled to consider the contract as being having entered into on those different terms (i.e., by retrospectively applying the policy exclusion which it would otherwise have applied from the outset). This isn't unfair or unreasonable in the circumstances.

I've considered the letters which Mr H has referred to in his response to our investigator's opinion. I don't doubt that Mr H wasn't aware of the specific disease which led to him requiring the treatment claimed for. And I also note that Mr H's consultant cardiac surgeon has said that none of his symptoms, in isolation, were related to his aortic stenosis. But this doesn't change my provisional findings. Vitality is entitled to apply the remedy available to it under CIDRA regardless of whether or not the condition being claimed for is linked to the medical condition which wasn't declared. It's up to Vitality to decide what medical condition(s) it wants to know about to decide what level of risk it is prepared to accept in return for the payment of the premium being charged. Vitality wasn't made fully aware of Mr H's medical history in response to the questions it asked and, if it had been, it wouldn't ever have covered any cardiovascular conditions. It wouldn't be fair or reasonable in the circumstances to require Vitality to now accept Mr H's claim for a condition which it would never have offered covered for.

I understand Mr H is also unhappy with the length of time taken by Vitality to consider his claim and says that his planned surgery was delayed as a result. Industry rules set out by the regulator require insurers to handle claims promptly and to provide policyholders with appropriate information on the progress of their claim. I've taken these rules into account when considering the timeline of events in this case.

When Mr H first submitted his claim, relevant medical evidence which Vitality needed to assess the claim was missing. Based on the information I've seen, a specific medical letter

which Vitality wanted to see doesn't seem to have been included with Mr H's initial claim. So, I don't think it was unreasonable for Vitality to request this before proceeding to make a decision about the claim. However, once this information was received, I don't think Vitality acted as quickly as it could have to assess matters. And I also note there were failed call-backs to Mr H during this time when he was awaiting an urgent update on whether his planned surgery could go ahead.

Vitality appears to have acknowledged these issues in its final response letter to Mr H but the final response letter goes on to refer to a monetary amount/gift details by way of compensation which were left blank. This seems to me to have been a template letter which wasn't amended correctly by Vitality. I can understand from Mr H's point of view, why this was entirely unsatisfactory. Vitality has now apologised to Mr H, via our service, for this error.

Overall, I think there were failings by Vitality in how it handled Mr H's claim but, taking into account the timeline of events, our published guidance on the payment of compensation for distress and inconvenience, and the fact that I don't think Vitality acted incorrectly in declining Mr H's claim, I don't intend to make an award of compensation in this case.

I'm sorry to disappoint Mr H and I know this won't be the outcome he was hoping for, but I don't currently intend to direct Vitality to do anything further."

So, my provisional decision was that I didn't uphold Mr H's complaint.

Both Vitality and Mr H acknowledged receipt of my provisional decision but didn't provide any comments in response.

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.

As neither party has provided any new evidence or additional submissions, I see no reason to change my provisional findings.

My final decision

My final decision is that I don't uphold Mr H's complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr H to accept or reject my decision before 20 June 2024.

Leah Nagle
Ombudsman