DRN-4495963

The complaint

Mrs F complains that Inter Partner Assistance SA ("IPA") hasn't paid a claim for medical expenses under her travel insurance policy.

What happened

Mrs F has been represented on this complaint by her husband. He was also the one who took out the policy on Mrs F's behalf. But for ease of reading, I've only referred to Mrs F in this decision. Any reference to Mrs F covers her actions, as well as the actions of her husband on her behalf.

Any reference to IPA also includes the actions of its agents.

Mrs F took out a single trip travel insurance policy online through a price comparison website on 2 November 2021. The policy was to cover a trip between 17 November 2021 and 1 January 2022. Mrs F unfortunately had to go to hospital whilst on the trip, and she made a claim for the medical expenses to IPA.

To assess the claim, IPA first asked for Mrs F's medical records. Following this, IPA declined the claim because it said that the policy Mrs F had wasn't suitable for someone with pre-existing medical conditions within the last two years prior to policy inception. IPA said Mrs F hadn't declared the pre-existing medical conditions she'd had. Had she done so, it would not have sold this policy to her. So, IPA voided the policy from inception and offered to refund the premium Mrs F paid.

Mrs F doesn't think she had any conditions she needed to declare. She says she had some previous conditions in 2016, so these weren't relevant when IPA asked about any pre-existing conditions in the last two years as the policy was taken out in 2021. She also didn't think the issues she had seen a GP about in the last two years were something that needed to be declared. These included a chest infection, lower back pain and bilateral calcaneus pain. Mrs F says all were self-managed, and IPA never informed her what kind of information would be relevant.

Our investigator didn't think Mrs F had taken reasonable care to answer the questions on IPA's website about the pre-existing conditions she had in the last two years. IPA had said that had she declared these, it would have offered her a different policy that would have been more expensive. Based on this, our investigator thought IPA should settle Mrs F's claim proportionately.

IPA didn't agree with our investigator's findings. As no agreement was reached, the complaint was passed to me to decide. I issued my provisional decision in November 2023. Here's what I said:

"Firstly, industry rules set out by the regulator (the Financial Conduct Authority) say insurers must handle claims fairly and shouldn't unreasonably reject a claim. And having considered everything so far, I don't think IPA handled Mrs F's claim fairly or reasonably.

Mrs F has provided an email from November 2021 where she referred to a phone call from IPA saying that if her trip went beyond 30 days, her claim wouldn't be covered. But that wasn't the right information as Mrs F had a single trip policy covering her entire trip. And when IPA declined the claim, it said Mrs F had pre-existing conditions within two years of taking out the policy. But it was referring to information on her medical reports dated March 2019, and the policy was taken out in November 2021 – so these were over two years prior to policy inception.

It wasn't until Mrs F brought the complaint to our service that IPA has given its final position on the claim. And that's what I've focused on in my decision. But I think IPA has caused Mrs F unnecessary distress and inconvenience in how it handled her claim, as above. I think IPA should pay her £100 to compensate for this. This takes into account the fact that Mrs F's husband has acted on her behalf, and I can only award compensation for the distress and inconvenience caused to Mrs F, not her husband.

I've then considered if IPA's decision to void Mrs F's policy, refuse her claim and refund her premium is fair and reasonable.

IPA says Mrs F answered medical questions incorrectly when she bought the policy. So, I think the key considerations under this complaint are the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA"). This is designed to make sure that consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the act.

A misrepresentation is a "qualifying misrepresentation" when 1) a consumer fails to take reasonable care not to misrepresent facts which the insurer has asked about, and 2) the insurer shows that without the misrepresentation it would not have entered into the contract at all or would have done so only on different terms.

I've first looked to see if Mrs F failed to take reasonable care. The standard of care required is that of a reasonable consumer. And one of the factors to be considered when deciding if a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

When taking out the policy through a price comparison website, Mrs F was asked the following:

> *"Does anyone in your party have a pre-existing medical condition, or is anyone on a waiting list for treatment or investigation?*
>
> *You do not need to declare pregnancy, however if you've experienced complications during your pregnancy we recommend you contact your provider before purchasing so this can be noted.*
>
> *You'll need to tell us about any medical conditions you have or have previously had. Your insurance won't always cost more to cover these conditions, but if you don't tell us about them any claim you make could be rejected."*

I think this question was clear, and Mrs F needed to take reasonable care to answer this question accurately. So far, both parties have focused on the medical question asked at the next step of the process on IPA's website – which asked about medical conditions in the last two years. But I need to first decide if Mrs F made a qualifying misrepresentation already on the above first question. And the above question doesn't refer to two years – rather, it asks "does anyone in your party have a pre-existing medical condition" and says that "you'll need to tell us about any medical conditions you have or previously had".

I've considered Mrs F's medical records and what she's told us about her medical history, and if she took reasonable care when answering the above question. Mrs F had gallbladder surgery in 2016, and hiatus hernia diagnosed around the same time. She had also consulted a GP about low back pain in January 2021 which was managed with painkillers, and bilateral calcaneus pain in July 2021 which was also managed with painkillers and for which Mrs F was referred to physiotherapy. Having considered these, and the question asked, I think a reasonable consumer would have realised these conditions were something an insurer would want to know about in response to the above question. So, I think Mrs F failed to take reasonable care when answering the question on the price comparison website as "no".

IPA says that had Mrs F answered "yes", she wouldn't have been offered the option to buy this policy, as it wasn't suitable for someone with pre-existing medical conditions. Instead, she would have been shown policies from a variety of insurers that do cover pre-existing medical conditions.

I'm satisfied that had Mrs F answered the above question "yes", IPA wouldn't have sold her this policy. Instead, she would have been directed via the price comparison website to a list of insurance policies from a variety of insurers who do offer cover for pre-existing medical conditions. Mrs F would have been presented with a range of options from different insurers at difference prices and with different benefits.

Overall, I don't think I can fairly say that it's more likely than not that Mrs F would have chosen to take out a similarly branded but more expensive policy with IPA which did cover pre-existing medical conditions.

So, I think Mrs F made a qualifying misrepresentation that IPA has accepted was careless (rather than deliberate or reckless). This means the remedy available to IPA under CIDRA is to void the policy from inception – this means to treat it as if it never existed – and refuse all claims. IPA should then refund the premium Mrs F paid. This is what IPA has offered to do. I'm sorry to disappoint Mrs F but I think this offer is fair and reasonable in the circumstances of this complaint."

IPA accepted my provisional findings, and Mrs F didn't have any further comments. As both parties have had the opportunity to review my provisional decision, and send anything else they want me to consider, I'm now issuing my final decision.

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 given me any new information to consider, I see no reason to depart from the findings I reached in my provisional decision. So, in the circumstances of this complaint, I've reached the same decision, and for the same reasons.

Overall, I think Mrs F made a qualifying misrepresentation that IPA has accepted was careless. So, I think the action IPA took was fair and reasonable, and it should now refund the premium Mrs F paid, along with interest. IPA should also pay Mrs F £100 to compensate her for the distress and inconvenience it caused in how it handled her claim.

My final decision

My final decision is that I uphold Mrs F's complaint in part. And I direct Inter Partner Assistance SA to do the following:

- refund Mrs F the premium she paid and add interest at 8% simple per annum from the date the policy was paid until the date settlement is paid, and
- pay Mrs F £100 for the distress and inconvenience caused in how it handled the claim.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs F to accept or reject my decision before 3 January 2024.

Renja Anderson
Ombudsman