DRN-4766180

The complaint

Mr and Mrs H are unhappy with the way Inter Partner Assistance SA (IPA) handled a claim on their single trip travel insurance policy ('the policy').

What happened

Whilst abroad in 2023, Mr H required medical treatment. IPA was contacted for assistance. Cover wasn't verified under the policy because IPA said it first needed to obtain and consider Mr H's medical records. This wasn't received before Mr H was discharged from hospital and he and Mrs H returned to the UK.

IPA subsequently declined the claim on the basis that Mr H hadn't declared bouts of vertigo when taking out the policy. And the medical treated he needed whilst abroad related to similar symptoms.

Mr and Mrs H appealed this decision as they said vertigo was considered by IPA to be a 'waived condition' under the policy, so they didn't need to disclose it.

IPA accepted the decision to decline the claim on the basis that he experienced a waived condition was unfair. It then decided it would cover a proportion of the costs claimed. That's because there were other medical conditions it says Mr H should've declared when applying for the policy but didn't. And he if had done, the policy would've been more expensive. As Mr and Mrs H only ended up paying 51% of the premium they should've been charged, IPA said it would cover 51% of the claim.

IPA also offered Mr and Mrs H £250 compensation to recognise the delays and poor customer service they received.

Our investigator looked into what happened and upheld the complaint. She concluded that it wasn't fair and reasonable for IPA to only pay 51% of the claim. She recommended the claim be paid in full and for IPA to pay Mr and Mrs H 8% interest on the payments they'd made for medical costs and other costs such as extending their accommodation and return flights.

IPA disagreed. So, this complaint has been passed to me to consider everything afresh to decide.

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.

That includes Principle 12 of the Financial Conduct Authority's Principles for Businesses ('the Consumer Duty') which says a firm must act to deliver good outcomes for retail customers (such as acting in good faith and avoid causing foreseeable harm).

It also includes The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA'). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract.

The standard of care is that of a reasonable consumer. And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation the insurer (in this case IPA) has to 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 the 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.

For the reasons I'll go on to explain, I don't think IPA has acted fairly and reasonably in this case by only covering 51% of the costs claimed under the policy.

Did Mr H make a misrepresentation?

I don't think Mr H did misrepresent his medical history when applying for the policy.

Although our investigator requested this, IPA didn't provide the online process Mr and Mrs H would've followed when applying for the policy.

Our investigator explained to the parties when upholding the complaint, that she'd referred to the airline/travel provider's website and the current online process when applying for travel insurance.

In response to our investigator's view, IPA hasn't disputed this online process or provided evidence of an alternative process that Mr and Mrs H would've followed. So, I'm satisfied on the balance of probabilities, that this is the same online process Mr and Mrs H would've followed when applying for the policy.

It says:

> The medical conditions listed in the Waived Conditions list below are covered subject to the normal terms and conditions of this insurance, provided the insured person can meet ALL of the following criteria:

> A. has NO other pre-existing medical condition(s) which is not listed within the Waived Conditions table; and
> B. is not awaiting surgery for the condition; and
> C. has been fully discharged from any post-operative follow-up.

It then lists numerous conditions as 'waived conditions' including vertigo.

I'm also satisfied that the waived conditions list contains another three medical conditions IPA says Mr H ought to have declared.

It then goes on to say:

> In addition to any medical condition on the 'Waived Conditions' list, you may be automatically accepted for cover, provided you do not have more than ONE of the following Medical Conditions or ANY other pre-existing medical condition.

1. Arthritis (Juvenile, Osteoarthritis, Rheumatoid or Psoriatic Arthritis, Reiter's Syndrome, Rheumatism):

- There must have been NO hospital admissions within the last 12 months.
- Must NOT affect the back more than any other area of the body.
- No more than 2 medications.
- No mobility aids (other than walking stick or frame).
- Must NOT be awaiting surgery.
- Must have NO lung problems.

2. Asthma (Wheezing):

- There must have been NO hospital admissions EVER.
- Must have been diagnosed prior to age 50.
- Must be controlled with no more than 2 medications (NO nebulizer, NO home oxygen).
- Must have been a non-smoker for at least 12 months.
- Must be able to walk 200 yards on the flat without becoming short of breath.

3. Hypercholesterolaemia (High/Raised Cholesterol):

- No more than 1 medication.
- Must NOT be the inherited form.
- Must have been a non-smoker for at least 12 months.

4. Hypertension (High Blood Pressure, White Coat Syndrome):

- No more than 2 medications.
- There must have been no change in treatment within the last 6 months.
- Must have been a non-smoker for at least 12 months.

5. Hypotension (Low Blood Pressure):

- Must NOT be associated with any underlying condition.

6. Osteoporosis (Osteopenia, Fragile Bones):

- There must have been NO vertebral (backbone) fractures

The medical conditions listed in the Waived Conditions table above are covered subject to the normal terms and conditions of this insurance, provided the insured person can meet ALL of the following criteria:

a) has NO other pre-existing medical condition(s) which is not listed within the Waived Conditions table; and b) is not awaiting surgery for the condition; and c) has been fully discharged from any post-operative follow-up.

Finally, it asks:

> Are ALL medical conditions for which cover is required included in the Waived Conditions list and the criteria met?

I'll refer to this as 'the medical question'.

The applicant can click on 'yes' or 'no'.

I'm satisfied that it's more likely than not that Mr H selected 'no'. That's because, I'm satisfised that had he selected yes, he would've been asked follow-up questions.

Mr H had been diagnosed with a form of skin cancer in 2022 which had been removed. I'm satisfied that Mr H didn't declare this when applying for the policy.

However, looking at the medical question, I don't think it's fair and reasonable to have expected Mr H to have declared skin cancer in answer to this question.

I think it's reasonable to interpret 'ALL medical conditions for which cover is required', as asking Mr and Mrs H if the conditions they want or require cover for are on the waived conditions list and meet the criteria. The question doesn't specify what conditions Mr H needed to declare at that stage.

If Mr H didn't require cover for skin cancer under the policy, I think he reasonably answered 'no' to the medical question.

I accept that if Mr H had answered 'yes' to the medical question he would've been asked more questions, including:

Do you or any person to be covered by the policy have any medical condition for which you have been prescribed medication or for which you have received, or are waiting to receive treatment (including surgery, tests, or investigations) within the last 12 months? Or any of the following medical conditions from which you or any person to be covered by the policy have suffered from or received medical advice, treatment (including surgery, tests, investigations by your doctor/consultant/specialist) or prescribed drugs or medication in the last five years:

Cancer is listed as one of those conditions (including skin cancer).

However, Mr H never got to these questions in the process, because having answered 'no' to the medical question, they didn't appear on the online process.

As I'm satisfied that Mr H didn't answer the medical question incorrectly or made a misrepresentation, I don't think it would be fair and reasonable for IPA to act as it would've done had he declared having had skin cancer in the last five years.

Further, and in the alternative, even if I'm wrong on that point, I'm satisfied that IPA hasn't provided the Financial Ombudsman Service with sufficient evidence supporting that Mr and Mrs H only paid 51% of the premium they would've been charged more if skin cancer had been declared. It's said that they would've been charged £78.40 for the policy instead of £40. However, it hasn't provided a breakdown of how this has been calculated or provided verified evidence from its underwriter.

So, even if Mr H did make a misrepresentation – which for reasons set out above, I don't think he did – I'm not satisfied that IPA has established that this amounted to a qualifying disclosure, entitling it only pay 51% of the claimed amount.

The handling of the claim

IPA accepts that the claim should've been handled better, and I agree.

Looking at its internal notes, it doesn't look like it was proactive in trying to support Mr and Mrs H whilst away and there were some delays. Further, IPA initially gave a different reason for declining the claim and after Mr and Mrs H went to the unnecessary trouble of challenging this (which I accept would've been frustrating), it provided a different reason for declining the claim. For reasons set out above, I think the further reason given is unfair. And I accept this would've also been upsetting and frustrating for Mr and Mrs H at an already stressful time.

I'm satisfied that £250 compensation offered by IPA fairly reflects this distress and inconvenience.

Putting things right

I direct IPA to:

- accept and pay the items which can be claimed for under the policy in full (including medical costs, extended accommodation and travel costs back to the UK) subject to the policy limits and any excess.
- pay simple interest at a rate of 8% per year* on each of the expenses personally incurred by Mr and Mrs H from the date on which they paid by them to the date those items were partially settled and then further interest on the outstanding balance until they're settled in full.
- pay (if it hasn't already done so) £250 compensation for distress and inconvenience.

My final decision

I uphold this complaint to the extent set out above and direct Inter Partner Assistance SA to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr and Mrs H to accept or reject my decision before 5 June 2024.

David Curtis-Johnson
Ombudsman