DRN-4589043

## The complaint

Mr M and Mr M complain on Ms K's behalf that Inter Partner Assistance SA (IPA) has turned down a medical expenses claim they made on Ms K's travel insurance policy.

Mr M and Mr M are represented in bringing Ms K's complaint, but for ease, I've referred mainly to them and to Ms K.

## What happened

The circumstances of this complaint are well-known to both parties. So I've set out a summary of what I think are the key events.

On 18 December 2022, Ms K took out a single trip travel insurance policy online via a price comparison website to cover a holiday she had planned for a few days later. It appears that Mr M helped Ms K with the policy application. During the online sale, Ms K declared that she suffered from COPD and had had four chest infections during the previous year. Based on the answers Ms K gave, IPA offered her a quote, which Ms K took up.

Ms K travelled abroad as planned. Unfortunately, it seems Ms K suffered an allergic reaction and subsequently, she went into cardiac arrest. She was taken to a local hospital. So Mr M and Mr M contacted IPA's medical assistance team to make a claim on the policy and to ask for IPA's help.

IPA arranged for Ms K to be transferred to a more specialist hospital for treatment. And it asked Ms K's GP to provide medical evidence so that it could validate the claim. Based on the GP notes, IPA considered that Ms K had failed to tell it about her full medical conditions. It noted that Ms K also had a food allergy; a diagnosis of asthma; osteoporosis; and that three days before she'd taken out the policy, she'd been prescribed antibiotics for an unresolved chest infection. IPA said that if Ms K had fully declared her medical history, it wouldn't have offered the policy. So it concluded that Ms K had made a qualifying, reckless misrepresentation under the Consumer Insurance (Disclosures and Representations) Act 2012. And it turned down Ms K's claim.

However, IPA did offer to refund the premiums Ms K had paid for the policy. And it felt its medical assistance team could have communicated better with Mr M and Mr M during the life of the claim. So it paid them £300 compensation.

Mr M and Mr M were unhappy with IPA's decision and their representative asked us to look into the complaint. It said Mr M and Mr M had had to repatriate Ms K at their own expense and had had to settle her medical expenses.

Our investigator didn't think IPA had treated Ms K unfairly. In summary, she felt IPA had asked Ms K clear questions during the online sales process which Ms K had answered incorrectly. And she was persuaded that IPA had shown that if Ms K had fully disclosed her medical history, it wouldn't have offered her a policy. So the investigator thought it had been fair for IPA to turn down the claim, cancel the policy and refund the premium.

Mr M and Mr M disagreed. In summary, their representative said that while Ms K had been prescribed antibiotics only a few days before taking out the policy, she'd been suffering from a productive cough, which was a well-known symptom of COPD. They said that antibiotics are a prophylactic for COPD and so the prescription of them wouldn't have led Ms K to conclude that she had an infection. They added that if the prescription of antibiotics had been important to IPA, it should have asked a specific question relating to their use. And they stated that the purpose of Ms K's GP visit on that date hadn't been because she was suffering from an infection but because she was seeking a referral for COPD. Therefore, the representative considered the prescription had been coincidental.

The complaint's been passed to me 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.

Having done so, whilst I'm sorry to disappoint Mr M and Mr M on Ms K's behalf, I don't think IPA has treated Ms K unfairly and I'll explain why.

First, it's clear that Mr M and Mr M are in a very upsetting situation. I was sorry to hear about the circumstances that led to this claim. I understand Ms K remains seriously unwell and incapacitated as a result of her illness abroad and I don't doubt what a distressing time this has been for Mr M, Mr M and Ms K's family.

I'd also like to reassure Mr M and Mr M that while I've summarised the background to this complaint and their representative's detailed submissions to us, I've carefully considered all that's been said and sent to us. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the law; the terms of the insurance contract; and the available medical evidence, to decide whether I think IPA handled Ms K's claim fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA 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 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.

When Ms K took out the policy online, she was asked information about herself and any medical conditions she'd had in the last five years. IPA used this information to decide whether or not to insure Ms K and if so, on what terms. IPA says that Ms K didn't correctly answer the questions she was asked during the online sales process. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these

principles to the circumstances of Ms K's claim.

IPA thinks Ms K failed to take reasonable care not to make a misrepresentation when she took out the policy online. So I've considered whether I think this was a fair conclusion for IPA to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions asked by the insurer were. During the sales process, Ms K was asked the following:

1. *'Have you had any medical condition for which you have received prescribed medication or check-ups within the last 12 months?*

2. *Have you had any of the following medical conditions for which you have received prescribed medication or treatment including surgery, tests, investigations or check-ups within the last 5 years?*

    - *Respiratory conditions*
    - *Heart conditions*
    - *High blood pressure and/or high cholesterol*
    - *Cancerous conditions*
    - *Neurological conditions (for example, stroke, brain haemorrhage, multiple sclerosis, epilepsy and dementia)*
    - *Mental health conditions (for example anxiety, depression and eating disorders)*
    - *Diabetes*

3. *Are you on a waiting list for treatment, tests or investigations or awaiting the results of any tests or investigations?'*

Ms K's policy schedule shows that she answered 'yes' to at least one of these questions and chose to add a condition. She declared that she had COPD and was therefore directed to a more targeted COPD-related medical screening, during which she declared that she had COPD and that she'd had four respiratory infections which had been treated with antibiotics during the previous year. Ms K was asked: *'Has the infection fully resolved?'* Ms K answered that it had. After Ms K had completed this part of the screening, she was asked to select either to 'add a condition' or 'finish declaring conditions'. It appears that Ms K chose not to declare any further conditions.

In my view, these questions (and options) were asked and set out in a clear and understandable way and ought to have prompted a reasonable consumer to realise what information IPA wanted to know. IPA thinks that Ms K ought to have disclosed other existing medical conditions, including asthma, food allergy and osteoporosis. And it also considers that Ms K had an unresolved chest infection when she took out the policy. So I've looked carefully at Ms K's medical records to decide whether I think she took reasonable care to answer IPA's questions.

It's clear, from Ms K's medical records, that at the time of policy application, she'd been diagnosed with osteoporosis and was prescribed regular medication to treat it. So I think Ms K ought to have answered 'yes' to question one in regard to osteoporosis. While Ms K was treated for COPD, she was also prescribed medication to treat asthma, she had a personal asthma action plan and I can see she underwent asthma reviews at her surgery. So I'm satisfied that Ms K ought to have answered 'yes' to both questions one and two in relation to asthma. In December 2021, Ms K was prescribed with an epi-pen to treat her food allergy and in May 2022, she attended A&E due to an allergic reaction to food. Again, then I think this condition fell within the scope of question one and therefore, Ms K ought to have

answered ‘yes’. Based on the medical evidence, I think it’s most likely that Ms K was aware of these conditions and she was most likely aware that she was prescribed medication to treat them. And I think therefore that Ms K ought to have been prompted to declare these conditions to IPA in response to its clear questions.

Mr M and Mr M strongly dispute that Ms K either suffered from four chest infections, or that a chest infection had been unresolved at the time of policy application. Ms K appears to have told IPA that she had had four chest infections, so I think it’s fair to say she believed she’d had four infections. I can see that in January 2022, Ms K attended A&E with shortness of breath and a cough. She was prescribed steroids. In August 2022, Ms K attended A&E with a productive cough and shortness of breath. She was prescribed antibiotics and steroids. In November 2022, she attended the surgery with a two-week history of a chesty cough. She was prescribed antibiotics and steroids. And on 15 December 2022, while at an appointment to discuss a referral for COPD, Ms K mentioned that while she’d finished the ‘rescue pack’ she’d been prescribed, she was still occasionally coughing up green and yellow (sputum). At that point, she was prescribed further antibiotics and steroids.

Some of Ms K’s attendances at A&E appear to have been marked as exacerbations of COPD. But it remains the case that Ms K felt she’d had four respiratory infections and she was prescribed steroids and antibiotics on at least three occasions during 2022. That formed the basis of her declaration to IPA.

I’ve carefully considered whether I think it’s fair for IPA to have concluded that Ms K ought to declared that her chest infection was unresolved. On balance, I think it was. That’s because while I accept the purpose of Ms K’s GP visit might not have been in regard to her symptoms, the GP noted that Ms K still had a productive cough and was prescribed both antibiotics and steroids. Ms K was still mid-way through a course of those antibiotics at the point she applied for the policy. And so I think she ought to have answered ‘no’ to the question I’ve set out above.

The claims notes indicate that Mr M told IPA that he’d helped Ms K apply for the policy and that he didn’t think it would be important to fill in the medical declarations. However, as I’ve explained, I’m satisfied that Ms K was asked clear questions at the point of sale, and given her medical history, that she ought to have been prompted to answer them correctly and fully.

IPA says that had Ms K answered its questions correctly, it wouldn’t have offered her this insurance policy. It’s provided evidence in the form of a retrospective screening which supports this position.

In my view then, the available evidence suggests that Ms K did make a qualifying misrepresentation under CIDRA. So I think IPA is reasonably entitled to apply the relevant remedy available to it under the Act. IPA said that it felt Ms K had made a reckless misrepresentation. Given Mr M appears to have suggested to IPA that he didn’t think it would be important to fill in the medical declarations, I don’t think it would have been unreasonable for IPA to have treated the non-disclosure as having been reckless.

However, since it’s refunded the premium Ms K paid, it appears that IPA’s applied the remedy available to it for careless misrepresentation under CIDRA. In either case though, I’m satisfied IPA was entitled to cancel the policy.

That’s because, CIDRA says, that even in cases of careless misrepresentation, an insurer is entitled to rewrite the policy as if it had all of the information it wanted to know at the outset. If it wouldn’t have offered the policy, it may cancel the policy from the outset and refund the premium. In this case, as I’ve explained, IPA says that if Ms K had answered its questions

accurately, it wouldn't have offered her a policy. I'm satisfied, based on the evidence its provided, that this was the case.

So whilst I sympathise with Ms K, Mr M and Mr M's position, based on the available evidence, I don't think it was unfair or unreasonable for IPA to decline this claim, cancel the policy and offer a refund of premium. Therefore, I find its actions are in line with CIDRA and it follows that I'm not directing IPA to do anything more.

IPA also concluded that Ms K's claim would have been excluded from cover in any event because it felt the claim was likely directly or indirectly linked to a condition she hadn't declared. The medical expenses section of the policy says that IPA doesn't cover claims for '*Pre-existing medical conditions as described in the pre-existing medical conditions section unless we have agreed in writing to cover you'.* A pre-existing medical condition is partly defined as:

*'Any other medical conditions for which you have been prescribed medication, received treatment or had a consultation with a doctor or hospital specialist for any medical condition in the past 2 years.'*

When Mr M called IPA to notify it about the claim, it appears that he told it that Ms K had suffered a cardiac arrest following an allergic reaction to the particular food type she was known to be allergic to, had been prescribed medication for and for which she'd attended A&E in May 2022. As I've set out above, Ms K didn't declare her food allergy to IPA and it hadn't agreed to cover that condition. Given what it seems Mr M told IPA at the outset about the cause of Ms K's cardiac arrest, I don't think it was unreasonable for it to have concerns that the claim might not have been covered regardless.

I appreciate Mr M and Mr M are seeking new medical evidence to support Ms K's claim. It's open to them to send any new medical evidence directly to IPA for its review. If they're unhappy with the outcome of any further consideration of the claim, they may be able to make a new complaint to IPA about that issue alone.

For completeness, I appreciate Mr M and Mr M are very unhappy with the way the claim was handled by the emergency medical assistance team and they feel they were caused distress and inconvenience. However, while I don't doubt how stressful and worrying the situation was for Mr M and Mr M, as I've explained, I think it was reasonable for IPA to have turned down this claim. I'm aware Mr M and Mr M have already accepted £300 compensation from IPA for communications issues. In my view, this was a fair step from IPA, even though Mr M and Mr M themselves weren't covered by the policy. This means then that I'm not telling IPA to pay any more compensation.

**My final decision**

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms K to accept or reject my decision before 8 April 2024.

Lisa Barham
**Ombudsman**