Complaint

Miss G complains because Inter Partner Assistance SA ("IPA") has refused to pay her travel insurance claim for medical expenses and a new return flight to the UK.

Background

Miss G held a travel insurance policy, provided by IPA. The policy was bought online through a price comparison website.

Unfortunately, Miss G became ill while on holiday and needed medical treatment. She had to extend her trip and contacted IPA to register a claim. After chasing IPA several times, Miss G booked a new return flight to the UK for a later date than she'd originally intended to travel.

IPA subsequently said Miss G's claim wasn't covered because she hadn't correctly answered the medical questions she'd been asked when she bought the policy. It said, if Miss G had answered the questions correctly, it wouldn't have sold her the policy.

Miss G complained to IPA. IPA investigated and said Miss G's policy wasn't designed for anyone who had any medical history in the previous five years. It said, as Miss G's medical records showed consultations for laryngitis, a mouth ulcer, angular cheilitis and cervical smears in the last five years, there was no cover for the claim under her policy. IPA offered to cancel the policy and refund the premium paid to Miss G.

As Miss G remained unhappy, she brought her complaint to this service.

Our investigator recommended that Miss G's complaint should be upheld. IPA didn't agree, so the complaint was passed to me. I made my provisional decision in April 2020. In it, I said:

"IPA says this policy doesn't cover pre-existing medical conditions and that Miss G misrepresented facts about her medical history to it when she took out the policy.

The terms and conditions of Miss G's policy say that claims arising, directly or indirectly, from pre-existing medical conditions will not be covered. I haven't seen any medical evidence to suggest that the illness Miss G is claiming for is related to any of the medical conditions which IPA has mentioned. So I don't think it's fair or reasonable for IPA to decline Miss G's claim based on the pre-existing medical condition exclusion set out in her policy.

But IPA also says Miss G incorrectly answered medical questions which she was asked when she bought her policy. I think the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA") are relevant to this situation, and I think it's fair and reasonable to apply these principles to the circumstances of Miss G's complaint.

CIDRA is designed to make sure consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the Act.

A "qualifying misrepresentation" is when a consumer fails to take reasonable care not to misrepresent facts which an insurer has asked about. The standard of care required is that of a reasonable consumer. One of the factors to be considered when deciding whether a

consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

When taking out her policy through a price comparison website, Miss G was first asked:

> *"Does any person to be insured have a pre-existing medical condition?*
>
> *To ensure you have the right cover for your trip it is important you tell us about your medical history. If you do not declare medical conditions this could invalidate your policy. Examples include diabetes, high blood pressure, depression and respiratory conditions (including asthma). You do not need to declare pregnancy as a medical condition. "*

Miss G answered "no" to this question.

Before completing the purchase of her policy, Miss G was asked to answer a second question about her medical history. This said:

> *"Important Information…*
>
> *Please note that the policy you have selected is not designed to cover claims arising from pre-existing medical conditions. If you can answer "no" to the following questions, please select "I Agree" to proceed*
>
> *1) Within the last 5 years have you or anyone you wish to insure on this policy suffered any medical condition that has required prescribed medication and/or treatment including surgery, tests or investigations?..."*

Miss G answered "I Agree" and proceeded to purchase the policy.

The first question Miss G was asked lists specific pre-existing medical conditions. While the medical conditions listed seem to be chronic-type illnesses, these are stated to be examples and therefore the list given is not exhaustive.

Our investigator didn't think the second question Miss G was asked gave a different definition of a pre-existing medical condition to the first question. I disagree. The second question, in referring to medical conditions which have required prescribed medication or treatment in the last 5 years, mirrors the definitions set out in the terms and conditions of Miss G's policy with IPA.

These are two separate questions which are displayed independently of each other, at different points in the sales process. While I can understand why Miss G might have interpreted the first question to be asking only about chronic-type illnesses, I think the second question Miss G was asked was clear as a stand-alone question. Miss G needed to take reasonable care to accurately answer both questions.

I don't intend to make a finding on whether I think Miss G took reasonable care in answering the first question, as I don't think this affects the outcome of her complaint. But I've considered whether I think Miss G took reasonable care in answering the second question in the way that she did. In doing so, I've reviewed Miss G's medical records and I've taken into account what she has told us about her medical history.

An insurer is entitled to decide the level of risk it is willing to insure in return for the payment of a premium. Under this policy, IPA only wishes to insure consumers who haven't been prescribed medication or received treatment for a medical condition within the previous 5 years. A consumer who can satisfy these criteria is likely to have a valid claim accepted under the policy. There may also be situations where – depending on factors such as the nature of the specific medical condition, the number and timing of any doctor's visits and the policyholder's overall medical history – I might think a consumer has taken reasonable care in answering the second question Miss G was asked in a certain way.

I don't think it's fair or reasonable for IPA to say Miss G incorrectly answered the second question because she had cervical smear tests. Generally, these are routine check-ups which are carried out at regular intervals and there's no indication Miss G had an underlying medical condition which meant she underwent cervical smears more regularly than usual.

I also don't think Miss G's doctor's visits for laryngitis or angular cheilitis mean she should reasonably have answered the second question in a different way.

Miss G's medical records show she visited her GP around two months before the policy was taken out for what is described as "Acute laryngitis (First)". Miss G was told to rest her voice and to take honey and lemon in hot water. So, Miss G wasn't prescribed any medication for what was seemingly an isolated episode of laryngitis and I don't think it's reasonable to consider that the advice she was given on how to treat the issue constitutes medical treatment for the purposes of the question she was asked.

Angular cheilitis is mentioned on a number of occasions in Miss G's medical records and I think it's clear this was a medical condition which Miss G was prescribed medication for more than once. However, as I understand it, the medications Miss G was prescribed were also available over the counter. Although Miss G was prescribed one of these medications in a higher strength than was available over the counter, I don't think this means she should reasonably have answered the second question differently. Based on the frequency of Miss G's doctor's visits for this condition and the prescriptions she received, I don't think a reasonable consumer would have realised this was something IPA would want to know about in response to the question asked. IPA has also mentioned a skin lesion in Miss G's medical records which it believes is likely to have been the first presentation of angular cheilitis. However I haven't seen any medical evidence to support this and, in any event, I don't think it's likely this would change my opinion about whether Miss G took reasonable care on this point.

In its response to our investigator's view, IPA also mentioned Miss G was advised by her GP to take supplements in the month before the policy was purchased. For the avoidance of doubt, I don't think it's fair or reasonable for IPA to consider that advice to take supplements precluded Miss G from answering "no" to the second question she was asked.

However, having reviewed Miss G's medical records which are available to me and having considered what she has told us about the investigations she underwent for a mouth ulcer, I think Miss G did fail to take reasonable care when answering the second question she was asked.

Miss G's medical records show, in the two years before buying this policy, she consulted her GP about a mouth ulcer. The GP recorded that Miss G had already seen a doctor, a dentist and an oral surgeon abroad about the same issue and had been prescribed medication. At the time of consulting her GP, Miss G already had a follow-up appointment booked with the

oral surgeon abroad. Miss G's GP noted the mouth ulcer needed an "urgent biopsy" but that Miss G was already being seen by an oral surgeon within the next two weeks.

Miss G told us this biopsy was to rule out the possibility of cancer. She says she was ultimately told a sharp object may have caused a cut and this would heal itself within a few weeks without further treatment, which it subsequently did.

But, regardless of what the outcome was, Miss G's medical records show she had repeated consultations for, was prescribed medication for and was referred to a specialist for urgent investigations into a mouth ulcer within the 5 years before buying this policy.

I think a reasonable consumer would have realised this was something IPA would want to know about in response to the second question asked, so I don't think Miss G took reasonable care when answering this question in the way she did.

This means I think Miss G made a "qualifying misrepresentation" under CIDRA, so IPA is entitled to apply the relevant remedy available to it under the legislation. I understand the illness Miss G is claiming for wasn't connected to her mouth ulcer but an insurer's remedies under CIDRA apply regardless of whether there is a connection between the consumer's medical history and the reason for their claim.

In cases of careless misrepresentation, if the insurer can show it wouldn't have entered into the contract on any terms, then CIDRA allows the insurer to avoid the contact and refuse all claims. The insurer should return the premium paid.

I'm satisfied here, if Miss G had answered "yes" to the second question, IPA wouldn't have sold her this policy. Instead, Miss G would have been directed back via the price comparison website to a list of insurance policies from insurers who do offer cover for pre-existing medical conditions.

Miss G would then have been presented with a range of policy options from different providers at different prices and with different benefits. I don't think I can fairly say, on the balance of probabilities that it's more likely than not that Miss G would have chosen to take out a similarly branded but more expensive policy with IPA which did cover pre-existing medical conditions.

IPA has offered to refund Miss G's policy premium, in line with the remedy for careless misrepresentation under CIDRA. I'm sorry to disappoint Miss G but I think this offer is fair and reasonable in the circumstances.

I understand Miss G says she chased IPA about her claim several times while she was abroad and when she didn't receive a response, had to arrange her own return flight home.

An insurer is entitled to make reasonable enquiries to satisfy itself that the circumstances of a claim are covered under a policy before confirming cover. This generally includes requesting medical information from the policyholder's GP. I'd expect an insurer to do this without any undue or excessive delay, but it's often unavoidable that requesting information from third parties will take some time. Given the dates involved in this case, I don't think IPA took an unreasonable amount of time to make a decision about whether Miss G's claim was covered. However, it does seem IPA could have communicated more effectively with Miss G about what the next steps were and what she needed to do to arrange an alternative flight back to the UK.

I have no doubt Miss G will have been inconvenienced by having to arrange a new return flight herself, but I don't intend to ask IPA to do anything further."

Miss G responded to my provisional decision and I've summarised what I think are her key points below:

- IPA is misleading customers and is selling a policy which it is almost impossible for anyone to be eligible for;
- the fact that the policy was bought online through a comparison website isn't relevant;
- the second question asked by IPA during the sales process needs to be read in the context of the first question;
- the limitations of this policy should be pointed out in a fair and clear way;
- an ordinary person on the street is unlikely to consider that a mouth ulcer constitutes a medical condition.

IPA accepted my provisional decision but questioned why I added interest to the premium refund, when this had been originally offered to Miss G in its final response letter.

My findings

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

I've taken into account all the comments Miss G has made in response to my provisional decision. I have sympathy with the situation she has found herself in, but I don't intend to change my provisional findings.

The role of this service is to impartially investigate individual disputes based on the specific circumstances involved. When considering this complaint, I've looked at the sales process Miss G followed and her medical history to decide whether I think she took reasonable care in answering the questions asked. Any discrepancies in the wording IPA used when declining Miss G's claim doesn't affect the outcome of her complaint – the wording of the questions she was asked when buying the policy are what's relevant.

So, the issue for me to decide is whether I think IPA has acted fairly and reasonably when dealing with Miss G's claim - the Financial Ombudsman Service doesn't have a general consumer protection function. It's up to IPA to decide what type of policy it wishes to offer and it's not within our remit to direct IPA to change its sales processes; that's a matter for the Financial Conduct Authority.

I specifically mentioned the policy was taken out online through a price comparison website. The way the policy was sold is relevant in terms of the actual sales process Miss G followed when buying the policy. The way the policy was sold is also relevant to what IPA would have done if Miss G had answered the second question in a different way.

I understand Miss G feels the second question asked should be read in the context of the first question. But, I think the second question is clear in its own right in asking whether anyone has required prescribed medication and/or treatment for a medical condition in the previous 5 years. I think this is clearly highlighted to the customer, as the second question is

headed *"Important Information"* and requires the customer to confirm their agreement to the question before they can proceed with the purchase.

Miss G has mentioned other medical conditions in her response to my provisional decision but what's relevant here is Miss G's actual medical history. Given the circumstances surrounding Miss G's mouth ulcer, I think it would have been reasonable for her to have this in mind when answering IPA's second question. Miss G had already seen a number of other professionals about the matter before seeing her GP – a doctor, a dentist and an oral surgeon. The investigations she needed were clearly urgent, and are noted as such in her medical records.

Overall, this means my decision remains that IPA's offer to refund the policy premium to Miss G is fair and reasonable in the circumstances.

I'm directing IPA to pay interest on the premium refund due to Miss G in order to put her back into the financial position she would have been in if things had happened as they should. I appreciate IPA offered to refund the premium to Miss G in its final response letter but Miss G chose to bring her complaint to this service instead of accepting IPA's offer at the time, as she was entitled to do. Interest at our standard rate reflects the fact that Miss G has been deprived of the use of this money.

My final decision

My final decision is that I don't uphold Miss G's complaint.

Inter Partner Assistance SA has already made an offer to refund Miss G the premium she paid for her policy and I think this offer is fair in all the circumstances. So, I direct Inter Partner Assistance SA to refund this premium to Miss G together with interest at 8% simple per annum from the date the policy was paid for until the date settlement is paid.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss G to accept or reject my decision before 1 June 2020

Leah Nagle
Ombudsman