DRN-2165693

The complaint

Mr T complains that Inter Partner Assistance SA ("IPA") acted unfairly and unreasonably when declining his claim under a travel insurance policy. He wants the claim accepted and paid, or the premiums refunded (though he later wanted both the refund and the claim paid).

What happened

Mr T took out an annual travel insurance policy with IPA through a comparison website. The day that he was due to go on holiday, Mr T became severely unwell and was unable to travel. It was diagnosed that Mr T had been suffering from a kidney stone. Mr T made a claim, but it was declined as IPA said Mr T had incorrectly answered questions about his health and pre-existing medical conditions when taking out the policy.

Mr T complained to IPA as he felt he'd answered the questions correctly and the process had been unclear, misleading and unfair. IPA said the policy Mr T had taken out wasn't designed for anyone with a medical condition which had required prescribed medication or treatment in the last five years. Mr T had told IPA he hadn't been prescribed medication or had a medical consultation in the last five years; if he had answered correctly, IPA said that it wouldn't have sold the policy to him. It said Mr T had seen a consultant several times and received treatment in the last five years.

Mr T complained to us and said his GP had confirmed that at the time the policy was taken out he wasn't suffering from any medical condition, illness or injury (and wasn't experiencing symptoms discussed later with a GP or awaiting diagnosis, treatment or tests). He denied seeing any consultant in the five years before the policy was taken out, but accepted that he had seen a GP more than once during this period. IPA confirmed to the investigator that it was treating Mr T's mistake as careless and was willing to refund the premium.

The investigator's view was that Mr T had reasonably answered "*no*" to questions about whether he had a pre-existing medical condition, but he had incorrectly answered clear questions about whether he'd had in the last five years suffered from medical conditions that required prescribed medication and/or treatment. She said he hadn't taken reasonable care in answering this question as only three months earlier he'd been to see a GP and was prescribed medication and had tests. The investigator noted that in the six months previously to seeing the GP, Mr T had been suffering symptoms on and off.

The investigator accepted that if Mr T had answered the questions correctly, IPA wouldn't have offered him this policy. She explained that the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA") applied and when a consumer made a careless mistake, the insurer was entitled to avoid the policy and refund the premium paid. The investigator thought IPA's offer to refund the premium was fair and reasonable.

Mr T disagreed. He said he didn't know he had a pre-existing medical condition and he didn't have any. Mr T repeated that he hadn't seen any consultant in the last five years, apart from when he became ill and needed to cancel his holiday. He felt the questions he'd been asked were unclear and ambiguous, and denied that he'd been careless in his answers. Mr T believed that the questions only applied if he had a pre-existing medical condition and they

could've been phrased differently to be clearer. Mr T's relative also disagreed and said that Mr T's answers were reasonable in the circumstances.

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.

When I refer to IPA, I'm also referring to its agents. The relevant rules and industry guidelines say that IPA has a responsibility to handle claims promptly and fairly. And it shouldn't reject a claim unreasonably.

To deal with points that I know has upset Mr T, though aren't critical to the resolution of this complaint, I accept he didn't see consultants in the five years before he took out the policy; he saw GP's and nurses in medical consultations. And the key issue isn't whether Mr T's illness was a pre-existing medical condition; it's whether IPA would've offered the policy in the first place, given Mr T's medical history. The claim has been declined on that basis.

Having looked at all the evidence available to me, I think the questions put to Mr T when he took out the policy were clear and unambiguous. I don't accept that only people who felt that they had a pre-existing medical condition needed to answer the questions or that it's unreasonable for insurers to ask about any prescriptions received or GP consultations in the last five years. Insurers are able to decide the risks they're willing to underwrite.

The policy Mr T took out was not intended for anyone who had received prescribed medications or treatment in the last five years – this point is set out within the screen journey of the consumer in taking out the policy and within the policy itself that says:

"Annual multi trip - This policy meets the Demands and Needs of a customer intending to travel more than once within the period of insurance, wishing to buy a standard travel insurance policy, who has not suffered a medical condition nor required prescribed medication, surgery, treatment, tests or investigations within the, five years leading up to the policy purchase date."

The key question Mr T was asked was "*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?".* But only three months earlier Mr T had received a prescription, and from his account to the GP at the time, he had been suffering from abdominal pains on and off for a significant period. This was not disclosed to IPA but was clearly covered by the question which specifically asked Mr T about this issue.

The relevant law in this case is CIDRA. This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). 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. One of these is how clear and specific the insurer's questions were. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless or careless.

If the misrepresentation was reckless or deliberate and an insurer can show it would have at least offered the policy on different terms, it is entitled to avoid the consumer's policy. If the misrepresentation was careless, then to avoid the policy, the insurer must show it would not have offered the policy at all if it wasn't for the misrepresentation.

If the insurer is entitled to avoid the policy, it means it will not have to deal with any claims under it. If the qualifying misrepresentation was careless and the insurer would have charged a higher premium if the consumer hadn't made the misrepresentation, it will have to consider the claim and settle it proportionately if it accepts it.

Mr T answered the questions about his medical history carelessly in my view. Given how recently he'd been to see the GP and received a prescription, I can't reasonably say otherwise. And as the policy isn't designed for anyone who has received a prescription in the last five years, IPA has shown that it wouldn't have been offered to Mr T if he'd answered the question correctly. I would comment in passing that its response that it would've passed to Mr T details of bodies who could assist simply reflects recent changes to industry practice and isn't a matter of concern.

Putting things right

As CIDRA reflects our long-established approach to misrepresentation cases, I think allowing IPA to rely on it to avoid Mr T's policy produces the fair and reasonable outcome in this complaint. The premium should be refunded.

My final decision

My final decision is that I uphold the complaint and Inter Partner Assistance SA should refund Mr T's premium in full. Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 9 October 2020.

Claire Sharp
Ombudsman