DRN-2314192

The complaint

Ms L complains about how Inter Partner Assistance SA ('IPA') dealt with a claim under her travel insurance policy when she fell ill abroad.

All references to IPA include the agents it has appointed to handle claims.

What happened

Ms L held a travel insurance policy, provided by IPA.

Unfortunately, Ms L fell ill while on holiday and was admitted to hospital. Ms L borrowed money from her family to pay the hospital a deposit needed for her treatment, and contacted IPA to register a claim under her policy.

IPA initially suggested it would organise a nurse-escorted flight home for Ms L. However, IPA subsequently discovered Ms L wasn't registered with a UK GP. IPA therefore said Ms L's claim wasn't covered under the terms and conditions of her policy.

Ms L said she hadn't visited a doctor in over two years, and her previous doctor at university hadn't informed her she'd been deregistered from its practice. IPA said if Ms L could obtain evidence that she'd been deregistered by her GP without her knowledge then it would assess the claim again.

Concerned about the rising medical costs, Ms L discharged herself from hospital and travelled back to the UK alone on her amended original return flight. Ms L was taken to hospital the day after her return to the UK.

Ms L complained to IPA, who said its decision to decline her claim was correct under the terms and conditions of her policy. However, IPA said because of the circumstances of Ms L's illness, it wouldn't be fair to apply the policy terms to her situation. IPA therefore said it would cover Ms L's claim and settle her hospital bills and other expenses. IPA also acknowledged it should have offered Ms L a nurse chaperone at her own expense and offered to pay her £400 compensation for failing to do this.

As Ms L remained unhappy, she brought her complaint to our service. Our investigator concluded that IPA hadn't acted incorrectly in declining Ms L's claim and said IPA had paid Ms L's medical bills as a gesture of goodwill. But our investigator acknowledged that IPA should have offered Ms L non-financial assistance while she was abroad and said the £400 offered was fair compensation for its failings.

Ms L didn't accept our investigator's opinion, so the complaint was passed to me. I made my provisional decision about Ms L's complaint in October 2020. In it, I said:

'Rules set out by the regulator (the Financial Conduct Authority's ('FCA's') 'Principles for Business') say:

- *a firm should pay due regard to the interest of its customers and treat them fairly.*

Under the FCA's 'Insurance: Conduct of Business Sourcebook', an insurer must:

- *handle claims promptly and fairly;*
- *provide reasonable guidance to help a policyholder make a claim, and provide appropriate information on its progress;*
- *not unreasonably reject a claim.*

In deciding what I think is fair and reasonable in this case, I've taken into account the above rules and guidance as well as the terms and conditions of Ms L's policy, and the specific circumstances of her complaint. Having done so, I don't think IPA acted fairly or reasonably by turning down Ms L's claim while she was abroad.

The terms and conditions of Ms L's policy say:

> *'**Significant or unusual exclusions or limitations**…*
>
> ***You** must be a permanent resident of, and registered with a General Practitioner in, the **United Kingdom**'.*

*Under the section of the policy entitled 'Important Health Requirements – For All **Insured Persons**', the terms and conditions say:*

> *'**You** must comply with the following conditions in order to have full protection under this policy. If **you** do not comply **we** may refuse to deal with **your** claim…*
>
> *This insurance will not cover **you** if **you**:*
>
> *4. are not a permanent resident of, and registered with a General Practitioner in the **United Kingdom**'.*

The requirement for a policyholder to be registered with a UK GP is common to most, if not all, travel insurance policies and I think this is clearly set out within Ms L's policy terms and conditions, which I note were sent to her in a link by email on 1 May 2019.

The primary purpose of the requirement to be registered with a UK GP is to enable an insurer to carry out reasonable investigations into a policyholder's medical history before confirming that a claim is covered. An insurer is entitled to be satisfied that a claim does not arise from a pre-existing medical condition and/or that the policyholder wasn't undergoing medical tests or investigations when the policy was purchased before it confirms cover.

Ms L wasn't registered with a UK GP. Ms L has explained the circumstances surrounding this and I understand she may have had no knowledge that she had been deregistered but, under a strict application of the policy terms and conditions, her claim isn't covered as she doesn't comply with the policy requirements.

However, this service makes decisions based on what we think is fair and reasonable in all the circumstances. In this case, based on the nature of Ms L's illness, I don't think IPA was disadvantaged by Ms L's failure to be registered with a UK GP and its inability to obtain her medical records as a result.

I'm pleased to see IPA has acknowledged this in its final response letter to Ms L. It has said the condition she suffered from abroad was a new diagnosis and, so, wouldn't have been a

condition which she was aware of or could have declared to it when renewing the policy. IPA has also acknowledged that Ms L wouldn't have been undergoing any tests or investigations for this condition prior to travelling as her lack of registration with a GP would otherwise have come to light sooner. I don't think IPA paid Ms L's claim as a gesture of goodwill – instead, it said it was fair to consider Ms L's claim as being covered under her policy.

IPA accepted cover four days after Ms L returned to the UK. However, I think IPA should have done this sooner, while Ms L was still abroad and before she travelled back to the UK.

Based on the evidence I've seen, IPA was in possession of all the necessary information it needed to confirm cover two days after Ms L's hospital admission, when it received a medical report confirming her condition was 'newly diagnosed'. There's also a note on IPA's file on the following day, saying Ms L's former GP had confirmed she didn't previously have the medical condition she had been diagnosed with abroad.

This means I think IPA's refusal to accept cover while Ms L was abroad was unreasonable in the circumstances. And IPA has acknowledged that even if Ms L's claim wasn't covered by her policy, it should have offered Ms L the option of having a nurse escort at her own expense.

I've considered what award of compensation I think is fair and reasonable in the circumstances for the distress and inconvenience Ms L experienced as a result of IPA's actions in this case.

The medical reports which I've seen are very clear in recommending that Ms L needed to return to the UK in business class, with a nurse escort. IPA's notes acknowledge that a nurse escort was necessary and ambulance transfers both abroad and in the UK were also being looked into. But, when making an award of compensation, I can't take account of what Ms L's repatriation should have cost IPA. Instead, I can only consider the impact of IPA's actions on Ms L.

Because IPA refused to accept her claim, Ms L discharged herself from hospital against medical advice. Ms L told us she did this because, understandably, she was worried about rising medical costs. Ms L travelled back to the UK alone on a long-haul flight, aware she was travelling both against medical advice and without the recommended medical assistance. Ms L says her medication was taken from her at the airport to be checked, she wasn't sure she was administering her own medication correctly (which was the reason a nurse escort had been recommended) and she didn't have appropriate monitoring equipment for her condition. I have no doubt that travelling alone, with a potentially serious newly-diagnosed medical condition will have been very frightening for Ms L.

While I haven't seen any medical evidence that Ms L's condition worsened because of the flight, I understand she was taken to hospital the day after her return.

Overall, I'm satisfied Ms L experienced significant distress and inconvenience as a result of IPA's actions in this case and I intend to make an award of compensation in the category which our service considers 'substantial'. I think a payment of £1000 compensation would be fair and reasonable in the circumstances.

While I appreciate the situation will also have been very worrying for Ms L's parents, they aren't insured under this policy and are not therefore eligible complainants under our rules. This means I can't make an award of compensation for any distress and inconvenience they themselves suffered.

I've seen an email from July 2019, from Ms L's father to IPA, confirming that the agreed

claim payment had been received. Ms L has subsequently told us about various expenses claimed for which IPA didn't pay. If Ms L is unhappy because certain costs claimed for are still outstanding, then she'd need to complain to IPA directly before this service would have the power to consider the matter. This is because the Financial Ombudsman Service can't get involved in a complaint unless the business concerned has been given an opportunity to resolve the issue first.'

So, my provisional decision was that IPA should pay Ms L a total of £1000 compensation, including the £400 compensation already offered.

IPA responded to my provisional decision and said it settled the claim as a gesture of goodwill, rather than as a claim that was covered under Ms L's policy. IPA said it didn't think my intended compensation award was justified and that our investigator had agreed its compensation offer of £400 in recognition of its failings was fair.

Ms L said she was happy, in principle, with my provisional decision but that she was disappointed to learn IPA had all the relevant information about her claim much earlier in the process than she was aware of.

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.

I've taken IPA's additional comments into account, but I won't be changing my decision.

Industry rules say it's unreasonable for an insurer to reject a policyholder's claim because of a breach of a policy condition or warranty unless the circumstances of the claim are connected to the breach. The medical evidence which IPA had showed Ms L's condition was newly diagnosed, so Ms L's lack of registration with a GP didn't have any impact on the claim in this case. Therefore, I don't think IPA acted fairly or reasonably by declining Ms L's claim and I think it should have accepted cover while Ms L was still abroad.

I'm not bound by our investigator's findings when reaching my decision, and I don't think IPA's offer of £400 fairly compensates Ms L for the experience of travelling home alone, against medical advice and without the recommended medical assistance.

I'm satisfied Ms L experienced distress and inconvenience at a level which falls into the range we'd consider as 'substantial' and I think an overall award of £1000 compensation is fair and reasonable for the impact of IPA's actions on Ms L.

Putting things right

IPA needs to put things right by paying Ms L a total of £1000 compensation for the distress and inconvenience she experienced.

This includes the £400 compensation which IPA has already offered.

My final decision

I'm upholding Ms L's complaint about Inter Partner Assistance SA and I direct it to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms L to accept or reject my decision before 7 December 2020.

Leah Nagle
Ombudsman