DRN-3146451

## The complaint

Miss B complains AWP P&C SA ("AWP") has not settled her medical bills following a claim for treatment abroad.

## What happened

Miss B took out a single trip STA Travel insurance policy, underwritten by AWP. She travelled abroad and unfortunately, while she was away, she became unwell with stroke-like symptoms. Miss B attended a hospital, and underwent tests and an MRI scan.

Following the tests, Miss B was diagnosed with "*major depressive disorder, generalised anxiety disorder and panic disorder"* and was prescribed medication.

Miss B said she called a number on the insurer's website, and was given authorisation for treatment before going ahead with the tests at the hospital. And in January 2019, she made a claim for the costs of the medical treatment she received.

AWP said the business Miss B called for authorisation of her treatment, which I will refer to as 'G', wasn't the correct one. It said G didn't provide the medical assistance line for Miss B's policy, so was unable to authorise treatment.

AWP said it would go on to assess Miss B's claim, but thought the treatment she received abroad was linked to a pre-existing condition of depression. It said this hadn't been declared when the policy was taken out. And it asked for further medical evidence.

There were significant delays in AWP receiving the medical evidence it requested from Miss B's GP. And many emails Miss B sent to AWP chasing an update went unanswered.

In October 2019, Miss B contacted AWP and said she had been told the medical provider abroad would be passing the unpaid bills to a debt collection agency. Miss B said she has been advised AWP could request that her account was put on hold and not passed to the debt collector, and she asked AWP to do this. And in December 2019 Miss B contacted AWP again about the progress of her claim, and advised she was being chased directly by a debt collector.

In June 2020, Miss B complained to AWP about the time taken to assess her claim, which had originally been made in January 2019. She said she had continued to be pursued by the debt collector in relation to the unpaid medical bills, and had been threatened with court proceedings.

AWP apologised to Miss B that it was unable to provide a final response to her complaint within the usual timescales, and advised of her right to bring her complaint to this service.

Miss B brought her complaint to us. She advised she'd settled the hospital bills with the debt collection agency, but had to borrow money to do so, and was experiencing financial hardship as a result.

An investigator here looked into what had happened and initially upheld the complaint. They said the significant delays in AWP reaching a conclusion on Miss B's claim were unexplained. And based on the information available, Miss B hadn't been treated fairly. They thought AWP should settle the claim and pay Miss B compensation.

In June 2021 AWP declined the claim on the basis that Miss B hadn't declared her pre-existing mental health conditions when she took out her policy.

Following the investigator's view, AWP provided this service with more information. And it issued a final response to Miss B's complaint. It said it had declined Miss B's claim, as she had consulted with a doctor in the 12 months prior to taking out her policy, and had been taking medication for a mental health condition, but had not declared this. And it said the diagnosis given following Miss B's hospital treatment abroad was directly linked to the pre-existing condition.

AWP apologised for the delays and poor communication during the assessment of Miss B's claim and offered £600 in recognition of this.

In light of the further information provided by AWP, an investigator reviewed everything again and issued a second view on the complaint. They said they thought Miss B's claim had been fairly declined. But AWP should pay £900 in recognition of the distress and inconvenience caused to Miss B by the delays in assessing her claim.

AWP accepted the investigator's view and the increased compensation amount. However, Miss B disagreed. In summary she said:

- she'd declared her mental health condition when taking out her earlier policy over the phone in 2016 and said her father confirmed the same on her behalf for her renewed policy in 2017;
- STA accepted her pre-existing medical conditions over the phone, but didn't confirm this in writing; and
- she called the telephone number on STA's website for authorisation of her treatment and didn't know this was for a different business. And the business she called confirmed the treatment was authorised, so this led her to believe she was covered.

**My provisional decision**

I issued a provisional decision and in summary I said:

> *Declinature of the claim*
> *The relevant law which applies here is The Consumer Insurance (Disclosure and Misrepresentation) Act 2012 (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. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.*

*AWP declined Miss B's claim, as it said she made a misrepresentation by not declaring her pre-existing medical conditions when she renewed her policy. However, AWP has not provided evidence which persuades me it was entitled to do this. In line with CIDRA, AWP can refuse to pay the claim if Miss B made a careless, deliberate or reckless misrepresentation, which AWP can evidence made a difference to the policy it would have offered, or if it wouldn't have offered a policy at all. As I've not seen evidence of this, I'm not persuaded it was fair for AWP to decline the claim.*

*To put things right, AWP should now re-assess the claim, subject to the remaining terms and conditions of the policy.*

*Authorisation of the claim*

*AWP has said Miss B visited the insurer's website for the country she was visiting, rather than the UK website. And this is why she was presented with an incorrect telephone number for medical assistance.*

*I don't think it would be reasonable for me to hold AWP accountable for the incorrect advice provided by the other business - G. And, having reviewed the policy documentation, I'm satisfied the correct telephone numbers to use in a medical emergency were provided in a way that was sufficiently clear.*

*However, I'm persuaded Miss B made efforts to contact her insurer for authorisation of the claim, and thought cover had been confirmed for her treatment. So, I don't think it would be fair for AWP to turn down the claim on the basis that it had not pre-authorised treatment.*

*Delays*

*There were significant delays in the handling of Miss B's claim – she waited more than two years for AWP to make a decision. AWP has accepted responsibility for the delays and agreed it didn't provide the right standard of service. It offered £600 to recognise the distress and inconvenience caused to Miss B. However, the investigator thought this should be increased to £900, and AWP agreed.*

*In these particular circumstances, I think £900 is fair. I say this because it's clear to me Miss B has suffered considerable distress and inconvenience due to the delays in AWP handling her claim. In particular because she was being chased by the overseas provider and later a debt collector, in relation to the medical bills which she*

*said she couldn't afford to pay. And she borrowed money to settle the debt, and has been left in financial difficulty. I accept this must have been very upsetting and worrying for her, and went on for a significant amount of time while she waited for an answer on her claim.*

**The response to my provisional decision**

Miss B responded to my provisional decision and accepted what I'd said.

AWP also responded, and said it had nothing to add.

**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.

As neither party has raised any further points, I see no reason to depart from the conclusions set out in my provisional decision and summarised above.

**My final decision**

For the reasons I've given, I direct AWP P&C SA to re-assess Miss B's medical expenses claim, subject to the remaining terms and conditions of the policy. And to pay £900 in compensation for the distress and inconvenience caused.

AWP P&C SA must pay the compensation within 28 days of the date on which we tell it Miss B accepts my final decision. If it pays later than this, it must also pay interest on the compensation, from the date of my final decision to the date of payment, at 8% simple.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 13 April 2022.

Gemma Warner
**Ombudsman**