DRN-3440425

The complaint

Mr K complains that AWP P&C SA has turned down a medical expenses claim he made on a travel insurance policy.

What happened

In December 2019, Mr K booked a holiday abroad through a travel agent I'll call T. At the same time, he took out a travel insurance policy through T to cover his trip. The policy was underwritten by AWP P&C SA. Mr K travelled abroad as planned a short while later.

Unfortunately, while Mr K was away, he became ill and was admitted to hospital with pneumonia. He incurred significant medical expenses and so he made a medical expenses claim on his travel insurance policy.

Mr K told us that AWP turned down the claim because it said that the pneumonia he'd suffered from was linked to an existing diagnosis of Chronic Obstructive Pulmonary Disease (COPD). It said Mr K hadn't declared his COPD to its medical screening line and it hadn't agreed to cover the condition. It told Mr K that the policy didn't cover medical expenses claims which were linked to a policyholder's pre-existing medical conditions unless it had agreed to cover the existing conditions.

Unhappy with AWP's decision, Mr K asked us to look into his complaint. Despite our requests, AWP didn't send us a copy of its complaint file and Mr K told us that he hadn't been sent a copy of the policy terms and conditions or a final response to his complaint.

On that basis, our investigator recommended that Mr K's complaint should be upheld. He felt that the provisions of the Consumer Insurance (Disclosures and Representations) Act 2012 should apply to Mr K's claim. He said that in order for an insurer to show a policyholder had made a misrepresentation to it, the insurer needed to demonstrate it'd asked the policyholder a clear question which the policyholder hadn't taken reasonable care to answer. In this case, he didn't think AWP had shown that it'd asked Mr K a clear question and so he didn't think it could fairly turn down the claim. He recommended that AWP should pay the claim, together with interest.

AWP didn't respond to the assessment or provide any evidence.

I issued a provisional decision on 9 March 2022. In my provisional decision, I explained why, based on the evidence I had available, I didn't think it had been fair for AWP to turn down Mr K's claim. I said:

'The relevant regulator's rules say that insurers must handle claims promptly and fairly. And they mustn't turn down claims unreasonably. So I've carefully considered, in the absence of any other available evidence, Mr K's version of events and what I think is most likely to have happened.

It's important I make clear that I don't think CIDRA applies to this circumstances of this case. I say that because Mr K didn't go through any kind of screening with AWP. He's said he was

never told that the policy didn't cover pre-existing medical conditions or that these needed to be declared to AWP. Mr K says he never made any kind of representation about his health to AWP and in fact, he had no direct dealings with AWP until he came to make a claim. Mr K took out the policy through T, an independent company. T was responsible for highlighting any significant restrictions on the policy cover at the point of sale. This means AWP isn't responsible for any of T's actions during the policy sale.

However, based on Mr K's testimony about what happened, which I find plausible and persuasive, I think his complaint should be upheld for other reasons. Mr K said his claim was turned down because AWP considered his diagnosis of pneumonia was linked to COPD. Unfortunately, I don't have a copy of any relevant medical reports which set out the treating hospital team's diagnosis and whether it made any link between COPD and pneumonia. Neither do I have the medical assistance team's notes and so I can't ascertain what, if any, input AWP's clinical team had into the claims decision. And in the absence of the exact policy terms, I don't know exactly what policy term AWP relied on to turn down this claim.

I've looked online at a copy of the current terms which apply to policies sold through T and which are underwritten by AWP. I find it's likely that the terms are broadly similar and so I've considered these when assessing this complaint. The medical expenses section of the policy contains the following exclusion:

'The insurer shall not pay for any claim directly or indirectly caused by, arising or resulting from, or in connection with:

A pre-existing medical condition unless the insurer has agreed to provide cover and you have paid any additional premium required.'

A pre-existing medical condition is defined as:

'Any respiratory condition (relating to the lungs or breathing), heart condition, stroke, Crohn's disease, epilepsy, allergy, cancer, psychiatric or psychological condition (including anxiety, stress and depression for which you have received treatment (including surgery, tests or investigations by your doctor or a consultant/specialist or prescribed medication) in the last five years.

Any medical condition for which you have received surgery, in-patient treatment or investigations in a hospital or clinic within the last 12 months, or are prescribed medication.'

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy, which is down to something a policy covers. In this case, I'm satisfied Mr K did incur medical expenses due to an illness while he was abroad. If AWP wishes to rely on an exclusion to turn down the claim, the burden of proof shifts and it's for AWP to show the exclusion applies.

In this case, I've seen no persuasive medical evidence to demonstrate that Mr K's pneumonia was caused directly or indirectly by his COPD. Mr K seems to accept he suffered from COPD, so I've made the reasonable assumption that this diagnosis falls within the definition of a pre-existing medical condition. While I acknowledge COPD is a respiratory condition, I don't think AWP has shown a link between COPD and Mr K's pneumonia. In the absence of medical evidence, either from the treating hospital, which links these conditions or evidence from AWP's Chief Medical Officer which states that on the balance of probabilities, Mr K's pneumonia was more likely than not linked to COPD, I don't find AWP has demonstrated that this exclusion can fairly be applied to Mr K's claim.

So I currently don't think AWP has treated Mr K fairly and I don't think it was fair for AWP to

turn down Mr K's claim. This means I currently think the fair and reasonable outcome here is for AWP to reassess Mr K's claim in line with the remaining terms and conditions of the policy.'

I asked both parties to send me any further evidence or information they wanted me to consider.

AWP told our investigator it had received a copy of my provisional decision. But it didn't provide any response or further evidence by the further deadline we gave.

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 provided any further evidence or comments for me to consider, I see no reason to change my provisional findings.

So my final decision is the same as my provisional decision and for the same reasons.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I uphold this complaint.

I direct AWP P&C SA to reassess Mr K's claim in line with the remaining terms and conditions of the policy.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K to accept or reject my decision before 18 May 2022.

Lisa Barham
Ombudsman