DRN-4256211

The complaint

Ms C complains about the way that Rock Insurance Services Limited has administered a single trip travel insurance policy.

What happened

The background to this complaint is well-known to both parties, so I've simply set out a summary of what I think are the key events.

In December 2019, Ms C and her partner, Mr S, booked a holiday abroad. They were due to travel in June 2022. On 16 March 2022, they took out a single trip travel insurance policy through Rock, which was underwritten by an insurer I'll call E.

However, Ms C didn't receive a copy of the policy documents, so on 18 March 2022, she called Rock. During the call, Rock's call handler attempted to send the documents by email to Ms C again, but they still weren't received. The call handler arranged for the policy documents to be issued by post to Ms C. These were sent on 5 April 2022 and received by Ms C on the following day.

Ms C said that she'd been annoyed that she hadn't received the documents at the outset, so she put them to the side. But on 10 May 2022, Ms C had checked the policy documents. She noted the documents stated that she and Mr S had declared that Mr S suffered from high blood pressure, but that they'd declined to pay the additional premium to cover that condition (and other specified linked conditions). So she emailed Rock that day. She said she and Mr S had realised that they'd declined to add medical cover for Mr S and asked Rock to get in contact, so that the condition could be added to their policy.

Very sadly, Mr S unexpectedly passed away two days later on 12 May 2022. On that basis, Ms C cancelled the trip.

Rock didn't respond to Ms C's email until 10 June 2022, when it emailed Ms C with details explaining how to add medical cover to the policy.

Ms C made a cancellation claim to E. But E turned down the claim. That's because it noted that the cause of Mr S' death was related to his existing high blood pressure. The policy terms specifically excluded claims which were caused by a policyholder's pre-existing medical conditions unless they'd been declared to and accepted by E. In this case, Ms C and Mr S had declined to add cover for Mr S' high blood pressure.

Unhappy with Rock's administration of the policy, Ms C complained. She said she and Mr S had never been asked whether they wanted to add cover for Mr S' high blood pressure during the online sales process. And she also felt that had Rock responded to her email of 10 May 2022 in a timely way, she and Mr S would've been able to add medical cover to the policy prior to his passing. She considered that the delay in Rock responding to that email had meant they'd been unable to add the cover they wanted, which had ultimately led to the decline of the cancellation claim. She asked us to look into her complaint.

Our investigator thought it was most likely that Rock had asked Ms C and Mr S screening questions during the online sales process and that they'd inadvertently chosen not to add cover for Mr S' medical condition. And while he couldn't be certain that Rock had emailed the policy documents to Ms C and Mr S following the policy sale, he was persuaded that Rock had posted these to Ms C on 5 April 2022 and the documents had been received the next day. So he concluded that Ms C had had some weeks to check the policy documents and to contact Rock if she wanted to make amendments to the policy. But she hadn't done so until 10 May 2022. The investigator felt that if Ms C had contacted Rock sooner, it was most likely that the cover would've been added to the policy and that the cancellation claim would therefore have been covered.

After the complaint was referred for an ombudsman's decision, Rock confirmed that it was prepared to pay Ms C £250 compensation to reflect the upset it considers she was caused by its delay in responding to her email of 10 May 2022 and for the delay in responding to her complaint.

I issued a provisional decision on 6 July 2023. In my provisional decision, I explained the reasons why I thought Rock's offer to pay her £250 compensation was fair and reasonable. I said:

'First, I'd like to offer my sincere condolences to Ms C for the loss of Mr S. I understand that this has been a very upsetting time for her.

It's also important that I make clear the parameters of this decision. I will only be considering whether Rock administered Ms C's policy. I won't be deciding whether or not it was fair for E to turn down the claim. That's because Rock is an entirely separate legal entity to E and it doesn't have the regulator's authority to assess claims. If Ms C is unhappy with the ultimate decision to turn down her claim (or the way in which E handled her claim), it's open to her to make a new complaint about that issue alone.

Did Rock sell the policy fairly?

It's common ground that Ms C and Mr S took out this policy online. I haven't seen any evidence that Rock carried out an assessment of Ms C and Mr S' demands and needs, so I don't think it recommended that they should take out the policy. This means it didn't need to check that the policy was suitable for them. But it did need to give them enough clear, fair and not misleading information about the contract so that Ms C and Mr S could decide if it was right for them.

Rock has provided me with a copy of the sales journey it says Ms C and Mr S would've followed during the online process. Ms C has seen a copy of the sales journey and has had the opportunity to comment on it. I appreciate Ms C has concerns that the sales journey I've seen didn't relate specifically to the purchase of her policy. However, I think it's more likely than not that the sales journey does reflect the information Ms C is likely to have seen and the questions that she and Mr S were asked. So I've gone on to think about what's most likely to have happened at the time of the sale.

The sales process includes a section called 'Medical screening questions'. It appears that Ms C and Mr S answered 'yes' to a question which asked them whether anyone to be insured on the policy needed cover for any medical conditions. Ms C and Mr S were then asked whether anyone to be insured on the policy had any medical condition where they'd been prescribed medication (amongst other things) within the last two years. They were subsequently asked whether anyone travelling on the policy had any circulatory or heart-related conditions. It appears that Ms C and Mr S declared that Mr S suffered from high blood pressure and that he was prescribed two medications for it.

Next, the sales process indicates that Rock calculated the additional premium which E would charge to cover Mr S' high blood pressure. It also set out a list of linked conditions which would be excluded for cover under the policy. Immediately underneath this box were two buttons, one which said: 'Add Cover' and one which said: 'No cover'. If 'No Cover' was selected, then Rock says Ms C and Mr S would've seen a screen which said:

'As you have selected no, you will not be covered for any claims arising directly or indirectly from your pre-existing medical condition(s) or any associated complications.'

Ms C strongly disputes that she or Mr S were asked to add or decline cover. I've thought about this carefully.

I can see that following the sale, a medical screening declaration was generated. The title of the document included the word 'declined'. This referred specifically to Mr S and the declaration of high blood pressure, along with information about Mr S' medications. It confirmed that the insurer would be prepared to offer cover for the condition at a cost of £23.33, but that it noted Mr S had declined this cover. It reiterated that there was no cover for Mr S' medical condition and also set out a list of excluded linked conditions.

In my view, it seems unlikely that such a screening document would've been generated unless Mr S and Ms C had decided to decline to add medical cover. And I note that in her email to Rock on 10 May 2022, Ms C specifically stated that she and Mr S had 'realised that (they) had declined the medical cover for (Mr S).' So on balance, I think it's more likely than not that Mr S and Ms C were asked whether or not they wanted to add medical cover and that they declined to do so, even if inadvertently.

I'd add too that I think Rock's screening questions were clear and that it clearly set out the possible implications on cover if Ms C and Mr S decided against paying the premium for Mr S' medical condition.

Rock says that following the sale, it emailed copies of Ms C and Mr S' policy documents to them. It can't provide us with any evidence to show that it definitely did do so, and therefore it's possible that these documents were emailed at the point of sale, but I can't discount the possibility that things didn't happen as they should. With that said, I've listened to a call between Ms C and Rock on 18 March 2022, two days after the policy sale. During the call, Ms C stated that she hadn't received her policy documents. The call handler checked Ms C's email address and it appears that they emailed the documents again while Ms C was on the line. Ms C says that despite this, the documents weren't received into her inbox. What's clear though is that the call handler also offered to arrange to send the policy documents by post to Ms C, which Ms C accepted. I think this was an appropriate and reasonable response from Rock and ensured that Ms C would be given the information she needed in good time.

The policy information was posted to Ms C on 5 April 2022 and Ms C says she received it a day later on 6 April 2022.

Did Rock's delay in responding to Ms C's email cause her to lose out?

As I've explained above, Ms C and Mr S' policy documents included a medical screening declaration which showed that cover for high blood pressure had been declined. I think this document was clear and also highlighted the potential impact upon cover, including for linked conditions. By Ms C's account, she received this document on 6 April 2022 – around five weeks before Mr S sadly passed away. I think the information Ms C was sent was clear enough to put her on notice that she hadn't added cover for Mr S' medical condition when the policy was purchased. And so I think Ms C had enough information available to her some

weeks earlier to check the level of cover and to get in touch with E/Rock to enquire about paying for medical cover if she'd wished to do so.

Ms C says she put the policy information to one side when she received it, because she'd been annoyed by the delay in its dispatch. She said she didn't check it until 10 May 2022, at which point she emailed Rock, stating that she'd realised she'd forgotten to add medical cover for Mr S and asking for it to contact her so that she could add the cover. Sadly, Mr S passed away only two days later, by which point, the additional premium for high blood pressure cover hadn't been paid. And it's agreed that Rock didn't respond to Ms C's email until 10 June 2022. So I've considered whether I think Rock's delay in replying to Ms C resulted in her being unable to add medical cover when she could otherwise have so.

But I don't think I could fairly or reasonably find that Rock's delay in responding to Ms C's email meant she was left without cover which she and Mr S would otherwise have been able to pay for. That's because of the very short timeframe between Ms C's email and Mr S' sad passing. Even if Rock had responded to Ms C and had provided her with information about how to add medical cover for Mr S within its own service level of 48 hours (which I don't find to be unreasonable), it seems most likely that Mr S would already have been taken ill. And as such, I still don't think Ms C would've been able to pay the additional premium to cover Mr S' medical condition prior to his passing. As such then, I don't think I could reasonably conclude that the delay in Rock responding to Ms C was ultimately the reason why her claim was declined.

With that said, it did take Rock a month to respond to Ms C's email. And it acknowledges that there were delays in its handling of Ms C's complaint. It recognises that these service failings would've added to Ms C's distress at an already very difficult time for her. Therefore, it has offered to pay Ms C £250 compensation. I currently think that this is a fair and reasonable award of compensation to reflect the material additional trouble and upset I think Rock is likely to have caused Ms C.'

I asked both parties to send me any additional evidence or comments they wanted me to consider.

Rock didn't respond by the deadline I gave.

Ms C disagreed with my provisional findings and I've summarised her response. She said that there'd been no discussion with Rock about posting her documents on 18 March 2022 – that call had taken place days later. She maintained that the sales process Rock had provided to me wasn't the process she'd followed. She queried how customers were supposed to know about all the different parties involved in the insurance policy – in particular, Rock and E. She stated that she and Mr S had only realised that cover for Mr S' condition was declined when they received the policy documents. She asked how I was to know a screening document wouldn't have been generated unless they'd declined the cover. She felt there'd been a glitch in the system, but that I had dismissed all she had to say and took Rock at face value.

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.

Having done so, whilst I'm very sorry to disappoint Ms C, I still think Rock's offer of compensation is fair and reasonable and I'll explain why.

Ms C's policy was sold by Rock and it was underwritten by E. Many travel insurance policies

are sold by brokers who aren't responsible for dealing with claims, or indeed authorised to deal with claims. I understand that Ms C wasn't aware of the parties involved in the sale and underwriting of her insurance policy. But it remains the case that if she's unhappy with the way her claim was handled, or with the insurer's decision to decline her claim, she'll need to complain separately to E about that issue alone.

I appreciate Ms C says that Rock didn't discuss posting her documents to her during the call of 18 March 2022. Even if the call did take place later though, Ms C told us that she'd received the documents on 6 April 2022. So I still think she'd had the relevant documents for around five weeks before she emailed Rock asking it to contact her and Mr S to discuss adding Mr S' medical condition to the policy.

It's clear how strongly Ms C feels that she and Mr S weren't presented with the option to declare Mr S' medical condition at the point of sale. I've thought about what Ms C has told us very carefully and I'd like to reassure her that I haven't dismissed what she's said or taken Rock's evidence at face value. But I have to make my decision based on the balance of probabilities – what I think is most likely to have happened, given the available evidence and circumstances. In this case, I've carefully weighed-up Ms C's testimony, alongside Rock's submissions and the screening document.

I don't think I've seen enough evidence to fairly or reasonably conclude that Rock's sales process had a glitch on the day Ms C and Mr S took out the policy, or that the sales process we've been sent isn't the journey Ms C and Mr S followed. And the screening document does specifically relate to Mr S, includes his date of birth and refers directly to his medical condition and the medications he took for that condition. On balance then, I think it appears more likely than not that Ms C and Mr S entered details about Mr S' medical condition during the online sale and declined to take out cover for it – even though I accept they may have done so inadvertently.

And as I've explained, Ms C and Mr S had received the policy documents - which showed that Mr S' medical condition wasn't covered - around five weeks before Ms C emailed Rock to enquire about how to add cover. I still find that the documents were clear enough to put Ms C on notice that Mr S didn't have medical cover. And that she therefore could have contacted Rock or E some weeks sooner to take out cover for Mr S' medical condition. It's still the case too that Ms C didn't email Rock to explore adding medical cover until two days before Mr S was sadly taken ill and passed away. So I still think that even if Rock had picked-up the email within its service level of 48 hours, it's very unlikely that cover would've been accepted and agreed by E prior to Mr S' illness.

I'd like to reiterate my condolences to Ms C for the loss of Mr S. I don't doubt what an upsetting and difficult time she's been through and I know that this decision is likely to come as a disappointment to her. But overall, I still think that Rock's offer of £250 compensation to reflect the impact its delay in responding to Ms C when she was already going through such a distressing time is fair and reasonable in all the circumstances. So my decision is that Rock must now make such a compensation payment to Ms C.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I think Rock has now made a fair and reasonable offer of settlement.

I direct Rock Insurance Services Limited to pay Ms C £250 compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms C to accept or reject my decision before 21 August 2023.

Lisa Barham
Ombudsman