DRN-4271519

The complaint

Mr and Mrs K are unhappy that Great Lakes Insurance SE declined a claim they made on their travel insurance policy and with the service they received.

What happened

In June 2020 Mr K had a problem with his gallbladder. His consultant at the time decided that they would wait to see if there were further issues. Over a year later, in September 2021, Mr and Mrs K took out an annual travel insurance policy. The policy certificate shows that no medical conditions were declared by them.

Mr and Mrs K were due to go on holiday on 4 April 2022. On 30 March 2022 Mr K went to the hospital and was seen for symptoms relating to his gallbladder. He was discharged and, at that time, was considered fit to go on holiday. Mrs K phoned Great Lakes to let them know about Mr K's change in health and paid an additional premium of £350. The following day Mr K was readmitted and diagnosed on 4 April with a gallstone bile duct blockage.

Mr and Mrs K claimed on their travel insurance for the cost of their holiday. It was declined because Great Lakes said Mr K was aware of the need to cancel his trip on the 30 March 2022, when the policy was upgraded.

Mr and Mrs K complained to Great Lakes about delays and the decision to decline the claim. Great Lakes maintained their decision to decline the claim and apologised for the delays. In relation to the claim Great Lakes said the symptoms which gave rise to the cancellation pre-dated the updated declaration in March 2022. And, they said Mr K should have declared his treatment in 2020 when the policy was taken out. Unhappy, Mr and Mrs K made a complaint to the Financial Ombudsman Service about the decision to decline the claim.

Our investigator looked into what had happened and didn't uphold the complaint. She thought Mr and Mrs K hadn't taken reasonable care when asked questions during the retrospective screening as they were asked if any of the travellers were awaiting surgery, a procedure, test or test results. She explained that the letter from Mr K's consultant reflected that there had been a discussion about out-patient appointments and possible surgery. So, she thought Great Lakes decision to decline the claim was reasonable, and in line with the relevant law.

Mr and Mrs K didn't agree. Mrs K said that during the call she was asked if there had been a problem in the previous 12 months. She said she had no idea there was to be a referral or a possible operation. She explained that the letter arrived a few days later, in the post and after the holiday had been cancelled. This didn't change our investigators thoughts about the overall outcome of the complaint. She accepted that Mr and Mrs K hadn't received the letter when they made the call. But she didn't think it was unreasonable for Great Lakes to rely on the contents of the letter, which suggested a discussion had taken place.

Mr and Mrs K highlighted the contents of the call they had with Great Lakes on the 30 March 2022 and that their answers were accurate. They said that to be told they'd failed to take reasonable care and it had resulted in a misrepresentation was devastating.

So, the complaint was referred to me to make a decision. Having reviewed the file I asked Great Lakes for further information, including what it would have done if Mr and Mrs K had declared Mr K's gallbladder issue at the point of sale. I didn't receive a response.

In July 2023 I issued a provisional decision upholding Mr and Mrs K's complaint in part. I said:

> I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.
>
> The relevant rules and industry guidelines say that Great Lakes has a responsibility to handle claims promptly and fairly. And, they shouldn't reject a claim unreasonably.
>
> Great Lakes says Mr and Mrs K answered medical questions incorrectly when they bought their policy and also when the additional screening took place. This means the law set out in the Consumer Insurance (Disclosures and Representations) Act 2012 ("CIDRA") are relevant and I think it's fair and reasonable to apply these principles to the circumstances of this case.
>
> CIDRA is designed to make sure consumers and insurers get an appropriate remedy if a policyholder makes what is called a 'qualifying misrepresentation' under the Act.
>
> A qualifying misrepresentation is when a consumer fails to take reasonable care not to misrepresent facts which an insurer has asked about. The standard of care required is that of a reasonable consumer. One of the factors to be considered when deciding whether a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.
>
> I'm sorry that it's caused distress to Mrs K that the phrase used is 'misrepresentation'. That's not to suggest, in this case, she's been dishonest or has deliberately misled the insurer. That phrase is taken from the relevant legislation that I must consider when making a finding about this complaint.
>
> <u>The sale of the policy in September 2021</u>
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> Mr and Mrs K were asked several questions when taking out the policy in September 2021.
>
> This included completing a medical declaration which said:
>
> > Declaring your pre-existing medical conditions will ensure that we offer you the right travel insurance cover. By not declaring any medical conditions, you may not be covered if you require medical treatment abroad.
> >
> > For each traveller named on this policy, please select Yes if they:
> >
> > a. Have, in the last two years, suffered from any medical or psychological conditions and for which they've received treatment, been prescribed medication, attended any consultations, investigations or check-ups …
> >
> > Does Traveller One have any pre-existing medical conditions?
> >
> > Underneath this question there were options to tick 'yes' or 'no'.
>
> Great Lakes says Mr and Mrs K should have answered 'yes' to this question as Mr K

had received treatment for his gallbladder in June 2020. So that was within two years of taking the policy out in September 2021. The policy certificate shows that no medical conditions were declared by Mr or Mrs K.

I've taken into account that Mr and Mrs K said they were asked to disclose medical conditions within the last 12 months. I don't doubt that's their honest recollection of what they were asked. But, the evidence I've seen suggests it's most likely that they were asked to disclose health conditions from the two years prior to taking out the policy.

I think Mr and Mrs K should have answered 'yes' to the question I've set out above. I think they should have told Great Lakes about the treatment for Mr K's gallbladder in June 2020.

The medical evidence says that Mr K was known to have gallstones following an ultrasound and that he'd seen a consultant. It says the decision was to 'to observe and watchful waiting'. So, I think Mr K had received treatment, attended a consultation and had investigations in relation to his gallbladder.

I don't think it was unreasonable for Great Lakes to conclude that Mr and Mrs K should have answered 'yes'. So, I think they did make a qualifying misrepresentation under CIDRA. I don't think that it was deliberate or reckless. I think it was more likely to have been an honest mistake.

That means Great Lakes is entitled to apply the relevant remedy available to it under CIDRA. This says that in case of careless misrepresentation, if the insurer wouldn't have entered into the contract of insurance it can cancel the policy and refund the premiums. If the insurer would have offered the insurance, but charged a higher premium it can proportionately reduce the amount to be paid on the claim.

Great Lakes hasn't confirmed whether it would have offered Mr and Mrs K cover if they'd answered 'yes' to the relevant question or if it would have charged more for cover. That's because they considered there to have been a further misrepresentation.

The upgrade to the policy on 30 March 2023

Mr K called Great Lakes on 30 March 2023 and I've listened to the calls which took place on that date.

In the first call Mrs K was asked if she intended to claim on the policy. She answered 'no' and said she really didn't want to claim on the policy. Great Lakes asked if all travellers were currently fit to travel – she answered 'yes'. She was then asked if anyone travelling was awaiting surgery, a procedure, test or test results.

Mrs K mentioned Mr K's gallbladder and that he may be having a scan (but said she didn't know). She said they didn't know where they were with everything and that they were going on holiday. She also said the gallbladder had 'flared up really badly'. The advisor asked if 'as of that second' Mr K was awaiting a scan. Mrs K responded to say, 'not of this second no'.

She was then asked, 'Do any travellers have any symptoms which haven't been diagnosed by a medical practitioner?'. Mrs K answered 'no'.

Mrs K was then asked if there was a diagnosis and said they knew it was his

gallbladder. She said she was trying to be honest and not lie. But she said it was uncomfortable as she was clearly struggling to give the right technical name for the condition. Mrs K said Mr K was diagnosed several years ago and suddenly the gallbladder had become uncomfortable earlier that day. She queried if she needed the medical name for gall bladder inflammation. Based on the discussion with Great Lakes Mrs K decided to call back with the correct name.

In the second call Mrs K explained Mr K had been unwell the previous night with a gallbladder attack. She said she wanted to be upfront. She said two years ago that he'd had a gallbladder incident with no further issues until that morning. She set out what had happened that morning and that he'd been given anti-biotics and painkillers. She also said she had no letter or referral before going on to explain that it was cholelithiasis (a 'gall bladder attack'). Mrs K again confirmed they had no intention to claim.

Mrs K went back through the same general medical questions she was asked during the first call, which I've outlined above. Mr K was on the call in the background. Mrs K confirmed they were both fit to travel. Great Lakes then asked if any travellers were awaiting surgery, a procedure, test or test results, including Covid-19. Mrs K answered 'no'.

When asked if Mr K was awaiting any procedures to treat the gallbladder or bile duct Mrs K replied 'no, not at the moment he isn't', and later said, 'we don't know what's happening'. Mrs K was then asked if he'd had any symptoms relating to the gallbladder within the last 12 months. Mrs K said he hadn't until this morning so Great Lakes recorded this as a 'yes'.

Great Lakes confirmed that the condition could be added for an additional premium. I'm not persuaded that Mrs K failed to take reasonable care when answering the questions asked during the calls. I'll explain why.

Mrs K's testimony is consistent with the medical evidence. There is a letter from Mr K's consultant, dated 30 March. I accept this letter wasn't available to Mrs K when she spoke to Great Lakes as she spoke to them on the 30 March which is the same date as the letter. She also said in the calls she hadn't received a letter from the hospital yet. It confirms that Mr K had been symptom free since June 2020 and that he was considered fit to travel. The consultant said:

> 'In view that your symptoms have completely resolved, I believe you might have passed a stone. You were quite well in yourself and are due to go on a cruise holiday for three weeks in four days time … You are fit and well otherwise.
>
> You mentioned you would like to go back and see [redacted], who is the same consultant you have seen two years ago, which I have now arranged for you to see her on a routine basis once you are back from your holiday. I have given you a prescription of pain killers and a prescription of anti-biotics to take with you on the cruise ship in case this happens again… We will see you as an outpatient in due course, for consideration of taking your gallbladder out'.

I think Mrs K gave reasonable answers to the questions she was asked and gave Great Lakes enough information about the circumstances surrounding the treatment. I don't think Mr and Mrs K had any intention to claim on the policy. The letter from the consultant makes no reference to Mr K being unfit to travel. I think Mr and Mrs K

were notifying Great Lakes of a change in health, prompted by an email Great Lakes had sent and Mr K's visit to the hospital that morning.

I think Mrs K gave Great Lakes full disclosure about the circumstances. They didn't pick up on the fact that the gallbladder issues in 2020 hadn't been disclosed and didn't currently appear on the declared medical conditions. In the call Great Lakes focused on what had happened in the last 12 months.

I've given careful thought to the question Mrs K was asked about whether Mr K was awaiting surgery, a procedure, test or test results. Mrs K was upfront during the call that she had no letter or referral. I also bear in mind that during the first call she discussed this with Great Lakes and it was positioned that she needed to answer on the basis that 'as of that second' whether Mr K was awaiting a scan.

As I've outlined above Mrs K was clear she didn't have a letter about the next steps. She also reiterated that they didn't really know what was happening. The consultant's letter suggests it is most likely that the arrangements for Mr K to see his previous consultant were made after Mr K spoke to the consultant because it says, 'which I have now arranged' (my emphasis). There's also no reference in the letter to the consultant having discussed seeing Mr K as an outpatient in the future or removing his gall bladder at the time he was released from hospital. I accept Mr K's testimony that he wasn't aware this was the consultant's plan until he received the follow up letter. I also bear in mind that previously Mr K had been advised to wait to see what happened. So, I don't think this suggests it is most likely that Mr and Mrs K were aware that there would definitely be follow up appointment, even if Mr K had expressed a desire to see his previous consultant. I think their evidence has been consistent and credible. It's also consistent with the medical evidence that's available.

I think there were a number of prompts during the call that Great Lakes ought to have picked up on. And I think they had a reasonable opportunity to explore information with Mrs K in more detail. For example, it was clearly important that Mrs K gave accurate information about the next steps for Mr K. But, despite being told that Mrs K had no letter, no referral and that 'we don't really know what's happening', Great Lakes continued to screen for the condition and take the additional premium. If this was the difference between cover being accepted, and not, I think they ought to have directed Mrs K to get more information from the treating team before proceeding. And, they also didn't identify the original non-disclosure which ought to have been obvious given that no medical conditions had been declared.

I think Mrs K was upfront and honest about the situation. And I think she gave a reasonable answer to the question about surgery, procedures and tests bearing in mind what she was told in the first call and what I think it's most likely they were told at the hospital. I think what's she said is consistent with the information she gave in the call to Great Lakes and with the information in the consultant's letter.

Based on all of the above I don't agree Mrs K failed to take reasonable care in the re-screening call.

Putting things right

I'm intending to say that Great Lakes should refund the additional premium Mr and Mrs K paid when they took out the upgrade to the policy. I think Great Lakes ought to have directed them to get more information rather than proceeding to cover the condition and take an additional premium. I don't think that was treating

Mr and Mrs K fairly.

I'm also intending to direct Great Lakes to reassess Mr and Mrs K's claim within 28 days of my final decision. This reassessment will be on the basis that they took reasonable care when answering the re-screening questions in March 2023 but didn't take reasonable care when they took out the policy. At that time Mr K had been free of symptoms for a year and had no further treatment, appointments or tests planned.

Great Lakes hasn't said whether it would have covered Mr and Mrs K if they'd declared the circumstances surrounding Mr K's gallbladder in June 2020. Great Lakes should rescreen for cover on the basis that Mr and Mrs K made a careless misrepresentation when they took out the policy (not a reckless and deliberate misrepresentation).

Mrs and Mrs K ought to be aware that in line with the relevant legislation that doesn't mean that their claim will necessarily be paid in full. It will depend on whether Great Lakes would have offered them cover if the condition had been declared and/or whether they'd have been charged more for the policy. If Great Lakes wouldn't have offered them cover at all then their claim will not be paid but they will receive a refund of the premium they paid. But if Great Lakes would have offered cover, but at a higher price, the relevant law says they can pay a proportionate settlement of the claim.

If Mr and Mrs K are unhappy with the outcome of the retrospective screening or the settlement of their claim, they may be entitled to make a further complaint to the Financial Ombudsman Service.

Great Lakes didn't respond to my provisional decision. Mr and Mrs K didn't agree with my findings. In summary, they said that Mr K was sure he was asked during the original sales process if he'd had medical conditions in the last 12 months. They highlighted that it was the 12 month timeframe which was used in the subsequent phone call and Great Lakes had made a number of mistakes. They also said that they failed to see how an innocent person could be found guilty of deceit. They said that at no time was it their intention to defraud anyone or act illegally.

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.

The further comments in response to my provisional decision haven't changed my thoughts about the overall outcome of the complaint.

I've taken into account what Mr and Mrs K have said about the question they were asked when the first took out the policy and the issues they've highlighted in relation to the general handling of their claim.

They say they were asked to disclose conditions from the previous 12 months when they took the policy out. I've thought about what is most likely to have been asked. Based on the evidence available to me I think it's more likely that they were asked to disclose conditions in the previous two years. I can see that the policy terms, on page 13, refers to the two-year timeframe. So, I think it's unlikely that the question wouldn't have reflected the same timescale referred to in the terms. And, the evidence Great Lakes has provided also shows that the two-year timeframe was used.

Although Mrs K was asked about conditions in the previous 12 months during the call that doesn't mean that was the same question asked at the point of sale. During the call she was amending the existing policy. So, it doesn't automatically follow that the question asked in the phone call was the same one that was asked at the time the policy was taken out.

Taking all of this information and evidence into account I think it's more likely that Mr and Mrs K were asked to declare conditions within the previous two years at the time they took the policy out.

As I said in my provisional decision, I don't think that the misrepresentation at the point of sale was deliberate or reckless. I think it was more likely to have been an honest mistake which was why I considered it to be a 'careless' misrepresentation. That reflects the language used in the relevant legislation that I need to consider and is not intended to suggest that Mr and Mrs K acted dishonestly when taking out the policy.

I'm not suggesting that Mr and Mrs K have committed a fraudulent act or acted illegally. In my provisional decision I said that Mrs K had also been honest and upfront when she contacted Great Lakes by phone to complete the rescreening. I don't think she was trying to defraud Great Lakes and I think she took reasonable care during that call when answering the questions. That's why I'm directing Great Lakes to refund the additional premium to her as I don't think they treated Mr and Mrs K fairly during that call.

Putting things right

I'm directing Great Lakes to refund the additional premium Mr and Mrs K paid when they took out the upgrade to the policy. I think Great Lakes ought to have directed them to get more information rather than proceeding to cover the condition and take an additional premium. I don't think that was treating Mr and Mrs K fairly.

I'm directing Great Lakes to reassess Mr and Mrs K's claim within 28 days of my final decision. This reassessment will be on the basis that they took reasonable care when answering the re-screening questions in March 2023 but didn't take reasonable care when they took out the policy. At that time Mr K had been free of symptoms for a year and had no further treatment, appointments or tests planned.

Great Lakes hasn't said whether it would have covered Mr and Mrs K if they'd declared the circumstances surrounding Mr K's gallbladder in June 2020. Great Lakes should rescreen for cover on the basis that Mr and Mrs K made a careless misrepresentation when they took out the policy (not a reckless or deliberate misrepresentation).

As I said in my provisional decision Mrs and Mrs K ought to be aware that in line with the relevant legislation that doesn't mean that their claim will necessarily be paid in full. It will depend on whether Great Lakes would have offered them cover if the condition had been declared and/or whether they'd have been charged more for the policy. If Great Lakes wouldn't have offered them cover at all then their claim will not be paid but they will receive a refund of the premium they paid. But if Great Lakes would have offered cover, but at a higher price, the relevant law says they can pay a proportionate settlement of the claim.

If Mr and Mrs K are unhappy with the outcome of the retrospective screening or the settlement of their claim, they may be entitled to make a further complaint to the Financial Ombudsman Service.

My final decision

I'm upholding Mr and Mrs K's complaint and direct Great Lakes Insurance SE to put things

right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K and Mrs K to accept or reject my decision before 25 August 2023.

Anna Wilshaw
Ombudsman