DRN-4810590

The complaint

Mrs S and Mr U are unhappy that Inter Partner Assistance SA (IPA) declined their travel insurance claim.

Mr U is the lead complainant on this complaint. For ease, I'll refer to Mr U mainly in this decision even though the policy was in joint names with Mrs S and Mr U.

Any reference to IPA includes all its agents.

What happened

On 26 July 2023, Mrs S and Mr U went on their holiday. They arrived at their destination and then purchased an annual multi-trip travel policy on the same day. IPA was the underwriter on the policy.

Mrs S was unwell unfortunately and was admitted into hospital. Mr U contacted IPA to start a claim for Mrs S's medical expenses. It said the claim couldn't be covered as Mrs S and Mr U bought the policy after the trip had already started.

Unhappy with IPA's response, Mr U brought the complaint to this service. He says IPA should've told him at the outset that the claim wouldn't be covered and he's incurred medical costs which could've been avoided. Our investigator didn't uphold the complaint. He said he'd looked at how the claim had been handled and he thought IPA had acted reasonably and in line with the policy terms.

Mr U disagreed. He asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

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.

Industry rules set out by the regulator (the Financial Conduct Authority) say that insurers must handle claims promptly and fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when making my final decision about Mrs S and Mr U's complaint.

I understand Mr U isn't disputing that he should've purchased the policy before their trip started. His dispute is that IPA should've told them whether they had cover for the medical expenses as soon they contacted it on 30 July 2023. They say the costs they incurred could've been avoided.

I've considered the information provided by both parties, including the claim notes. Call recordings between Mr U and IPA were requested, but IPA hasn't been able to provide them. So I've based my decision on the available evidence.

- Mr U contacted IPA's medical team on 30 July 2023 at 03:08am. He informed IPA that his partner was on her way to hospital as she was unwell, and he couldn't

accompany her because he was with their small child. The advisor informed Mr U that once cover was confirmed, IPA would provide everything that's medically necessary. As Mr U didn't know the hospital name that Mrs S was being taken to, the advisor asked Mr U to call back and let IPA know.

- At 09:17am on the same day, the hospital informed IPA that the policy was purchased after Mrs S and Mr U arrived at their holiday destination, so it wasn't valid. The hospital and IPA said Mrs S should be moved to a public hospital. IPA sent Mr U an email to confirm this.

- Mr U had two further calls with IPA at 09:30am and at 09:45am on the same day and said he was very unhappy about not being told he didn't have cover and that his policy was invalid.

- On 11 August 2023, Mr U made a complaint to IPA.

Mr U says had he been told at the outset that the policy was invalid, they would have gone to a public hospital and applied for a health card. Instead, he's incurred a substantial financial cost for Mrs S being treated at a private hospital. Mr U made a payment for the medical costs on 30 July 2023. He believes IPA is directly responsible for the loss they've incurred.

While Mr U says he realises the policy should have been purchased prior to travelling, he says he should've been told by IPA that there was no cover for the medical expenses at the outset, to avoid the costs they've incurred. Mr U thinks IPA took responsibility for the claim and then denied it.

I've looked at the process IPA followed when Mr U made the first call to it at 03:08am. I can see a claim was opened. Mr U explained Mrs S was on her way to the hospital and he wasn't accompanying her because he was with their young child. At this point, it wasn't known if Mrs S would be admitted or what hospital she was going to. The advisor said cover would be confirmed once the medical information was provided, she explained what documents would be needed to proceed and IPA will wait to receive the hospital name.

A few hours later, at 09:17am, the hospital informed IPA that the policy wasn't valid. IPA spoke to Mrs S and confirmed the policy wasn't valid and she needed to go to a public hospital. Mr U spoke to IPA a further two times and said he wasn't happy that he was informed the policy wasn't valid.

IPA sent an email that same morning to Mr U to confirm what he could do in this situation and provided details of how he could apply for a Global Health Insurance Card (GHIC).

I've considered Mr U's comments carefully. Based on the information provided, I can't see that IPA hadn't managed Mr U's expectations about the cover available. IPA said cover will be confirmed once the required documents were provided. At this point, IPA wasn't aware of the hospital that Mrs S was going to. So, I'm not persuaded that IPA didn't manage expectations appropriately. We would expect an insurer to take the policy holder's details and confirm cover once the required information is received. Until these details are received, it's not unusual for insurers not to validate cover at this point. As soon as the hospital informed IPA the policy wasn't valid, it informed Mrs S and Mr U. An email to Mr U followed the call which confirmed there was no cover available and to transfer Mrs S to a public hospital. It provided information on how to apply for a (GHIC) which would cover Mrs S's medical expenses. I can't see there were any delays in communicating this to Mrs S and Mr U. This is the process I would expect IPA to have followed and I'm therefore satisfied it acted fairly and reasonably. No arrangements were made as far as I can see to move Mrs S to a public hospital. But I do appreciate, by this point, it might not have been

possible to do this physically.

Mr U says he felt his claim had been confirmed on the first call. However, I don't agree. There's nothing in IPA's notes of the call which suggest that cover had been confirmed. IPA logged the claim, but it hadn't validated the claim as it needed further information before it could do so. In this case, the hospital informed IPA the claim wasn't valid and there was no delay caused in communicating this. As soon as IPA was informed, it contacted Mrs S and Mr U to inform them and provided options for them and followed this up with an email to Mr U. In the meantime, Mrs S had the treatment at the same hospital.

I don't think IPA could have confirmed cover until it received all the information it needed. However, I've thought about Mr U's comments that he would've been able to manage his costs had IPA informed him the claim wasn't covered on that first call. The notes of that call confirm Mr U didn't know which hospital Mrs S was being taken to or whether she was going to be admitted. So, even if he'd known the claim wasn't covered, it's unclear what Mr U would have done to manage those costs at the beginning. Mrs S was already on her way to the hospital requiring medical treatment.

Mr U says if IPA had asked him when the policy was purchased, it would've known that there was no cover straightaway. I do understand but the situation was not usual where the policy was purchased after the trip had already started. So while IPA could've asked the question, I also see why it didn't and I don't think that's unreasonable.

I appreciate that Mr U feels strongly about the claim not being covered and not being informed of this at the outset. But it's an unusual situation where a travel policy is taken out after having arrived at a destination. I also do understand that the medical costs are difficult to bear. But my role is to look at the evidence available and make a decision based on that evidence.

Overall, I'm sorry to disappoint Mrs S and Mr U, but I don't think IPA did anything incorrectly in the first call. In the circumstances of this complaint, I'm satisfied that IPA has treated Mrs S and Mr U fairly and reasonably. It follows therefore that I don't require IPA to do anything further.

My final decision

For the reasons given above, I don't uphold Mrs S and Mr U's complaint about Inter Partner Assistance SA.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs S and Mr U to accept or reject my decision before 22 August 2024.

Nimisha Radia
Ombudsman