DRN-4829988

The complaint

Mrs D and the estate of Mr D complain that Astrenska Insurance Limited has turned down a medical expenses claim Mr and Mrs D made on a travel insurance policy.

Mr K has brought this complaint on Mrs D and the estate of Mr D's behalf. But for ease of reading, I'll refer to Mr and Mrs D.

What happened

In September 2022, Mr D took out an annual multi-trip travel insurance policy online, through a broker I'll call S. The policy covered Mr and Mrs D. The policy documentation showed that Mr D hadn't made any medical declarations when he purchased the policy.

Mr and Mrs D travelled abroad. Unfortunately, in October 2022, Mr D became very unwell whilst he and Mrs D were on holiday and he was admitted to hospital. He was diagnosed with congestive heart failure, triple vessel disease, hypertension, atrial fibrillation and a type of heart attack. The treating doctors concluded that Mr D needed cardiac surgery.

So a medical expenses claim was made on Mr and Mrs D's policy. Astrenska let Mrs D know that it would need to obtain Mr D's medical records before it could confirm cover. In the meantime, it asked her to sign a guarantee of expenses without admission of policy coverage form (WAL). This meant that Astrenska would agree to pay Mr D's expenses but that if the claim was later found not to be covered, Mrs D agreed to repay its outlay. Mrs D signed and returned the WAL form.

Sadly, Mr D's condition deteriorated and he passed away in early November 2022, whilst he was still abroad in hospital. Astrenska covered the cost of Mr D's funeral overseas.

Once Mr D's medical records were received, Astrenska fully assessed the claim. It noted that Mr D suffered from seven medical conditions which it considered he ought to have declared at the time of sale. These conditions included atrial fibrillation; impaired contractility, hypertension and high cholesterol. Mr D was prescribed medication for the treatment of these conditions. Astrenska considered these particular conditions were linked to the cause of Mr D's claim. And it considered that Mr D had deliberately or recklessly failed to disclose his medical conditions when he took out the policy. So it concluded that Mr D's claim wasn't covered and, in July 2023, it let Mrs D know that it would be taking steps to recover roughly £85,000 of medical expenses it had paid out.

Mrs D was very unhappy with Astrenska's decision and she complained. She said Mr D had declared his existing conditions and the relevant medication he took. But Astrenska maintained its stance. However, it acknowledged that there'd been an unreasonable delay in turning down the claim and so it offered to pay Mrs D £200 compensation to reflect this.

Remaining unhappy with Astrenska's stance, Mrs D asked us to look into this complaint.

Our investigator considered the available evidence. And he concluded, on balance, that the information indicated that Mr D hadn't declared his medical conditions when he took out the

policy. The investigator felt Mr D ought to have declared his medical history and that Astrenska's conclusion that his failure to do so was deliberate or reckless was reasonable. So the investigator didn't think it had been unfair for Astrenska to turn down this claim.

Mrs D disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 14 May 2024, which explained the reasons why I didn't think it had been unfair for Astrenska to turn down Mr and Mrs D's claim. I said:

'First, I'd like to offer Mrs D my sincere condolences for the loss of Mr D. It's clear she and Mr D found themselves in a very worrying and upsetting situation and I was very sorry to hear about the circumstances of this claim.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the law; the terms of the insurance contract; and the available medical evidence, to decide whether I think Astrenska handled Mr and Mrs D's claim fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. 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.

When Mr D took out the policy online, he was asked information about himself and Mrs D and relevant medical conditions they'd had. Astrenska used this information to decide whether or not to insure Mr and Mrs D and if so, on what terms.

Astrenska says that Mr D didn't correctly answer the questions he was asked during the online sales process. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these principles to the circumstances of this claim.

And Astrenska thinks Mr D failed to take reasonable care not to make a misrepresentation when he took out the policy online. So I've considered whether I think this was a fair conclusion for Astrenska to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions the underwriter asked a consumer were. In this case, Mr D took out the policy through S – which was responsible for the sale of the policy. S maintains Mr D took out the policy online and it's provided me with a copy of the online sales process it says Mr D followed. I appreciate Mrs D thinks Mr D may have taken out the policy over the phone with S. But S has consistently told Astrenska that the policy was purchased online and I think it's reasonable for Astrenska to rely on S' version of events. Particularly given S wasn't able to locate any calls from Mr D around the time of sale, despite Astrenska's search request. I note Mrs S has already made a complaint to S about the sale of the policy and it issued a final response to that particular complaint in August 2023.

The online sales process shows that Mr D would have been shown a screen called 'Medical Declaration'. This included the following questions:

- *'Are you or anybody to be insured on this policy currently receiving or has received in the last 12 months, any advice, medication or treatment for any diagnosed illness, injury or disease?*

  Illness (e.g. High Blood Pressure, glaucoma, diabetes)
  Disease (e.g. Parkinson's lung disease)'

- *Have you or anyone to be insured on this policy suffered from or received ongoing treatment for any heart and/or cancer condition in the last five years?*

- *Is anyone currently under investigation or awaiting test results for any diagnosed or undiagnosed medical condition?'*

Mr D was asked to answer yes or no to each of these questions. The policy quotation Mr D was sent briefly set out a medical declaration section which included a form of these questions. And the policy schedule Mr and Mrs D were sent after the sale had completed included a statement which said 'Medical conditions declared? No.' While I appreciate Mrs D says Mr D did declare his existing conditions at the time of sale, the available evidence from the time shows, on the balance of probabilities, that it's most likely Mr D didn't declare any medical conditions during the sales process.

In my view, the medical questions were asked in a clear, specific and understandable way and ought to have prompted a reasonable consumer to realise what information Astrenska wanted to know. Astrenska thinks Mr D ought to have disclosed a number of existing medical conditions. So I've looked carefully at Mr D's medical records to decide whether I think he took reasonable care to answer Astrenska's questions.

Mr D's medical notes show that his 'active problems' included severe dilation of his left atrium, mitral regurgitation, atrial fibrillation, glaucoma and essential hypertension. Mr D had also been referred to dermatology in September 2022 for multiple skin lesions. The records show too that Mr D was prescribed anticoagulant medication for atrial fibrillation; medication for a slow heart rate; medication for systolic dysfunction and hypertension; medication for high blood pressure and medication for gout and cholesterol. So the records indicate that Mr D had received ongoing treatment for cardiac conditions over the previous five years; that he'd been receiving medication for diagnosed illnesses over the 12 months before the policy was taken out and that he was under referral for investigation into skin lesions. Given the conditions I've noted and the medications Mr D was prescribed, I currently think it was fair for Astrenska to conclude that Mr D's medical conditions fell within the scope of its questions. I think too that Mr D ought reasonably have been prompted to answer 'yes' to the questions I've set out above.

Astrenska says that had Mr D answered the medical questions correctly, it wouldn't have offered him an insurance policy on the same basis. It's provided us with a retroactive medical screening to demonstrate that it would have offered cover on less favourable terms. In my view then, the available evidence suggests that Mr D did make a qualifying misrepresentation under CIDRA. So I think Astrenska is reasonably entitled to apply the relevant remedy available to it under the Act.

It's clear that Astrenska has classed Mr D's misrepresentation as deliberate or reckless. CIDRA states:

‘A qualifying misrepresentation is deliberate or reckless if the consumer—

(a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and

(b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.’

I think the questions Mr D was asked during the sales process and the information about medical conditions which was set out on the policy documentation ought to have made it sufficiently clear to Mr D that medical information was relevant to Astrenska’s assessment of risk. And, given the number of conditions he had and the medication he was prescribed, I don’t think it was unfair for Astrenska to conclude that Mr D knew that or didn’t care that he hadn’t answered the medical questions correctly. On that basis, I don’t think it was unreasonable for Astrenska to consider that Mr D had made a deliberate or reckless misrepresentation.

CIDRA says that in cases of deliberate misrepresentation, an insurer may avoid the contract, refuse all claims and retain the premium a policyholder has paid for cover. By turning down Mr and Mrs D’s claim and keeping the premium they paid for the contract, I find that Astrenska has acted in line with CIDRA. And I don’t think it’s turned down the claim in an unreasonable way. So while I sympathise with Mrs D’s position, I don’t think Astrenska acted unfairly when it decided to decline this claim.

Nonetheless, Astrenska accepts that there were unreasonable delays in it making and communicating its claims decision to Mrs D. This took place around eight months after the claim had first been made and I don’t doubt how upset and concerned Mrs D must have been when she learned Astrenska intended to recover the medical expenses it had paid out. So while I don’t think it was unreasonable for Astrenska to ultimately decline the claim, I do think it ought to have reasonably made and communicated this decision much sooner. And therefore, I currently think it was reasonable, appropriate and proportionate for Astrenska to offer to pay Mrs D £200 compensation to reflect the trouble and upset this delay caused her. If Astrenska hasn’t yet paid Mrs D this amount, it should now do so.

I understand Mrs D also has concerns about the way Astrenska’s medical assistance team handled this claim. This isn’t a concern Astrenska has previously had an opportunity to look into and so it wouldn’t be appropriate for me to consider it here. If Mrs D would like to make a new complaint about that particular issue alone, she should contact Astrenska to do so before we can potentially consider it.’

I asked both parties to provide me with any further evidence or comments they wanted me to consider.

Astrenska confirmed it had nothing more to add.

Mr K confirmed that Mrs D had received my provisional decision and told us that the matter was with Mrs D’s solicitor. We asked whether or not the solicitor intended to make representations or respond to the provisional decision. However, Mr K told us that Mrs D expected me to proceed. He said the matter was with Mrs D’s solicitor in relation to dealings with the insurer. Neither Mr K nor Mrs D made any substantive comments or representations on my provisional findings.

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, as neither party has provided me with any further substantive evidence or comments, I see no reason to depart from 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 it was fair for Astrenska to turn down this claim and that it's already made a fair offer of compensation.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D and the estate of Mr D to accept or reject my decision before 3 July 2024.

Lisa Barham
Ombudsman