DRN-5066889

The complaint

Ms H complains that Inter Partner Assistance SA (IPA) has turned down a medical expenses claim she made on a travel insurance policy.

What happened

Ms H held an annual travel insurance policy which provided European cover.

In July 2023, Ms H was abroad in a country I'll call A, which wasn't in Europe. On 31 July 2023, she called IPA's medical assistance team because she had experienced a back spasm. She told IPA's call handler that the pain had worsened and her movement was affected. IPA's call handler told Ms H to call an ambulance and provided her with the name of a local treating facility in A.

Ms H was accordingly taken by ambulance to hospital and admitted for treatment. IPA sent Ms H a claim pack and sent the hospital a verification of benefits email, which confirmed Ms H had a valid insurance policy. I understand Ms H also had to pay a deposit of $500.

IPA subsequently looked into Ms H's claim and obtained medical evidence. It originally declined the claim because it said Ms H had misrepresented her health at the outset.

Ms H was very unhappy with IPA's position and she disputed its decision. She felt IPA had confirmed at the outset that all of her costs would be covered. She said that two of the conditions it had referred to had been diagnosed after the policy had been purchased and that she hadn't required treatment or diagnosis for the third condition. She asked us to look into her complaint.

Following Ms H asking our service for help, IPA confirmed that as the policy only provided European cover, Ms H's claim would never have been covered. But it offered to pay her £300 compensation, along with a refund of the premiums she'd paid for her cover.

Our investigator thought Ms H's complaint should be upheld. In brief, she thought it was most likely IPA had told Ms H that all of her costs would be covered. And she thought it had been reasonable for Ms H to rely on IPA's call handler's advice. So she recommended that IPA should pay Ms H's medical bills, together with £300 compensation.

IPA disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 20 September 2024, which explained the reasons why I didn't think IPA had treated Ms H fairly. I said:
'The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account - along with other relevant considerations, such as regulatory guidance and principles; the policy terms and the available evidence – to decide whether I think IPA handled this claim fairly.

I've first considered the policy terms, as these form the basis of the contract between Ms H and IPA. I can see from Ms H's policy schedule that she took out annual European cover.

The policy terms set out the countries which IPA considers to be Europe and it's clear that A isn't one of those countries. On that basis then, given all of Ms H's costs were incurred in A, on a strict interpretation of the policy terms, it's clear that the medical expenses claim isn't covered under the contract.

However, I can depart from a strict interpretation of the policy terms if I consider their application produces an unfair result. That's the case here, for reasons I'll go on to explore.

Both parties accept that Ms H called IPA on 31 July 2023, the day she was taken to hospital. Ms H says she was told that all of her costs would be covered. It's unfortunate that IPA doesn't have a copy of the call so I can listen to exactly what was said. I do have a copy of the case opening pack IPA's call handler sent Ms H after the call. The accompanying cover letter says that IPA will send a verification of benefits letter to the treating hospital to prove a policyholder has valid insurance. The letter says: 'It does not guarantee that we will cover the expenses, only that you hold a valid insurance with us. Case coverage will be decided once we have determined whether your situation meets the terms and conditions of your policy.'

Based on the case opening pack and the information stated in it, I find it's less likely that Ms H was told that her medical expenses were guaranteed to be paid.

But, in my view, the key pieces of evidence in this case are IPA's written notes of Ms H's contact with it, in particular, its notes of a call, dated 31 July 2023, at 13.46. The note says: 'She is currently in (A).' It sets out Ms H's symptoms and states that Ms H was 'not able to move.' The note goes on to say: 'I asked her to call an ambulance and provided a facility she can go to.'

It's clear that during this call, the call handler took Ms H's details and located her policy on IPA's systems. It's also clear that the call handler knew which country Ms H was in. As the expert in the situation, I think the call handler was best placed to tell Ms H upfront that her policy didn't provide any cover for costs she incurred in A and that if she sought medical treatment, she'd need to self-fund it.

Instead, the call handler directed Ms H to call an ambulance, which took her to the hospital the call handler recommended. I can see that Ms H called IPA to let it know where she was and was told to send it her medical report. I've also seen a copy of the email IPA sent Ms H later that day confirming that it had sent the hospital a verification of benefits email. Again, at both of these further points of action, IPA, as the expert in the situation, could have let Ms H know that her costs wouldn't be covered by her policy.

It seems to me then that based on the information IPA's call handlers gave Ms H and the information it sent to the hospital; it was reasonable for her to believe that she did have a valid insurance policy in place. And I also don't think it was unreasonable for her to rely on the medical assistance team's suggestion to call an ambulance. Once she'd done so and had been admitted to hospital, she was in the hands of the treating doctors with a view to investigating and treating her symptoms. I appreciate that Ms H's policy schedule did state that she only had European cover, but given the chain of events, in this particular case, I think it's fair to say that IPA had at least three chances to point out the geographical limitations of this contract. It didn't do so.

IPA says that even if it had pointed out the lack of cover in A, Ms H would still have incurred the treatment costs. Ms H says if she'd known she wasn't covered, she'd have rested in bed for a couple of days to see if her symptoms improved. In my view, this is entirely plausible. And it's also entirely possible that rather than calling an ambulance or going to hospital, Ms H may have sought treatment with a primary care physician or at a pharmacy, thus

significantly reducing her potential costs. Based on what I've seen (and in the absence of the call recording), it appears Ms H called an ambulance based on what IPA told her to do rather than because she felt she needed one.

So, on these specific facts, it seems to me that Ms H's losses broadly flowed from IPA's failure to highlight her lack of cover and from its suggestion that she call an ambulance and go to hospital. On that basis, I find that IPA has significantly prejudiced Ms H's financial position.

I appreciate IPA says it would never have offered Ms H cover if she'd accurately represented her medical conditions when she took out the policy. I note it's provided no medical evidence at all to show any potential misrepresentation at the point of sale. But even if it had, given the chances it had to mitigate Ms H's financial losses from the outset, I may still conclude that the complaint should be upheld.

Overall, I currently don't find that it was fair or reasonable for IPA to turn down Ms H's claim. I'm mindful too that over the past year, Ms H has received regular chasers from the hospital and debt collection agencies, she's been given differing reasons for the claim decline, and it appears too that Ms H has had to chase IPA up for updates. So in addition to its unfair decision to decline this claim, I also think IPA has caused Ms H avoidable, material trouble and upset for which it should pay compensation.'

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

Ms H said she had nothing to add and IPA let us know that it accepted 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 Ms H had nothing more to add and as IPA accepted my provisional findings, I see no reason to change them.

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

Putting things right

I find that IPA must:

• Settle Ms H's claim in line with the remaining terms and conditions of the policy and any applicable excesses;

• Add interest at an annual rate of 8% simple to any of the medical expenses Ms H has already settled directly, from four weeks after the claim was made until the date of settlement*; and

• Pay Ms H £300 compensation.

*If IPA considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Ms H how much it's taken off. It should also give Ms H a tax deduction certificate if she asks for one, so she can reclaim the tax from HM Revenue & Customs if appropriate.

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 Inter Partner Assistance SA to put things right as I've set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms H to accept or reject my decision before 5 November 2024.

Lisa Barham
Ombudsman