DRN-5176503

## The complaint

Mrs D and Mr S are unhappy that Inter Partner Assistance SA (IPA) declined a claim made on their annual 'silver plus' travel insurance policy.

## What happened

I issued a provisional decision explaining why I wasn't intending to uphold Mrs D and Mr S' complaint. I said:

…….

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

That includes IPA's regulatory obligation to handle insurance claims fairly and promptly. And to not unreasonably decline a claim.

It also includes The Consumer Insurance (Disclosure and Representations) Act 2012 ('CIDRA'). This 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 (in this case IPA) 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.

I know Mrs D and Mr S feel very strongly about what's happened, and I appreciate they will be very disappointed, but I'm satisfied that IPA has acted fairly and reasonably by declining the claim for the costs associated with their son's first hospital admission whilst abroad.

Did Mrs D and Mr S make a misrepresentation?

IPA has provided the online process, it says, Mrs D and Mr S would've followed when applying for the policy they ended up with. In the absence of anything to the contrary, I accept that the questions asked in the example online journey I've been provided are likely to be the ones answered by Mrs D and Mr S when applying for the policy.

One of the eligibility questions asks:

> Within the last 2 years has anyone you wish to insure on this policy suffered any

> medical or psychological condition, disease, sickness, illness or injury that has required prescribed medication (including repeat prescriptions) or treatment including surgery, tests or investigations?

I'm satisfied that this question is clear, that Mrs D and Mr S answered it 'no' and that IPA has fairly and reasonably concluded they answered the question incorrectly.

IPA has relied on entries in Mrs D and Mr S's son's medical records reflecting that he was seen by a GP and prescribed medication. I've taken into account Mrs D and Mr S's submissions on those consultations and even if I accepted what they say, I'm satisfied that IPA has fairly and reasonably concluded that Mrs D and Mr S's son was seen in hospital for a respiratory condition in the two years before applying for the policy for which he received treatment.

So, I think Mrs D and Mr S reasonably ought to have answered 'yes' to the eligibility question referred to above and they misrepresented the answer to that question.

Was this a 'qualifying' misrepresentation?

I've considered whether this amounted to a qualifying misrepresentation under CIDRA. And I find that it did.

I'm satisfied that if the eligibility question referred to above had been answered correctly, Mrs D and Mr S wouldn't have been able to take out the silver plus policy they ended up with. I'm satisfied from what I've seen that they would've received an alert to return to the quotation page to add any medical conditions and then, on the balance of probabilities, would've been presented with different types of travel insurance policies.

I think that's also supported by the demands and needs statement which appears at page 3 of the silver plus policy booklet which says:

> Annual multi trip – This policy meets the Demands and Needs of a customer intending to travel more than once within the period of insurance, wishing to buy a standard travel insurance policy, who has not suffered a medical condition nor required prescribed medication, surgery, treatment, tests or investigations within the two years leading up to the policy purchase date.

So, I find that the answer to the eligibility question referred to above mattered to IPA.
I think Mrs D and Mr S acted carelessly when answering this question (as opposed to deliberately giving the wrong answer or acting recklessly when answering it).

I've looked at the actions IPA can take in line with CIDRA and it's entitled to do what it would've done if Mrs D and Mr S hadn't made a careless qualifying misrepresentation. As I'm satisfied that silver plus policy wouldn't have been offered to them, I think it's fair and reasonable for IPA to not pay the claim in respect of their son's first hospital admission. That's because the policy wouldn't have been in place and so IPA doesn't have to cover any claims.

Usually in cases like this, I would expect to see the insurer refund the premiums.
However, Mrs D and Mr S's son was again admitted to hospital during the same trip abroad (for a different reason) and IPA did agree to cover the associated costs of that second hospital admission. As I'm satisfied this policy wouldn't have been in place, it wasn't required to do that. So, I'm satisfied IPA acted fairly and reasonably by doing so in this case.

As the value of the claim in respect of the second admission to hospital was more than the

premium paid for the policy, I don't think it would be fair and reasonable for me to direct IPA to refund the premium to Mrs D and Mr S.

I've considered all points made by Mrs D and Mr S including what they say about the reason their son needing medical attention abroad wasn't related to any conditions not declared when taking out the policy. However, I don't think that's relevant to the reason why the claim in respect of the first hospital admission was declined. The silver plus policy wouldn't have been in place had the eligibility question been answered correctly when applying for the policy, so no claim could've been made on it.

I've also considered the newspaper article provided by Mrs D and Mr S. However, each case is different, and I've focused on the circumstances of this complaint when deciding whether IPA has acted fairly and reasonably.

Claim handling

IPA accepts that it should've provided Mrs D and Mr S with better service at times. It says it didn't proactively update them, meaning Mrs D has to chase for updates. Further, Mrs D didn't get call backs as promised. IPA paid £150 compensation.

Mrs D and Mr S also say that that they were given incorrect information and were told by one of IPA's representatives that the claim in respect of the first hospital admission would be paid, when it hasn't been.

I haven't been provided with other evidence to support what Mrs D and Mrs S says about that. However, even if that's right and IPA caused further unnecessary upset and disappointment as a result, it has agreed to pay the claim in respect of their son's second admission to hospital which for reasons set out above, it didn't have to. Even taking into account the premium which hasn't been refunded, I think the value of the claim is more than any additional compensation I would be minded to direct IPA to pay Mrs D and Mr S for further distress and inconvenience caused by being giving incorrect information (if that was the case) and any other service failings caused by IPA.

So, I don't think IPA has to do anything more to put things right.

……..

I invited both parties to provide any further information in response to my provisional decision.

IPA replied to say that it agreed with my provisional findings.

Mrs D and Mr S disagreed and raised several points in reply. In summary they said:

- When applying for the policy, they answered all questions honestly as no-one had any pre-existing medical conditions.
- As their doctor agreed, the policy wording was misleading which ultimately led them to provide incorrect information.
- IPA had acted in error on several occasions.

**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, I'm satisfied that there's no persuasive reason to depart from my provisional findings.

I'd considered the points raised by Mrs D and Mr S and the documents they've provided in response to my provisional decision when provisionally deciding this complaint.

I remain satisfied that the eligibility question asking about medical conditions when applying for the policy (and referred to in my provisional decision) is clear and that Mrs D and Mr S answered it 'no'.

For reasons set out in my provisional decision, I remain satisfied that IPA has fairly and reasonably concluded Mrs D and Mr S answered that question incorrectly and that the answer to the question mattered to IPA in this case. If they'd answered it 'yes' as I think IPA has reasonably concluded they should have, they wouldn't have been offered the policy they bought.

IPA accepts that it should've provided Mrs D and Mr S with better service at times, and I've explained in my provisional decision why £150 compensation fairly reflects the impact this had on them.

I know Mrs D and Mr S will be very disappointed. But for the reasons set out above and for reasons set out in my provisional decision (an extract of which is set out in the 'what happened' section of my decision and forms part of this final decision), I don't think IPA has to do anything more to put things right in this case.

**My final decision**

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D and Mr S to accept or reject my decision before 26 December 2024.

David Curtis-Johnson
**Ombudsman**