DRN-5221205

The complaint

Miss F complains that Astrenska Insurance Limited voided her travel insurance policy and declined to pay her claim for her child's medical costs.

What happened

Miss F took out an annual multi-trip travel insurance policy on 27 October 2022 through a seller. The policy was underwritten by Astrenska. Miss F was the policyholder, and her child (who I'll call Master G) was insured under the policy. The cover period was between 27 October 2022 and 26 October 2023.

Miss F and Master G travelled abroad on 20 November 2022, and they were due to fly back on 13 December 2022. But unfortunately, Master G fell ill whilst abroad, and needed medical treatment. He was first admitted to hospital on 25 November 2022, and from then on, had several emergency admissions which led to Miss F and Master G missing their original return flight home.

Astrenska said it would repatriate Miss F and Master G back to the UK, but Miss F didn't think this would be safe for Master G due to his medical concerns. So, Astrenska said it would pay for an appointment to assess if Master G was fit to fly. There were several medical reports in January 2023 which showed that Master G wasn't cleared for international travel. And on 24 January 2023, Astrenska's medical team agreed Master G wasn't fit to fly.

Miss F disputed that Astrenska had said she had arranged one of the appointments to assess if Master G was fit to fly without authorisation, so it refused to pay for it. Astrenska said it would only pay for appointments it had authorised. However, Miss F said this appointment had been arranged by Astrenska, so it should pay for it.

After accepting Master G wasn't fit to fly, Astrenska requested his previous medical history from his GP on 3 February 2023. Whilst waiting for this, Miss F asked Astrenska to pay for specific treatment for Master G, recommended by a doctor on 16 February 2023. But Astrenska said that this wasn't emergency treatment as per the policy terms, so this wasn't covered by the policy. Miss F didn't agree, and she provided further medical reports from 4 April 2023 onwards which said the treatment was medically necessary.

Astrenska received Master G's previous medical history on 25 February 2023, and its Chief Medical Officer ("CMO") reviewed these on 27 February 2023. Following this, Astrenska said Master G had a condition that Miss F should have declared when she took out the policy – namely, reflux. It carried out a retrospective screening to see what impact this would have had if Miss F had made a medical declaration for this condition at the point of sale. Having done so, Astrenska said that had Miss F declared this condition, and answered the follow up questions correctly, it wouldn't have offered a policy at all.

Astrenska told Miss F on 22 March 2023 that it was likely her claim would be declined, and it notified the local agent not to accept any costs going forward on 23 March 2023. Astrenska formally voided Miss F's policy from inception in its letter dated 8 April 2023 (but this was sent to Miss F on 17 April 2023) due to misrepresentation. Astrenska is asking Miss F to repay the costs it has already paid – over £50,000.

Miss F said that she had told the sales agent about the reflux, but as Master G had got the 'all clear' from a doctor and he wasn't on any medication, the sales agent said this didn't need to be declared. Unhappy with Astrenska's response, she brought a complaint to our service. Miss F wants Astrenska to cover all medical costs until Master G is fit to fly.

One of our investigators looked into what had happened. In short, he thought Miss F should have declared Master G's previous medical history. And had she done so, he was satisfied Astrenska wouldn't have offered her the policy. So, he didn't think Astrenska had acted unfairly or unreasonably in voiding the policy. But he reminded Astrenska that it should refund Miss F the premium she paid (or deduct this from any amount it was seeking to recover from Miss F).

He also thought it was most likely Astrenska had arranged the appointment to assess if Master G was fit to fly, so he thought it would be fair and reasonable for Astrenska to deduct the cost of this appointment from the amount it was seeking to recover from Miss F. But he didn't think Astrenska had acted unfairly or unreasonably in declining to pay for the specific treatment at the time, as he thought it had fairly said this wasn't emergency treatment as per the policy terms.

Miss F didn't accept the investigator's findings. In summary, she said:

- She did disclose Master G's previous medical condition, but the sales agent made a mistake in saying it didn't need to be declared.
- If Astrenska was correct to void the policy, it should have done so much sooner, and this would have allowed her to place Master G on a local health insurance policy sooner, saving her significant costs.
- She shouldn't pay for any of the appointments arranged by the insurer.

Astrenska responded to say it was satisfied with the investigator's findings and didn't have any further comments to add. As no agreement was reached, the complaint was passed to me to decide, and I issued my provisional decision in September 2024. After reviewing new evidence and comments from both parties, I issued another provisional decision in December 2024. I have included the contents of both decisions below.

My provisional decision in September 2024:

"Did Astrenska act fairly and reasonably when it voided the policy?

Firstly, this complaint is against Astrenska, who is the underwriter of the policy. So, whilst I've referred to some actions by the seller, these are simply set out for background. I cannot make a finding against the seller under this complaint.

Astrenska says Miss F should have declared Master G's reflux when she took out the policy. And had she done so, it would have asked her further questions about Master G's medical history. It said that had Miss F answered these correctly, it wouldn't have offered her a policy.

So, I think the key considerations under this complaint are the principles set out in the Consumer Insurance (Disclosure and Representations) Act 2012 ("CIDRA"). This is designed to make sure that consumers and insurers get an appropriate remedy if a policyholder makes what is called a "qualifying misrepresentation" under the act.

A misrepresentation is a "qualifying misrepresentation" when 1) a consumer fails to take reasonable care not to misrepresent facts which the insurer has asked about, and 2) the insurer shows that without the misrepresentation it would not have entered into the contract at all or would have done so only on different terms.

I've first looked to see if Miss F failed to take reasonable care. The standard of care required is that of a reasonable consumer. And one of the factors to be considered when deciding if a consumer has taken reasonable care is how clear and specific the questions asked by the insurer were.

Miss F took out the policy in person through a seller. While doing so, she was asked the following question:

> *"Do you, or anyone on the policy have any medical conditions to declare, or are you/they taking any prescribed medication?"*

Astrenska says Miss F failed to take reasonable care when she answered this as "no" because Master G had been diagnosed with reflux. And had she answered "yes", she would have been directed to take out the policy over the phone or online, and she would have been asked further questions about Master G's medical history.

Miss F says that she told the sales agent about the reflux but Master G had been given the 'all clear' by the doctor. Miss F says the sales agent said the reflux didn't need to be declared in this situation. However, the policy was taken out on 27 October 2022, and the 'all clear' was given the next day, on 28 October 2022. Miss F has since clarified that she told the sales agent that the reflux had got better since changing Master G's milk.

I've reviewed Master G's medical records, and I can see that there had been a likely diagnosis of reflux. He had also visited A&E twice, which included being observed at a ward, due to feeding problems in September 2022. Master G had also been prescribed medication for the reflux, but he wasn't taking this at the time the policy was sold.

Firstly, Astrenska has explained that any potential advice given by the sales agent is the responsibility of the seller, and not Astrenska as the underwriter. Overall, Miss F needed to take reasonable care when answering the questions asked when taking out the policy.

I've thought about the question she was asked. I think the question is clear that medical conditions need to be declared, although it's not specific about what is meant by a medical condition. But it's clear that Miss F knew Master G had been diagnosed with reflux and he'd been admitted to A&E twice the previous month due to issues regarding feeding (including choking, vomiting and breathing difficulties).

I appreciate Master G's symptoms had got better after changing his milk. And I can see from Master G's medical notes that a health visitor had commented on 12 October 2022 that changing Master G's milk had made a massive difference, and there were no further choking episodes.

Miss F was asked about "any medical conditions to declare". I think a reasonable consumer would understand this to mean something significant and/or ongoing. Considering Master G's diagnosis and the severity of his symptoms just the previous month before taking out the policy, I think a reasonable consumer would have considered this to be something that the insurer needed to know about based on the question it asked.

That means that I currently think Miss F failed to take reasonable care when she answered the above question "no". Astrenska has explained that had Miss F answered the question "yes", she would have been directed to buy the policy over the phone or online, and she would have been asked to make a medical declaration. So, I've considered those questions next.

Astrenska says Miss F would first have been asked the following questions:

"Q1. Have you been prescribed medication in the last 2 years whether you are taking it or not? This includes tablets (including Morphine based pain killers), inhalers or injections.

Q2. Do you currently routinely visit a GP, hospital or clinic for check-ups/consultations or treatments? This includes annual reviews or reviews once every 2 years for a condition.

Q3. Are you visited by a doctor or nurse, or carer for check-ups or treatment (including dressings being changed)?

Q4. Have you been admitted into hospital or undergone surgery in the last 2 years?

Q5. Have you received treatment for heart, stroke, or respiratory related illness in the last 2 years?

Q6. Are you currently waiting for any results of tests/investigations or awaiting any consultations or referrals or on any waiting lists?"

Astrenska says Miss F should have answered Q1 and Q4 as "yes" as Master G was prescribed two different over the counter medications for his reflux, and he'd been admitted into hospital in September 2022. I can see that Master G was prescribed medication on 7 and 23 September 2022. Master G also attended A&E on 13 and 23 September 2022, and it looks like he was admitted to a ward during both visits for observation. So, I think it would have been reasonable for Miss F to answer Q1 and Q4 as "yes".

This would then have led to Miss F having to make a medical declaration for Master G's reflux. Miss F would have first been asked the following question about the reflux:

"How old is the person with this condition?"

As Master G was under a year old, the option Astrenska would have selected was "12 or younger". This would have led to Astrenska recording the condition as "paediatric gastro-oesophageal reflux", with final two questions being asked as follows:

"How many unplanned hospital admissions has the child had for this condition in the last 12 months?

Has this condition caused any problems with breathing?"

Astrenska says Miss F should have answered the first question as "more than 1" and the second as "yes". Had she done so, the medical score for the condition would have meant Astrenska wouldn't have offered the policy at all.

Master G visited the A&E first on 12 September 2022, but he was asked to return by a doctor on 13 September 2022. The medical notes suggest he was admitted to a ward for observation during this time, requested by the doctor. The medical notes for these visits refer to vomiting, ongoing feeding issues, and the diagnosis is recorded as "proven feeding problems in newborn".

However, there are no discharge notes from the ward. But Miss F has said that Master G went to the ward for observation. Astrenska has said this would have been considered to be an admission for screening purposes at the point of sale.

Master G visited the A&E again on 23 September 2022 and I can see discharge notes from the ward on that day. The medical notes for this visit refer to choking, going purple, vomiting and a diagnosis is recorded again as "proven feeding problems in newborn". The discharge note from the ward refers to "likely reflux".

So, it looks like Master G was admitted to a ward twice in September 2022 following a visit to the A&E. Miss F has also said Master G went to a ward on both occasions. Based on everything I've seen so far, I think it would have been reasonable for Miss F to answer the question "How many unplanned hospital admissions has the child had for this condition in the last 12 months?" as "more than 1".

The above notes also refer to choking and Master G going purple. There are also several referrals in the medical notes about Master G going blue and choking during feeding. Overall, I think it would have been reasonable for Miss F to answer the question "Has this condition caused any problems with breathing?" as "yes".

For the reasons I've set out above, I currently think Miss F failed to take reasonable care not to make a misrepresentation. I'm also satisfied Astrenska has shown that without the misrepresentation it wouldn't have offered her the policy. So, that means I think Miss F made a qualifying misrepresentation.

Astrenska hasn't shown she did so recklessly, which means it should apply the remedy under CIDRA for careless misrepresentation. This means that in the circumstances, Astrenska can void the policy from inception, but it must return the premium Miss F paid for the policy. Astrenska has agreed to do so.

That also means that, in effect, Miss F didn't have a policy in force when she travelled abroad. So, strictly speaking, Astrenska isn't liable for any costs involved with the claim. However, my remit is to decide what's fair and reasonable in all the circumstances of a complaint.

<u>Did Astrenska handle Miss F's claim fairly and reasonably?</u>

Whilst I don't currently think Astrenska acted unfairly or unreasonably when it voided the policy due to misrepresentation, I don't think it handled Miss F's claim fairly and reasonably for a significant period of time leading up to that decision. And I currently think this had a significant impact on Miss F. I'll set out the key events and my provisional findings below.

The first phone call Astrenska had with Miss F was on 27 November 2022, after Master G had been admitted to hospital. The notes of the call say that "The baby had similar symptoms when he was born. Then was diagnosed with reflux." Another call note on 29 September 2022 says the case had been referred to underwriter for assessment. It was also noted that Miss F "states that the child once had reflux when he was 1 week old but that she tried to declare it but the lady on the phone said its fine, there's no need".

Based on the above, I think Astrenska was aware of Master G's previous diagnosis of reflux already in November 2022. But I can't see that it requested his previous medical history from the GP until 3 February 2022. This was after Astrenska's medical team had accepted Master G wasn't fit to fly back home. It accepted this on 24 January 2022, and asked Miss F's consent for the medical records on 26 January 2022 – which it received on 1 February 2023.

I'd expect an insurer to request the previous medical history from a GP as soon as possible to allow it to validate a claim. Based on what I've seen so far, I don't think Astrenska acted fairly or reasonably when it didn't do so as soon as it became aware of Master G needing medical treatment abroad in November 2022. Instead, it requested these two months after Master G had first been admitted to hospital.

Astrenska also only did so after accepting Master G wasn't it to fly back home. It would have been aware of how expensive the treatment was in the country where Miss F was travelling in. So, it would have known that there were likely significant costs involved with the claim – and if Astrenska would decline the claim, these costs would need to be borne by Miss F.

Additionally, in the circumstances of this complaint, Astrenska was already aware that Master G had previously been diagnosed with reflux. So, if it had concerns about validating cover, I think it would have been fair and reasonable for Astrenska to request the information about Master G's previous medical history much sooner than it did.

I can see that Miss F told Astrenska on 19 January 2022 that she wanted to cancel the policy and put Master G on his father's local health insurance plan. Miss F has explained she wasn't able to do so while this policy was in force. So, Astrenska was aware that Miss F wanted to mitigate any financial impact, and she had options to do so – but she was restricted by the policy she held with Astrenska.

Astrenska received the medical records from the GP on 25 February 2023, and these were reviewed by the CMO on 27 February 2023. However, it wasn't until 22 March 2023 that Astrenska said it was likely the claim would be declined, and the policy wasn't formally voided until 17 April 2023 (in a letter dated 8 April 2023). I don't think Astrenska acted fairly or reasonably in taking almost two months to formally void the policy, after it had the information to show Miss F had made a misrepresentation when she bought the policy.

I currently think the delay in Astrenska requesting the previous medical history, and then in voiding the policy when it had the information to do so, meant that Astrenska prejudiced Miss F's position, and prevented her from mitigating her financial losses. So, I don't think it would be fair or reasonable for Astrenska to seek to recover all of its costs from Miss F.

It's difficult to say for certain what costs Miss F would have incurred even if Astrenska hadn't delayed anything. It would have taken some time for Astrenska to receive information from Master G's GP regardless (here it took about three weeks), but I think Astrenska should also have made it clear to the GP how important it was to get the information as soon as possible.

Miss F has shown that Master G now holds two local health insurance policies. One was approved on 12 September 2023 and backdated to 1 May 2023. The other was approved on 7 December 2023 and backdated to 1 June 2023. Miss F says there would have been other options available for Master G earlier, but I haven't seen evidence of these. However, I accept it would be difficult to prove what insurance may have been approved for him earlier.

That said, based on what I've seen, I'm persuaded it's likely Miss F would have been able to place Master G on a local health insurance policy sooner, and I don't currently see a reason why it wouldn't have been backdated – same as the two policies he's on now. This would have meant Miss F would have likely had some, if not all, of Master G's medical costs covered by a local health insurance policy.

Overall, I don't think it would be fair or reasonable for Astrenska to seek to recover all of its costs from Miss F. This is because due to the delays it caused in how it handled the claim, I think Astrenska prejudiced Miss F's position and prevented her from mitigating her financial losses. I accept there may have been costs she would still have had to pay because a local health insurance policy is likely to be different to a travel insurance policy. For example, Miss F says the policies don't cover ambulance costs. I invite both parties to make representations on this aspect in response to my provisional decision – I'll set this out further in the "putting things right" section below.

I've also considered that the significant delay caused by Astrenska would have caused Miss F significant distress and inconvenience. It's clear that she was highly concerned about Master G's health, and the unnecessary delays would have contributed to this worry for several months. It would also have been frustrating when she'd asked Astrenska to cancel this policy, but it didn't do so until several months later.

I've also listened to a call Miss F had with Astrenska on 22 March 2023, when it told her it had suspected for quite a long time that Master G should be able to fly. However, it's not clear why it would make such a statement, considering there were several medical reports saying he wasn't fit to fly – including on 13 January 2023, 19 January 2023 (by Astrenska's chosen doctor), 26 February 2023, and 22 March 2023. And Astrenska's medical team had agreed Master G wasn't fit to fly on 24 January 2023. Miss F was understandably very distressed about this statement made by Astrenska.

Overall, I think Astrenska caused Miss F significant distress and inconvenience in how it handled the claim and policy voidance.

<u>Outstanding treatment that wasn't covered</u>

It's unclear why Astrenska said it wouldn't pay for one of the appointments to assess if Master G was fit to fly, and that it hadn't arranged it. Its own claim notes clearly show it had been in touch with a few providers to arrange this, and the medical report for the appointment says it was scheduled by insurance company for flight clearance. So, I agree with our investigator that it would be fair and reasonable for Astrenska to pay for the appointment on 13 January 2023, as this ended up being an additional appointment arranged by Astrenska.

Miss F has also complained that Astrenska didn't authorise specific treatment for Master G. Astrenska says it didn't consider this to be emergency treatment as per the policy terms.

The policy terms explain that "this policy is not private medical insurance; we cover treatment which cannot wait until you return home from your trip, with the aim of ensuring you are well enough to return to the UK". The description of cover under the "Emergency Medical Expenses" says that "this section covers medical expenses, up to the sum insured, if during your trip abroad you become ill or suffer an injury and it is necessary to receive treatment from a medical practitioner as an inpatient or outpatient".

Master G received a diagnosis of a new condition in early January 2023. The specific treatment is in relation to this diagnosis. But I've seen an email which Miss F forwarded to Astrenska on 7 January 2023 which said this treatment wouldn't be recommended due to the risks involved, and how this could potentially cause harm.

There was also a further report on 16 February 2023 that recommended the specific treatment to improve medical events and manage the condition. However, I don't think Astrenska acted unfairly or unreasonably when it said this didn't show the treatment was emergency medical treatment as per the policy terms at the time.

I say this because there was conflicting evidence whether or not this treatment was necessary. Some doctors recommended it, whilst others didn't due to the risks involved. The medical evidence also referred to the treatment being to improve and manage the condition, rather than it being emergency treatment as per the policy terms. Overall, I don't think Astrenska acted unfairly or unreasonably when it declined to pay for Master G's specific treatment.

I note that there was one further report on 4 April 2023 commenting on the medical necessity of the specific treatment – which was two weeks before Astrenska voided the policy. However, Astrenska had already made Miss F aware that it would be declining the claim, so I don't think it acted unfairly or unreasonably when it didn't consider this report – nor would I expect it to do so now. It was also only shortly after this report when Astrenska voided the policy, and Miss F was in a position to make alternative arrangements to seek treatment and coverage for Master G. But I have taken this two-week gap into account when considering what's a fair and reasonable way to resolve Miss F's complaint.

Summary of my findings

Here's a summary my key provisional findings:

- *Astrenska became aware on 27 November 2022 that Master G had previously suffered from reflux, and on 29 November 2022 that Miss F hadn't declared the reflux. However, Astrenska didn't seek to validate the claim until 3 February 2023, when it requested Master G's previous medical history.*
- *Astrenska became aware on 19 January 2023 that Miss F wanted to cancel the policy and mitigate any financial impact, and she had options to do so.*
- *Astrenska had the information to void Miss F's policy on 25 February 2023, but it didn't do so until 17 April 2023.*

I think these delays caused Miss F detriment, which could have been avoided, had Astrenska sought to validate the claim, and then void the policy, as soon as possible. I'm persuaded it's likely Miss F could have placed Master G on a local health insurance policy sooner, and that it would have been backdated.

Overall, due to how Astrenska handled Miss F's claim and policy voidance, I currently think it should bear the costs that would have been covered by a local health insurance policy instead, as well as the costs for any appointments specifically arranged by Astrenska, from the start of the claim until the policy was voided on 17 April 2023.

As I'm minded to direct Astrenska to bear these costs, despite the policy being void, I don't think it would be fair for me to ask it to refund the premium Miss F paid for the policy or pay her compensation for the significant distress and inconvenience caused separately.

Putting things right

Subject to further representations from the parties, I intend to direct Astrenska to take the following action. For simplicity, I'm intending to direct Astrenska to "pay" for costs – however, if it's already done so, then it should simply not seek to recover these costs from Miss F.

- *Pay for the appointment on 13 January 2023.*
- *Pay for any appointments specifically arranged or requested by Astrenska.*
- *Pay the costs that would have been covered by a local health insurance policy from the start of the claim up until 17 April 2023 on provision of the relevant policy cover information from Miss F.*
- *Recover the costs that Miss F would have incurred even if it hadn't caused any delays. These are costs wouldn't have been covered by a local health insurance policy.*

Miss F has explained that the hospital has granted her financial assistance to pay for some of Master G's medical costs. So, Astrenska may be able to recover some of its costs from the hospital. I'll leave it up to Astrenska if it wishes to do so."

My provisional decision in December 2024:

"Astrenska agreed with the decision I'd reached on misrepresentation, but it disagreed with some of my findings. I've summarised its key arguments as follows:

- *Master G's presenting issues were breathing difficulties. And whilst reflux was mentioned from the outset, this isn't typically associated with causing breathing issues. So, Astrenska didn't consider it necessary to conduct a retrospective screening at this point as it wasn't viewed as being directly or indirectly related to the presenting problem.*
- *It wasn't until 18 January 2023 that the medical information indicated that there may have been similar episodes of breathing issues prior to the purchase of the insurance, and the medical consent form was sent that day.*
- *Astrenska explained to the GP the urgency of the medical records when it requested these on 3 February 2023, and it chased these on 14 February 2023.*
- *Astrenska accepts that it was clear that there was relevant pre-existing medical history once the GP records were received on 25 February 2023. However, it was essential for reviews and enquiries to take place to reach an informed decision about coverage. Astrenska says it also had to rely on third parties when determining this, and it also required approval from the underwriters before the formal declinature letter was sent. But it says Miss F was aware on 22 March 2023 that the claim may be declined.*
- *It was a matter of choice for Miss F whether or not to arrange a local health insurance policy for Master G, and there is no indication on Astrenska's file that its involvement prevented her from doing so.*
- *Astrenska isn't responsible for the collection of premiums or any policy administration, which means it could not provide advice about this or action any cancellation. Miss F needed to discuss this with the seller of the policy.*
- *Miss F didn't have a local health insurance policy in force prior to 1 May 2023, and it would be impossible for Astrenska to assess and determine which costs may have been covered under a hypothetical policy, underwritten by different company operating outside of the UK. Astrenska considers this recommendation unreasonable in the circumstances.*

- *Astrenska says the appointment it arranged took place on 18 January 2023, and it didn't arrange the one on 13 January 2023. As things stand, it has paid for the appointment for 13 January but it hasn't been billed for the appointment on 18 January. Astrenska doesn't think it should be held liable for the appointment for 13 January, but it will pay for the appointment on 18 January if it receives an invoice for it.*
- *Any costs already settled by Astrenska in good faith prior to coverage being declined should be reimbursed by Miss F.*

Miss F accepted the outcome set out in my provisional decision. I requested further information from her in relation to the local health insurance policies as per my provisional decision. Having done so, the following has become apparent:

- *Master G didn't qualify for the policies that allowed cover to be backdated from an earlier date.*
- *The only option Miss F says she had was to place Master G on a private health insurance policy through his father's insurance. However, this also didn't offer an option to backdate his cover.*

As both parties have now had the opportunity to respond to my provisional decision, I've considered everything again. As the above changes my findings, I'm issuing a second provisional decision.

What I've provisionally 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.

Misrepresentation

As neither party has given me anything new to consider in relation to misrepresentation, I see no reason to change my findings on this aspect of Miss F's complaint. So, I think Miss F made a qualifying misrepresentation that was careless. That means that Astrenska can void the policy from inception, but it must return the premium Miss F paid for the policy. Astrenska has agreed to do so.

Claim-handling

I've considered all the points Astrenska has raised, but these don't change my overall findings that I think it caused significant delays in how it handled the claim and policy voidance. I'll explain why.

As I set out in my provisional findings, the notes of the first call Miss F had with Astrenska on 27 November 2022 said that "The baby had similar symptoms when he was born. Then was diagnosed with reflux." But the notes above this said that "Mother called last Friday when the baby started experiencing breathing difficulties and turning purple." So, I think Astrenska should have been aware from the outset that Master G had experienced similar symptoms (breathing difficulties) previously and he had been diagnosed with reflux.

And in any event, I think a Astrenska should have requested the previous medical history from Master G's GP as soon as possible to allow it to validate the claim. I don't think Astrenska acted fairly or reasonably when it didn't do so as soon as it became aware of Master G needing medical treatment abroad on 27 November 2022.

Astrenska says it sent a medical consent form for Miss F to sign on 18 January 2023, but the records I've seen show this request was made on 26 January 2023 and Miss F returned the form on 1 February 2023. Astrenska then sent a request for medical records to the GP on 3 February 2023. I set these dates out in my provisional decision based on the evidence on file.

I can see that Astrenska requested an "early" response from the GP in its request for medical records on 3 February 2023. And I'm glad to see it chased this over the phone on 14 February 2023. But considering the concern Astrenska had about the validity of the claim and the costs involved, I don't think this was enough in the circumstances. Naturally, I don't know for certain if further emphasis or chasers would have made a difference. But I think it's more likely than not that the GP records would have been received sooner, had Astrenska done more.

I appreciate that Astrenska would have needed some time to assess the records, as well as carry out a retrospective screening. But I'm not persuaded this should have taken as long as it did.

Astrenska says it had to rely on third parties, and it needed approval from the underwriter, before it could formally decline the claim. Aside from the GP, Astrenska has referred to the administrator of the policy as well as the underwriter. But I don't think it's fair for Astrenska's internal processes, or its agreements with third parties, to unreasonably delay a claim when the decision itself lies with Astrenska as the insurer. I think it's more likely than not that had Astrenska acted more promptly, it would have been in a position to void Miss F's policy much sooner than it did.

I haven't set out a timeline of when I think the above would reasonably have happened because I don't think this makes a difference to the outcome of the complaint. I'll explain why in the next section.

<u>The impact on Miss F</u>

Miss F accepts she wouldn't have been able to place Master G on a policy that offered backdated cover any sooner than she did. She also accepts the only option she had was to place Master G on his father's policy. Master G's father's policy offered enrolment in November each year, or on an exceptional basis in certain life events, including losing health coverage.

I've looked at the official information about the requirement for losing health coverage that allows for enrolment outside the normal health insurance application period. However, I haven't seen persuasive evidence to show that Master G held qualifying health coverage to allow him to be added on his father's policy before November 2023.

So, based on what I've seen, I currently don't think Astrenska's delays led to a financial loss for Miss F. I haven't seen persuasive evidence to show that she would have been able to place Master G on another health insurance policy before 17 April 2023. That means that I don't think I can fairly ask Astrenska to pay for Master G's medical costs as I think it's more likely than not that the costs would have been incurred even if Astrenska hadn't caused any delays.

That said, if there were any appointments specifically requested by Astrenska, I think it should pay for these. This is because had it voided the policy sooner, these aren't costs Miss F would have incurred.

I had already considered who had arranged the appointment on 13 January 2023 when I reached my provisional findings. And the report for the appointment says it was scheduled by the insurance company for flight clearance. So, I think it's more likely than not that it was arranged by Astrenska, and I think it should bear the cost of the appointment.

But aside from financial losses, for the reasons I set out in my previous provisional decision and above, I think the unnecessary delays and how Astrenska handled the claim caused Miss F substantial distress and inconvenience over several months.

Whilst I now don't think Astrenska's actions caused Miss F financial loss, it still caused her significant worry and uncertainty about options available to her. And this was whilst worrying about the health of her baby. I also referred in my first provisional decision to a phone call that would have been very distressing for Miss F. To put things right, I think Astrenska should pay her £3,000 as compensation.

Putting things right

I'm currently minded to direct Astrenska to take the following action:

- *Pay Miss F £3,000 for the substantial distress and inconvenience caused*.*
- *Pay for the appointment on 13 January 2023.*
- *Pay for any appointments specifically requested by Astrenska.*
- *Refund Miss F the premium she paid.*

I haven't awarded interest on the above amounts because Astrenska paid for costs it didn't need to, which means Miss F hasn't had to pay for these when she should have done.

** Astrenska must pay the compensation within 28 days of the date on which we tell it Miss F accepts my final decision. If it pays later than this, it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% simple per annum."*

Neither party accepted my second provisional decision. I've summarised the key arguments from both parties below.

In short, Astrenska said the following:

- It's essential for it to rely on formal medical reports before requesting GP records. Taking this measured approach prevents unnecessary delays and complications to both the patient and healthcare providers.
- Astrenska didn't directly request any appointments, so other than the appointment on 13 January 2023, it won't be liable for any other appointments.
- The award for distress and inconvenience is disproportionate in the circumstances of this complaint. And any award I make will be used to reduce Miss F's final balance, rather than pay it to her directly.
- Astrenska will attempt to seek to recover its costs from the providers who approved Master G financial assistance, subject to receiving the necessary information from Miss F. But if this is unsuccessful, it will seek to recover the remaining costs directly from Miss F.
- Astrenska will not seek to recover the costs from Miss F that were paid by a local agent after the claim was declined.

In short, Miss F said the following:

- The local agent already recovered the costs it paid after the claim was declined from the hospitals due to the financial assistance, so there would be nothing to recover by Astrenska regardless.
- Had Astrenska cancelled the policy after her request on 19 January 2023, she would have been able to place Master G on another policy by 1 February 2023.
- Had Astrenska not delayed voiding the policy, she would have been able to apply for financial assistance sooner.
- Astrenska didn't cancel the policy with the providers, which prevented Miss F from getting another policy or financial assistance, as it appeared she had a valid policy.
- Had Miss F paid the costs herself at the time, she would have got a significant self-pay discount, which should be taken into account.
- Overall, Miss F doesn't think she should be liable for the costs, and Astrenska should recover its costs directly from the providers.
- Any compensation award for distress and inconvenience caused should be paid directly to her, so she can manage any bankruptcy application effectively.
- Astrenska's actions had a significant negative impact on her and Master G's health.

I've only summarised both parties' arguments above, but I've considered everything they've said and provided when reaching my final decision.

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.

For clarity, I've only considered Astrenska's actions in relation to this complaint up until 18 April 2023, which is when it issued its final response letter. If Miss F is unhappy with Astrenska's actions after this, she can raise these as a new complaint to Astrenska in the first instance.

Misrepresentation and outstanding treatment that wasn't covered

Neither party has given me any new persuasive evidence in relation to these issues. So, I see no reason to change my findings on these aspects of Miss F's complaint. That means that I've reached the same decision, for the reasons I did in my first provisional decision.

I think Astrenska acted fairly and reasonably when it voided the policy from inception, but it must return the premium Miss F paid for the policy, as it has agreed to do. Considering there's a significant balance outstanding, I think it's fair and reasonable for Astrenska to deduct the premium from the final balance after any other deductions have been made.

As for the specific treatment that wasn't authorised, I don't think Astrenska acted unfairly or unreasonably when it declined to pay for this at the time.

Claim-handling

I've considered the comments Astrenska made, but these don't change the findings I reached in my provisional decisions, for the reasons I did. Overall, I think Astrenska should have requested Master G's previous medical records as soon as possible after it became aware of Master G needing medical treatment abroad on 27 November 2022. And I think it should have done more to chase the GP for those records. Lastly, I think Astrenska should have acted more promptly to void Miss F's policy.

Had Astrenska done so, I think it's likely it would have been in a position to void the policy much sooner than it did. But I haven't set a timeline of when I think this would reasonably have happened because I don't think this makes a difference to the outcome. I'll set this out in the next section.

Miss F has also said that Astrenska should have cancelled the policy after she said she wanted to do so on 19 January 2023, as she wanted to add Master G on his father's policy. But I can also see that Miss F expressed concern about Master G's father's policy during a phone call with Astrenska on 3 February 2023. This is based on Astrenska's contact notes. But crucially, I'm not persuaded this makes a difference to the outcome of the complaint, for the reasons I'll set out in the next section.

The impact on Miss F

Miss F has provided a lot of information on the options she would have had, had Astrenska voided or cancelled her policy sooner. But it's important to bear in mind that when deciding a complaint, I need to decide what I think is most likely to have happened at the time. This means that I need to avoid applying the benefit of hindsight, as well as deciding what *could* have happened.

On 19 January 2023, the contact notes show that Miss F wanted to add Master G on his father's policy. I set out my findings on this in my second provisional decision, and explained why I'm not persuaded Master G could have been added on his father's policy.

Miss F has since referred to other routes to add Master G on a policy. However, it's my understanding that Master G wouldn't have been eligible for these policies as he didn't have eligible immigration status at the time. So, I'm not persuaded that Miss F would have been able to add Master G on his father's policy, or any other policy Miss F has since referred to.

Miss F has explained that she had financial assistance approved by two providers – one in September 2023 and the other in May 2024. Both were backdated to December 2022. She says she would have been able to apply for these sooner if she didn't have an active policy in place. It looks like these are based on household/family size and income.

However, I'm also mindful that Miss F has explained that Master G's father's financial situation changed in June 2023. She has also referred in another context to being counted as two house income due to her immigration status. It also looks like it took some time for the financial assistance to be approved regardless. And I haven't seen persuasive evidence in the contemporaneous notes that this was an option. Overall, I'm not persuaded Miss F would have been able to arrange this before 17 April 2023 (when the policy was voided), even if Astrenska had voided or cancelled the policy much sooner.

That means that if Astrenska had stopped paying for Master G's treatment earlier, I'm not persuaded that Miss F would have been able to pay for this at the time or have any coverage in place. So, when Astrenska continued to pay for the treatment, there was no break in treatment and Miss F didn't have the financial burden of it at the time. Because of this, I don't think it would be fair for me to direct Astrenska to bear those costs.

Miss F mitigated her position by obtaining financial assistance after Astrenska considered her complaint. And Astrenska has said it will attempt to seek to recover its costs from the providers that approved Master G's financial assistance, subject to receiving the necessary information from Miss F. But if this is unsuccessful, it will seek to recover the remaining costs directly from Miss F. This is a matter for Miss F and Astrenska to arrange.

Miss F has said that had she paid the costs herself, she would have had a significant discount for the self-pay rate. However, I think Astrenska is entitled to recover the costs it paid from Miss F. Miss F can ask the providers for the self-pay invoices instead, where appropriate. However, this is for her to arrange.

Astrenska doesn't think an award of £3,000 for the distress and inconvenience caused is proportionate. But firstly, it's important to bear in mind that this all happened whilst Miss F's baby was unwell, and in need of treatment. So, she would have been more vulnerable to any unnecessary distress and inconvenience caused by Astrenska in the circumstances.

For the reasons I've set out in my decisions, I think Astrenska caused significant delays (first in validating the claim and then voiding the policy), leading to significant worry and frustration during that time. The uncertainty of claim coverage would also have caused significant worry due to the cost of health services. I also set out my findings about a distressing statement Astrenska made to Miss F during a phone call on 22 March 2023 in my provisional decision.

It's clear that the distress and inconvenience caused by Astrenska in this complaint had a substantial impact on Miss F at the time and continues to do so. I'm not persuaded to change the award I set out in my second provisional decision.

Astrenska says it will use any award for distress and inconvenience to reduce Miss F's debt. However, Miss F says this should be paid directly to her. I've considered what's fair and reasonable in all the circumstances of this complaint. Considering the significant amount Astrenska is seeking to recover from Miss F, which she says she's unable to pay, I think a fair and reasonable outcome is for Astrenska to reduce Miss F's debt by £3,000, to reflect the distress and inconvenience caused. This should be done to the final balance, after any other deductions are made, to reduce Miss F's financial burden.

Lastly, Astrenska has said it will not seek to recover the costs from Miss F that were paid by a local agent after the claim was declined. However, Miss F says that the local agent has already recovered these costs from the providers directly.

Putting things right

Astrenska should take the following action:

- Reduce Miss F's debt (final balance) by £3,000 to recognise the substantial distress and inconvenience caused.
- Pay for the appointment on 13 January 2023.
- Pay for any appointments specifically arranged or requested by Astrenska, if any.
- Refund Miss F the premium she paid.

I haven't awarded interest on the above amounts because Astrenska paid for costs it didn't need to, which means Miss F hasn't had to pay for these when she should have done.

Astrenska may pay any of the amounts by reducing Miss F's final balance, rather than pay these directly to her.

My final decision

My final decision is that I uphold Miss F's complaint in part. I direct Astrenska Insurance Limited to put things right in the way that I've set out in the "putting things right" section.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss F to accept or reject my decision before 20 February 2025.

Renja Anderson
Ombudsman