DRN-5372734

## The complaint

Mr and Mrs C complain about the way Inter Partner Assistance SA (IPA) has settled a medical expenses claim they made on a travel insurance policy.

## What happened

In January 2024, Mr and Mrs C took out a single trip travel insurance policy through a broker to cover a trip they had planned between 30 March and 6 April 2024. The policy was underwritten by IPA.

Unfortunately, while Mr and Mrs C were away, their two children, Master C and Miss C, both became unwell and in the early hours of 3 April 2024, they were admitted to hospital. Mr and Mrs C say Master C was diagnosed with bronchitis and Miss C was diagnosed with pneumonia.

So Mrs C called IPA's emergency medical assistance team to make a claim on the policy. Master C and Miss C were discharged from hospital on 4 April 2024, although Miss C required further outpatient treatment. Mr and Mrs C say the treating doctor told them to return to the hospital on the following day to obtain a fit to fly certificate and then to return home as soon as possible to try and prevent Miss C's condition from deteriorating.

Mrs C called the emergency medical assistance team. She says she was told she would get a call back. However, as Mrs C didn't hear anything more, she and Mr C organised early return flights and flew back to the UK on 5 April 2024.

As Mr and Mrs C had paid the treating hospital upfront for Master C and Miss C's treatment, they made a claim for their medical expenses following their return to the UK, as well as claim for the costs of their new flights and hospital benefit.

IPA accepted and partly settled Mr and Mrs C's claim. But it said Mr and Mrs C had failed to tell it about a pre-existing medical condition Miss C had suffered from and which it felt it should have been told about. (Although it didn't explain to Mr and Mrs C what the condition was). It considered that Mr and Mrs C had made a qualifying misrepresentation under relevant law because it said that if it had been told about Miss C's condition, it would have charged an additional premium. It concluded Mr and Mrs C had only paid 96% of the premium they ought to have paid. It said it had overpaid Mr and Mrs C for Master C and Miss C's medical expenses, and therefore, it didn't agree to pay any outstanding pharmacy bills or hospital benefit.

And IPA didn't agree to pay for the costs of Mr and Mrs C's new flights, because it said the emergency medical assistance team hadn't authorised the family returning to the UK early.

But IPA accepted that there'd been delays in its handling of the claim and so it paid Mr and Mrs C £150 compensation.

Mr and Mrs C were unhappy with the way IPA had settled their claim and so they asked us to look into their complaint.

Our investigator didn't think IPA had treated Mr and Mrs C fairly. She noted that IPA appeared to have charged an additional premium because it thought Mr and Mrs C ought to have told it about a dry cough Miss C had experienced. But she didn't think IPA had provided persuasive evidence of the additional premium it would have charged Mr and Mrs C had they told it about Miss C's cough. So she wasn't persuaded that IPA had shown Mr and Mrs C had made a qualifying misrepresentation under relevant law and she felt IPA should pay Mr and Mrs C's full medical expenses claim, plus interest.

The investigator also recommended that IPA should cover the costs of Mr and Mrs C's new return flights to the UK. That's because she felt Mr and Mrs C had followed the recommendation of their treating doctor in returning to the UK early and because she didn't think IPA had provided Mr and Mrs C with sufficient guidance. The investigator also recommended that IPA should pay Mr and Mrs C total compensation of £350.

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

I reviewed the complaint and asked for some more information from IPA about what had happened when Mrs C called IPA on 4 April 2024. Specifically, I asked for a copy of the call, a copy of the medical report Mrs C sent it and information about what recommendations IPA's clinical team would've given Mr and Mrs C about Miss C and Master C's fitness to travel/ongoing treatment.

Despite a number of chase requests, IPA hasn't provided the information I asked for. So I'm satisfied it's now appropriate to issue a decision based on the evidence I do have.

**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 don't think IPA has treated Mr and Mrs C fairly and I'll explain why.

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, amongst other relevant considerations, such as regulatory principles, the law, the available medical evidence and the policy documentation, to decide whether I think IPA handled this claim fairly.

*Has IPA shown Mr and Mrs C made a qualifying misrepresentation?*

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 and Mrs C took out the policy through a broker, they were asked a number of questions about the health and circumstances of the people to be insured under the policy. IPA used this information to decide whether or not to insure Mr and Mrs C and their children, and if so, on what terms. IPA says that Mr and Mrs C didn't correctly answer all of the questions they were asked during the application 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 Mr and Mrs C's claim.

IPA thinks Mr and Mrs C failed to take reasonable care not to make a misrepresentation when they applied for the policy. So I've considered the available evidence to decide whether I think this was a fair conclusion for IPA to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions asked by the insurer were. The post-sale documentation from the broker shows that during the sales process, Mr and Mrs C were asked:

*'Does anyone you'd like to insure need cover for a pre-existing medical condition? This might be where you have received prescribed medication or check-ups in the last 24 months.'*

If Mr and Mrs C had answered 'yes, they would have been asked more questions so IPA could decide whether or not to offer cover.

In my view, IPA's question is clear enough to prompt a policyholder to realise that IPA wants to know about any condition they've had in the past two years where they've been prescribed treatment or had a check-up. Mr and Mrs C took out the policy in January 2024, so the period January 2022 until January 2024 is relevant in this case.

IPA provided us with a copy of Miss C's medical records. These show that in October 2022, Mr and Mrs C sought medical advice on three occasions for Miss C because she was suffering from tonsillitis. And in March 2023, the GP notes 'emergency treatment', as Miss C had had a cough for the past month.

So it seems to me that Mr and Mrs C ought to have answered 'yes' to the above question in relation to Miss C's health. And therefore, I don't think IPA unfairly concluded that Mr and Mrs C had made a misrepresentation at the time of policy sale.

However, in order to rely on the relevant remedy available to it under CIDRA, IPA needs to show that the misrepresentation was a qualifying one. This means it needs to provide evidence that it would have offered cover on different terms, or not at all, if it had been aware of all relevant facts at the outset.

When IPA assessed Mr and Mrs C's claim, it told them that had it known about Miss C's conditions, it would have charged them an additional premium of £2.42. So it said Mr and Mrs C had paid 96% of the premium they ought to have done and it accordingly settled their claim proportionately.

Our investigator (repeatedly) asked IPA for evidence as to how this premium had been calculated and evidence of any retrospective screening it had carried out. But it simply provided an email from the broker which listed the condition it thought should have been declared and that Mr and Mrs C would have been charged an additional premium of £7.64.

But despite our requests, IPA hasn't provided us with sufficient evidence to show how either additional premium was calculated or what exactly was taken into account. I'd expect to see

an extract from underwriting guidance (or similar), a full copy of the retrospective screening which was carried out including all the questions asked and answers given with the new premium displayed and/or a statement from an underwriter, in order to be satisfied that IPA treated Mr and Mrs C fairly and in the same way it would have treated others in the same situation. I also note that the figures relating to the additional premium which IPA quoted in its final response letter and in its dealings with our service are different, which I find concerning. I appreciate that IPA is reliant on a third party to provide this information but it's IPA's responsibility to demonstrate that there has been a qualifying misrepresentation.

So, therefore, like the investigator, I'm not persuaded that IPA has shown Mr and Mrs C made a *qualifying* misrepresentation under CIDRA. So I don't think it's fair or reasonable for IPA to have made any proportionate deduction from the settlement it pays Mr and Mrs C.

This means I think IPA must now settle any medical expenses which it previously declined to pay as a result of settling the claim proportionately, in line with the contract and consider a hospital benefit claim. And it must add interest to any additional settlement it pays at an annual rate of 8% simple to the settlement from the date the claim was originally paid until the date of settlement.

*Was it fair for IPA to turn down Mr and Mrs C's claim for the new flights?*

I've carefully considered the policy terms and conditions, as these form the basis of the contract between Mr and Mrs C and IPA. Mr and Mrs C's claim was made under the medical expenses section of the policy. This says:

*'We will pay you up to the amounts shown in the Table of Benefits for the following expenses which are necessarily incurred during a trip as a result of you suffering unforeseen injury due to an accident, illness, disease and/or compulsory quarantine:*

- *With the prior authorisation of the Emergency Medical Assistance Service, the additional costs incurred in the use of air transport or other suitable means, including qualified attendants, to repatriate you to your home if it is medically necessary.'*

This isn't an unusual term in travel insurance policies. Most travel insurers will only cover a policyholder's early return if it's been pre-authorised and if its medical team consider early repatriation to be medically necessary.

IPA turned down Mr and Mrs C's claim for their new flight costs because it said its emergency medical assistance team hadn't authorised their early return to the UK and that it wouldn't have deemed an early return to be medically necessary.

I've thought about this very carefully. Mrs C says Miss C's treating doctor told her to return to the UK as quickly as possible due to the potential for her condition to deteriorate once she was taken off nebulisers. She says she called IPA for advice on 4 April 2024 and didn't get the call back she was promised. Therefore, she says she followed the doctor's advice and arranged new flights.

IPA's notes show Mrs C called the emergency medical assistance team on 4 April 2024 and that she was told to send through a medical report. The notes say that the report would be 'stepped up' to IPA's medical team. It isn't clear from the notes exactly when IPA received the medical report, but Mrs C says it was sent through that day. However, IPA's notes on 7 April 2024 say that the 'MR' (medical report) was already on file and that IPA was intending to ask Mrs C for a copy of the policy certificate.

Given the lack of detail in IPA's notes about what happened, I asked it to provide a copy of the call recording, a copy of the medical report and what its medical team's recommendations would have been in terms of Miss C and Master C's ongoing treatment needs. Despite being chased for this evidence, it hasn't been provided. I would remind IPA that the Financial Conduct Authority's Dispute Resolution Rules which govern the operation of our service grant the Ombudsman the power to require a party to provide evidence. DISP 3.5.9 entitles me to reach a decision on the basis of what has been supplied and take account of the failure by a party to provide information requested.

On that basis, I've placed significant weight on Mrs C's detailed and consistent testimony about what happened when she called on 4 April 2024. I think IPA, as the expert in the situation, had the chance to review the claim and let Mrs C know whether an early return would be covered. I also think it had the chance to give Mrs C guidance about next steps and what treatment might be appropriate for Miss C and Master C. It didn't do so. And it doesn't appear it made any call back to Mrs C either. Nor has IPA provided me with a copy of the medical report, so I haven't been able to consider what the treating doctor's recommendations were. Therefore, based on the circumstances of this individual case, I find it's fair to rely on Mrs C's account that she was told to arrange an early return for Miss C and that it was reasonable and appropriate for her to do so.

This means that while I accept Mr and Mrs C's new flight costs aren't strictly covered by the policy terms, I find it would be fair and reasonable for IPA to settle the costs, in line with the remaining terms and conditions of the policy. And I find too that IPA must add interest to the settlement of the flight costs from the date the claim was originally paid until the date of settlement.

*Fair compensation*

IPA acknowledges that it didn't handle this claim as well as it should have done. There were significant delays in its handling of the claim over many months. It paid Mr and Mrs C £150 compensation to reflect this.

However, like the investigator, I don't think this award goes far enough. Mr and Mrs C were abroad, with their children unwell and in hospital. I think IPA missed opportunities to give them support and guidance and it compounded this by causing significant delays in progressing the claim. I'm also mindful that despite Mrs C's requests, at no point did IPA explain the basis on which it had calculated the settlement proportionately. So I think IPA's actions are likely to have caused Mr and Mrs C additional, unnecessary trouble and upset over a few months.

So I agree that a fair and reasonable total award of compensation in these circumstances is £350 – which means IPA needs to pay Mr and Mrs C an additional £200.

**Putting things right**

I direct Inter Partner Assistance SA to:

- Settle the remainder of Mr and Mrs C's medical expenses claim, in line with the policy terms and conditions, with no proportionate deduction;
- Settle the costs of Mr and Mrs C's new flights, in line with the policy terms,
- Add interest to both of the above amounts at an annual rate of 8% simple from the date the claim was originally paid until the date of settlement+;
- Consider a claim for hospital benefit in line with the policy terms; and

- Pay Mr and Mrs total compensation of £350 (less the £150 it's already paid them) *.

+ If IPA considers that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr and Mrs C how much it's taken off. It should also give Mr and Mrs C a tax deduction certificate if they ask for one, so they can reclaim the tax from HM Revenue & Customs if appropriate.

* IPA must pay the compensation within 28 days of the date on which we tell it Mr and Mrs C accept 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% a year

**My final decision**

For the reasons I've given, my final decision is that I uphold this complaint and I direct Inter Partner Assistance SA to put things right as I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr C and Mrs C to accept or reject my decision before 25 July 2025.

Lisa Barham
**Ombudsman**